

CHAPTER 4

ACTUARIAL SERVICES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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

11:4-3.5 Guaranteed annual endowments

Guaranteed annual endowments shall not be included as benefits in policies entitled to participate in dividends.

11:4-3.6 Severability

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

11:4-3.7 Effective date

The effective date of this regulation shall be August 1, 1963.

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

11:4-4.1 General provisions

(a) Passbooks resembling those used for savings deposits in banks shall not be used in connection with policies to which this regulation applies which contain guaranteed annual endowment benefits.

(b) No reference shall be made in any material used in connection with such policies to "passbook" or "premium deposit" or other language which might give the impression to an applicant or person insured that the transaction involves premium deposits of a savings nature.

(c) The practice of using such books is determined to be an unfair method of competition and unfair or deceptive act or practice in the business of insurance in that it is a "statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby" as defined at N.J.S.A. 17B:30-3.

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-4.2 Unfair practice

The use of such books as described at N.J.A.C. 11:4-4.1(a) is determined to be an unfair method of competition and unfair or deceptive act or practice pursuant to N.J.S.A. 17B:30-18, and such books shall not be used in connection with policies to which this regulation applies.

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-4.3 Scope

(a) This practice shall be discontinued with respect to policies to which this regulation applies because it conflicts with N.J.S.A. 17B:25-5 which requires "that the policy constitute the entire contract between the parties".

(b) The reference to such language as "deposits" in such books, but not in the policy itself, is in conflict with the required provision that the policy constitute the entire contract.

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-4.4 Severability

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

11:4-4.5 Effective date

The effective date of this regulation shall be August 1, 1963.

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. RESERVE STANDARDS FOR INDIVIDUAL HEALTH INSURANCE POLICIES

11:4-6.1 Purpose

Pursuant to N.J.S.A. 17B:19-5, the Commissioner of Insurance is authorized to promulgate rules establishing the minimum reserve standards and mortality, morbidity or other contingency bases which must be utilized by health insurers to calculate policy and loss reserves. This subchapter establishes such regulations.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4-6.2 Scope

This subchapter applies to all insurers authorized to write health insurance in this State.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4-6.3 Definitions

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

“1959 Accidental Death Benefits Table” is the minimum standard for accidental death benefits adopted by the National Association of Insurance Commissioners.

“Active life reserve” is the pro rata unearned premium reserve and the additional reserve required to fund the current cost of the future health benefits.

“Claim reserve” is the present value of amounts not yet due on claims and reserves for future contingent benefits.

“1964 Commissioner’s Disability Table” is the minimum standard for total disability due to accident or sickness adopted by the National Association of Insurance Commissioners.

“Health Insurance” is defined at N.J.S.A. 17B:17-4.

“1974 Hospital Table” is the minimum standard for hospital expense benefits adopted by the National Association of Insurance Commissioners to replace the 1956 Inter-Company Hospital Table.

“1956 Inter-Company Hospital Table” is the minimum standard for hospital expense benefits adopted by the National Association of Insurance Commissioners.

“1956 Inter-Company Surgical Table” is the minimum standard for surgical expense benefits adopted by the National Association of Insurance Commissioners.

“Mortality table” is a table used to determine life expectancy.

“Morbidity table” is a table used to determine health expectancy.

“1974 Surgical Table” is the minimum standard for surgical expense benefits adopted by the National Association of Insurance Commissioners to replace the 1956 Inter-Company Surgical Table.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4-6.4 Active life reserve-general

(a) Active life reserves are required for all in-force policies and are in addition to any reserves required in connection with claims.

(b) This subchapter contains minimum standards for active life reserves. Higher, adequate reserves shall be established by the insurer in any case where experience indicates that these minimum standards do not place a sound value on the liabilities under the policy.

As amended, R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

This section was recodified from 6.1(a)-(c) with substantive changes.

11:4-6.5 Types of individual health insurance policies

(a) Type A are policies which are guaranteed renewable for life or to a specified age such as 60 or 65, at guaranteed premium rates.

(b) Type B are policies which are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the insurer reserves the right to change the scale of premiums.

(c) Type C are policies in which the insurer has reserved the right to cancel or refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue; however, policies shall not be considered of this type if the insurer has reserved the right to refuse renewal provided the right is to be exercised at the same time for all policies in the same category, unless premiums are based on the level premium principle.

(d) Type D are all other individual policies.

(e) The definitions set forth in (a) through (d) above do not classify “franchise” as a type of policy. Such policies are frequently written under an agreement limiting the insurer’s right to cancel or refuse renewal. Usually the right is reserved to refuse renewal of all policies in the group or other categories such as those ceasing to be members of the association, and this would place such policies in Type D in accordance with the last clause under (c) above. However, if premiums are based on the level premium principle or if the renewal undertaking for the individual meets the requirements for Type A, B or C, the franchise policy should be so classified for reserve purposes.

(f) A policy may have guarantees qualifying it as Type A, B or C until a specified age or duration after which the guarantees, or lack of guarantees, may qualify it as Type A, B, C or D. In such case, the policy in each period shall be considered for reserve purposes according to the type to which it then belongs.

(g) Where all of the benefits of a policy, as provided by rider or otherwise are not of the same Type A, B, C or D, each benefit shall be considered for reserve purposes according to the type to which it belongs.

As amended, R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Recodified with substantive changes from 6.1(e) and Notes (a)-(c).

11:4-6.6 Reserve standards for policies of Type A, B or C

(a) The maximum interest rate for reserves shall be the maximum rate permitted by law in the valuation of currently issued life insurance.

(b) The mortality assumptions used for reserves shall be according to a table permitted by law in the valuation of currently issued life insurance.

(c) Morbidity or other contingency:

1. The minimum standard for total disability due to accident or sickness, shall be the 1964 Commissioner's Disability Table.

2. For policies issued prior to January 1, 1986, minimum standard for hospital expense benefits shall be the 1956 Inter-Company Hospital Table. For policies issued after December 31, 1985, the minimum standard for hospital expense benefits shall be the 1974 Hospital Table.

3. For policies issued prior to January 1, 1986, the *minimum* standard for surgical expense benefits shall be the 1956 Inter-Company Surgical Table. For policies issued after December 31, 1985, the minimum standard for surgical expense benefits shall be the 1974 Surgical Table.

4. The minimum standard for accidental death benefits shall be the 1959 Accidental Death Benefits Table.

5. As to all other benefits, the insurer shall adopt a standard which will produce reserves that place a sound value on the liabilities under such benefit.

(d) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same policy, but the mean reserve on any policy shall never be taken as less than one-half the valuation net premium.

(e) The minimum reserve shall be on the basis of a two-year preliminary term.

(f) The reserve method shall be the mean reserves diminished by appropriate credit for valuation net deferred premiums. In no event, however, shall the aggregate reserve for all policies valued on the mean reserve basis, diminished by any credit for deferred premiums, be less than the gross pro rata unearned premiums under such policies.

(g) Provided the reserve on all policies to which the method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above, an insurer may use any reasonable assumptions as to the interest rate, mortality rates, or the rates of morbidity or other contingency, and may introduce an assumption as to the voluntary termination of policies. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such policies, including but limited to the following:

1. The use of mid-terminal reserves in addition to either gross or net pro rata unearned premium reserves;

2. Optional use of either the level premium, the one-year preliminary term, or the two-year preliminary term method;

3. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

4. The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity;

5. The computation of the reserve for one policy benefits as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued;

6. The use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

(h) For statement purposes the net reserve liability may be shown as the excess of the mean reserve over the amount of net unpaid and deferred premiums, or, regardless of the underlying method of calculation, it may be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve."

As amended, R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Recodified from 6.1(f) with substantive changes.

11:4-6.7 Reserve standards for policy Type D

The minimum reserve standard for policy Type D shall be the gross pro rata unearned premium.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4-6.8 Claim reserves—present value of amounts not yet due on claims

(a) Reserves are required for claims on all health insurance policies, whether of Type A, B, C or D, providing benefits for continuing loss, such as loss of time or hospitalization.

(b) As to claim reserve standards for total disability due to accident or sickness, the following rules shall apply:

1. The maximum interest rate for reserves shall be the maximum rate permitted by law in the valuation of life insurance issued on the date of the health insurance.

2. The reserve shall be established in accordance with the 1964 Commissioner's Disability Table, except that for unreported claims and resisted claims and, at the option of the insurer, claims with a duration of disablement of less than two years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years.

3. For policies with an elimination period, the duration of disablement shall be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

4. A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within six months of the new disability shall be considered a continuation of the previous disability.

(c) As to reserve standards for all other claim reserves, the following rules shall apply:

1. The maximum interest rate for reserves shall be the maximum rate permitted by law in the valuation of life insurance issued on the date of the health insurance.

2. The reserve shall be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years along the lines of Schedule O.

(d) As to valuation procedures, the insurer may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim reserves.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Section recodified from 6.2; Old 6.8 was repealed.

11:4-6.9 Loss of time policies

In the case of loss of time policies containing a change or changes in the premium or benefits after a fixed duration of coverage prior to the terminal age, the reserves shall be calculated along the principles set forth on page 160 of the 1941 Proceedings of the National Association of Insurance Commissioners.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Recodified from 6.3.

11:4-6.10 Tabular reserves, deficiency reserve requirement

Because of the aggregate and average nature of tabular reserves, no deficiency reserves will be required, even though for some ages and plans for some classifications of risks the premiums charged may be less than the tabular net premiums.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Recodified from 6.4.

11:4-6.11 Commissioner's Disability Table

The 1964 Commissioner's Disability Table shall be used without adjustment as the minimum standard for women as well as men.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Recodified from 6.5.

11:4-6.12 Active life reserve factors, elimination period

The active life reserve factors for disability benefits with an elimination period of seven days shall be considered generally appropriate for benefits with a shorter or no elimination period.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Recodified from 6.6.

11:4-6.13 Policy applicability

The reserve standards set forth in this regulation shall apply to policies issued on or after January 1, 1965, and, at the option of the insurer, for prior issues.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Recodified from 6.7.

11:4-6.14 Severability

If any provision of this subchapter or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect other provisions or applications of the subchapter which can be given effect without the invalid provision or application and to this end, the provisions of this subchapter are severable.

R.1984 d.512, eff. November 5, 1984.

See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

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

11:4-7.1 Filing requirements

(a) Every application must be filed with the Commissioner of Insurance within 20 work days after the insured has signed it or within 20 work days of the inception date of the policy, whichever is earlier.

(b) Each application shall show the following information:

1. Name and address of company, and signature by authorized company representative;

Name, address, New Jersey license number and signature of producer;

3. Name and address of insured;

4. Effective date and expiration date of policy;

5. Policy number, if available;

6. Coverages applied for, including limits, amounts of insurance, deductibles, and so forth;

7. Exposure identification class, territory, description and use of automobile, and so forth;

8. Premiums:

i. The premium developed by the rating system approved for the company for the coverages applied for, identified as "Normal Premium";

ii. The additional premium to be charged in consideration of the additional hazard, identified as "Additional Premium";

iii. The total of the two amounts identified as "Premium Payable".

9. Underwriting information in support of the additional premium under (a)8ii above. In the case of automobile insurance, liability and physical damage, a copy of the abstract of driving record from the Division of Motor Vehicles shall be submitted. Such abstract is not required if the coverage applied for is excess coverage over the coverages and limits available under any residual market mechanism providing automobile insurance pursuant to statute. In the case of fire insurance, an inspection report, based upon an inspection performed by a qualified person, shall be submitted.

10. Each application shall be signed by the insured and it shall contain the following statement:

"I consent to the premium shown as 'Premium Payable' on this application which is higher than would normally apply because of the greater hazard involved."

11. The application form shall contain the following statement signed by the producer of record (broker or agent) or by an officer of the company providing the coverage:

"Under penalty of N.J.S.A. 17:29A-16 and N.J.S.A. 17:29A-22, I declare that this application was fully completed as shown, before signed by the applicant."

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

In (b): deleted "New Jersey Automobile Insurance Plan" and added text regarding "any residual market mechanism."

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-7.2 Premium charges

(a) Premium charges in excess of those produced by the rating system approved for the submitting company shall be reasonable and adequate and not unfairly discriminatory, and shall be proportionate to the additional hazard, subject to the following provisions on business for which coverage is available under any residual market mechanism created by statute:

1. Insurance available from these plans shall be rated in accordance with the rating systems approved for these

facilities and the procedures applicable to such business shall be followed, if written under the Consent to Higher Rate provision. Any surcharges to be applied to such business must be documented by any required inspection report.

2. An insured qualifying for coverage under these plans shall not be offered coverage at lower limits, lower amounts or otherwise reduced coverage except at a proportionate reduction in the otherwise applicable premium.

3. If an insured eligible for insurance from these plans requests limits or amounts of insurance higher than available thereunder, the excess portion may be written at rates higher than produced by the company's rating system, subject to the standards set forth above.

Amended by R.1991 d.3, effective January 7, 1991.

See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

In (a): deleted "New Jersey Automobile Insurance Plan" and added text regarding "any residual market mechanism..."

In (a)1: deleted text defining documentation by motor vehicle reports for automobile insurance and reference to cases of fire and crime insurance.

Amended by R.1996 d.4, effective January 2, 1996.

See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-7.3 Approval of applications

(a) Applications complying with the above rules will be approved by the Commissioner of Insurance on a current basis and the submitting carrier can expect to be notified promptly of such action.

(b) Applications that fail to comply with any of the above requirements or do not meet the requirement of being reasonable and adequate and not unfairly discriminatory will be disapproved. Notification of such disapproval will be sent by the Commissioner to the company, the producer of record and the insured.

(c) The company and the insured shall have the same legal remedies as are available in the case of disapproval of any rate filing.

(d) If a filing is disapproved, the policy with respect to which the filing had been made may be cancelled by the company on the basis of the premium that is applicable under the rating system approved for the company (normal premium), but such cancellations must be on a *pro rata* basis. However, if a disapproval is sustained upon an appeal by the insured, cancellation shall be *pro rata* on the basis of the "premium payable" as defined above.

(e) If the company wishes to continue the policy in force after the "consent to rate" filing has been disapproved, it may do so by charging the normal premium as of the policy's inception date.

(f) Nothing in this regulation shall prevent a company from filing a rate that produces a premium lower than that produced by the approved rating system, including the rating systems applicable under any residual market mechanism created by statute.

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

In (f): deleted text regarding "New Jersey Automobile Insurance Plan" and added reference to "... any residual market ... but not limited to."

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

1. A special permit holder, proposing to use the rates adopted by the Conference on Gift Annuities, must demonstrate to the Commissioner that these rates meet the above requirements.

(b) An applicant for a special permit shall submit, with his application to the Commissioner, a schedule of its annuity rates for each form of annuity that it proposes to issue.

(c) A special permit holder which adopts rates for a proposed new form of annuity or which proposes to change the rates on its existing annuities shall submit such rates to the Commissioner for his approval before they become effective.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added (a)1.

SUBCHAPTER 8. CHARITABLE ANNUITIES

11:4-8.1 Purpose

(a) N.J.S.A. 17B:17-13.1 provides that qualified organizations as defined therein may enter into annuity agreements under conditions which are different from those which are applicable to organizations which are deemed to be insurers. This subchapter protects the interest of individual holders of annuities and their beneficiaries by requiring:

1. The use of forms which clearly set forth the conditions of the agreement being entered into;
2. The maintenance of segregated assets in such form and such amount as will protect the interest of the annuitants; and
3. The submission to the Commissioner, by the issuers of charitable annuities, of periodic reports which will enable the Commissioner to determine that the requirements of law and of this subchapter are being met.

(b) Charitable annuities are different from other annuities in that a significant part of the consideration paid for the annuity represents a gift to the issuing organization. In order to assure that such a gift results, this subchapter specifies maximum rates of income to annuitants for charitable annuities.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted text in subsection (a).

11:4-8.2 Forms of agreement

An applicant for a special permit shall submit, with his application to the Commissioner, a copy of each form of agreement which it proposes to issue to annuitants. If a holder of a special permit proposes to institute a new form of agreement with annuitants, the form shall first be submitted to the Commissioner for his approval before it is put into use.

11:4-8.3 Annuity rates

(a) The original consideration for periodic payments payable to the holder of a charitable annuity may not be less than the net single premium, computed according to interest and mortality assumptions permitted by N.J.S.A. 17B:19 for guaranteed periodic payments, plus a life insurance net single premium, computed according to the same assumptions for an amount of death benefit equal to one-half of such original consideration. For this purpose the original consideration shall include the gross amount paid by the annuitant to the special permit holder in order to provide the annuity payments and the residue.

11:4-8.4 Surplus and reserves

(a) Each special permit holder shall have and maintain segregated assets at least equal to the sum of:

1. The reserves on its outstanding agreements calculated in accordance with the provisions of N.J.S.A. 17B:19; and
2. A surplus equal to \$100,000 or to ten per cent of the amount in paragraph 1 above, whichever is greater.

(b) In determining the reserves of any special permit holder, a deduction shall be made for all or any portion of an annuity risk which is lawfully reinsured by an authorized insurer, but such reinsurance shall not relieve a special permit holder from the requirement that the surplus shall be at least \$100,000.

(c) The Commissioner may consider that each corporation or association in a group of two or more corporations and/or associations which has met all other requirements of this section has met the requirements as to the amount of segregated annuity fund assets, provided:

1. The segregated assets of each such organization shall equal at least 110 per cent of the sum of the reserves on its outstanding agreements calculated in accordance with the provisions of N.J.S.A. 17B:19;
2. The combined segregated assets of all such organizations, when considered as a unit, meet the requirements of this section concerning the amount of segregated assets;
3. The organizations enter into an agreement by which each organization pledges the full amount of its segregated annuity assets as liable for the payment of each annuity and all annuities issued under the agreement by each organization and all organizations in the group;

4. Such agreement shall be determined by the Commissioner to protect the public at least to the same extent as though all annuities were issued by a single organization;

5. No change may be made in such agreement and no organization may be added to or released from such agreement without the prior approval of the Commissioner; and

6. The Commissioner may require that, in addition to any other reports that he shall normally require from permit holders, the group of organizations file annually a consolidated report in order to demonstrate that the requirements of this section are met on a consolidated basis.

(d) Each member organization within the group will be **subject to all** requirements of the law and of this subchapter other than the requirement of \$100,000 minimum surplus; this minimum must be satisfied by the group, however.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B-19".

11:4-8.5 Compliance with investment requirements

The segregated assets held by a special permit holder shall be invested in the same manner and subject to the same restrictions as provided in N.J.S.A. 17B:20 for domestic insurers, unless more restrictive provisions are contained in applicable statutes regulating any such special permit holder.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B-20". Deleted text "However, prior to ... chapter 19 of the code."

11:4-8.6 Annual report

(a) As of December 31 of the calendar year in which a special permit is issued, and as of December 31 of each succeeding calendar year, the holder of a special permit shall submit a report to the Commissioner. Such report shall be submitted to the Commissioner within 120 days following the end of the calendar year to which the report applies. The annual report shall be in such form as the Commissioner shall prescribe within three months prior to the end of each preceding calendar year.

(b) Each special permit holder shall submit, as part of the annual report, a statement by a qualified actuary setting forth his or her opinion as to the adequacy of reserves. A qualified actuary for the purpose of this subsection means a member in good standing of the American Academy of Actuaries, or a person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the insurance regulatory official of the domiciliary state.

(c) Each domestic special permit holder shall submit, as part of the statement by the qualified actuary, a copy of the

workpapers used by the actuary to calculate the required reserves.

(d) Each special permit holder shall respond on a timely basis to any inquiry of the Commissioner, or his designee, regarding the annual report.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added (b)-(d).

11:4-8.7 Special permit

Anything in this subchapter to the contrary notwithstanding, no organization referred to by N.J.S.A. 17B:17-13.1 may enter into annuity agreements with donors until it has satisfied the Commissioner of Insurance that it satisfies all of the requisite provisions of the law and has received from the Commissioner a special permit authorizing it to do such business.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B:17-13.1."

11:4-8.8 Separability of provisions

If any provision of this subchapter or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect the provisions or applications of this subchapter which can be given effect without the invalid provision or application, and for this purpose the provisions of the subchapter are separable.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted "regulation" and substituted "subchapter".

11:4-8.9 Penalties

Failure to comply with the provisions of this subchapter will subject any special permit holder to the penalties provided by N.J.S.A. 17B:17-13.1d and any other penalties available to the Commissioner of Insurance.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted "Effective date" rule and substituted "Penalties".

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

11:4-9.1 Purpose and scope

(a) This subchapter establishes data requirements and filing procedures for participating insurers in rating organizations to adopt or modify a rating organization's approved prospective loss costs.

(b) This subchapter applies to all rating organizations which file prospective loss costs and all insurer filings which adopt or modify a rating organization's prospective loss cost filing for personal lines property/liability insurance made pursuant to N.J.S.A. 17:29A-1 et seq. This does not apply to private passenger automobile insurance rate filings for which the use of rating organizations are specifically prohibited by N.J.S.A. 17:33B-31.

(c) All filings made pursuant to this subchapter shall be made in accordance with N.J.S.A. 17:29A-1 et seq., N.J.A.C. 11:1-2 and 11:1-32.

11:4-9.2 Definitions

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

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

"Department" means the New Jersey Department of Insurance.

"Expenses" means that portion of a rate attributable to commissions and brokerage, other acquisition expenses, general expenses, taxes, licenses, and fees.

"Loss costs multiplier" means the adjustment reflecting expenses, profit loading and any modifications that the insurer uses on the loss costs to produce final rates.

"Minimum premium" means the smallest amount of premium for which an insurer will issue coverage under a given policy.

"Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

"Rate" means the unit charge by which the measure of exposure or the amount of insurance specified in a policy of insurance or covered thereunder is multiplied to determine the premium. The unit charge may be expressed as a single number or as a prospective loss cost and an adjustment to account for the treatment of expenses, profit and variations in loss experience.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of ratemaking for two or more insurers.

"Supplementary rate information" means any manual or plan of rates, statistical plan, classification, rating schedule, rating rule and any other rule used by an insurer in making rates. This includes policy-writing rules, rating plans, territory codes and descriptions, and rules which include factors or relativities such as increased limits factors, classification relativities or similar factors used to determine the rate in effect or to be in effect.

11:4-9.3 Prospective loss cost filing requirements for rating organizations

(a) A rating organization that desires to file prospective loss costs with the Commissioner shall develop a filing containing advisory prospective loss costs and supporting actuarial and statistical data.

(b) Rating organizations that file advisory prospective loss cost filings with the Commissioner shall:

1. Submit a filing that contains the advisory prospective loss costs and the underlying loss data and other supporting actuarial information for any calculations or assumptions underlying those loss costs. Filings of prospective loss costs shall be filed and become effective in accordance with N.J.S.A. 17:29A-1 et seq. and N.J.A.C. 11:1-2; and

2. No longer develop or file minimum premiums with the filing of prospective loss costs.

(c) A rating organization may print and distribute manuals of prospective loss costs, as well as rules and other supplementary rate information filed and approved pursuant to N.J.S.A. 17:29A-1 et seq.

(d) Rating organizations shall continue to develop and file rules, relativities and other supplementary rate information on behalf of their member/subscriber insurers.

11:4-9.4 Prospective loss costs filing requirements for insurers

(a) In order for an insurer to incorporate a rating organization's approved prospective loss costs to establish its own rates, an insurer shall:

1. Be a participating insurer in the rating organization; and

2. File its loss costs multiplier using the Filing Adoption Form (as set forth in Appendix A to this subchapter and incorporated herein by reference). An insurer's loss costs multiplier shall be filed and become effective in accordance with N.J.S.A. 17:29A-1 et seq. and N.J.A.C. 11:1-2. An insurer's final rates shall be a combination of the approved prospective loss costs and the approved loss costs multiplier.

APPENDIX B

NEW JERSEY FORM NA-1

NON-ADOPTION OF PROSPECTIVE LOSS COST

- 1. Insurer: _____ NAIC#: _____

- 2. Rating Organization Affiliation: _____
- 3. Line of Insurance: _____
- 4. Rating Organization Designation Number: _____
- 5. Effective Date of Non-Adoption: _____
- 6. Rating Organization Designation Number
Currently Being Used: _____
- 7. Effective Date of Use: _____

SUBCHAPTER 10. (RESERVED)

SUBCHAPTER 11. LIFE INSURANCE SOLICITATION

11:4-11.1 Authority

This rule is adopted and promulgated by the Commissioner of Insurance pursuant to N.J.S.A. 17B:30-1 et seq.

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-11.2 Purpose

(a) The purpose of this regulation is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

(b) This regulation does not prohibit the use of additional material which is not in violation of this regulation or any other New Jersey statute or regulation.

11:4-11.3 Scope

(a) Except as hereafter exempted, this regulation shall apply to any solicitation, negotiation or procurement of life

insurance occurring within this State. This regulation shall apply to any issuer of life insurance contracts.

(b) Unless otherwise specifically included, this regulation shall not apply to:

- 1. Annuities;
- 2. Credit life insurance;
- 3. Group life insurance;
- 4. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA);
- 5. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

11:4-11.4 Definitions

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

"Buyer's guide" means a document which contains, and is limited to, the language contained in this appendix to this subchapter or language approved by the Commissioner of Insurance.

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

“Equivalent level annual dividend” means that amount which is calculated by applying the following steps:

1. Accumulate the annual cash dividends at five per cent interest compounded annually to the end of the tenth and 20th policy years;
2. Divide each accumulation of step 1 by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in step 1 over the respective periods stipulated in step 1. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;
3. Divide the results of step 2 by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

“Equivalent level death benefit of a policy or term life insurance rider” means an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for ten and 20 years at five per cent interest compounded annually to the end of the tenth and 20th policy years respectively;
2. Divide each accumulation of step 1 above by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step 1 over the respective periods stipulated in step 1. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

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

“Life insurance cost indexes” means the following:

1. “Life insurance surrender cost index” is calculated by applying the following steps:
 - i. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and 20th policy years;
 - ii. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at five per cent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph i of this paragraph;
 - iii. Divide the result obtained in subparagraph ii above (subparagraph i for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph ii (subparagraph i for guaranteed-cost policies) over the respective periods stipulated in subparagraph i. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

- iv. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at five per cent interest compounded annually to the end of the period stipulated in subparagraph i and dividing the result by the respective factors stated in subparagraph iii (this amount is the annual premium payable for a level premium plan);

- v. Subtract the result of subparagraph iii from subparagraph iv;

- vi. Divide the result of subparagraph v by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

2. “Life insurance net payment cost index” is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

“Policy summary”, for the purposes of these rules, means a written statement describing the elements of the policy, including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION;

2. The name and address of the insurance agent, or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary;

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written;

4. The generic name of the basic policy and each rider;

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity whichever is earlier:
 - i. The annual premium for the basic policy;
 - ii. The annual premium for each optional rider;
 - iii. Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;
 - iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

v. Cash dividends payable at the end of the year with value shown separately for the basic policy and each rider (Dividends need not be displayed beyond the 20th policy year);

vi. Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above;

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate;

7. Life insurance cost indexes for ten and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders, which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life;

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance costs indexes are displayed;

9. A policy summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed, in addition to a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide;

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide;

11. The date on which the policy summary is prepared.

Note: The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph 5 of this subsection shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or each class of insureds if death benefits do not differ within the class.

Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

11:4-11.5 Disclosure requirements

(a) The insurer shall provide, to all prospective purchasers, a buyer's guide and a policy summary at least seven days prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the policy summary contains such an unconditional refund offer, in which event the buyer's guide and policy summary must be delivered with the policy or prior to delivery of the policy.

(b) The insurer shall provide a buyer's guide and a policy summary to any prospective purchaser upon request.

(c) In the case of policies whose equivalent level death benefit does not exceed \$5,000, the requirement for providing a policy summary will be satisfied by delivery of a written statement containing the information described in N.J.A.C. 11:4-11.4(g)2 through 7, 10 and 11.

(d) In the case of policies whose equivalent level death benefit is less than \$2,000, the provision of a policy summary and a buyer's guide will be optional for the insurer.

(e) For in-force premium-paying policies, policy holders shall have the right to obtain a Policy Summary at cost. The company may charge a reasonable fee for preparing this summary, not to exceed \$5.00, and may utilize reasonable assumptions in providing the cost disclosure information, so long as they are clearly disclosed. In calculating cost indexes on policy anniversaries 10 and 20 years from the date of request, the initial cash value, defined as the cash value of the policy (exclusive of policy loans and the value of dividend accumulations or dividend additions but including any terminal dividend) on the policy anniversary at the beginning of the period for which the indexes are calculated, should be reflected as follows:

1. The "equivalent level death benefit" defined in N.J.A.C. 11:4-11.4 is reduced by the amount of the initial cash value;

2. The "guaranteed cash surrender value" determined in N.J.A.C. 11:4-11.4 is reduced by the amount of the initial cash value; and

3. The "equivalent level premium" determined in N.J.A.C. 11:4-11.4 is increased by 4.7619 percent of the amount of the initial cash value.

As amended, R.1982 d.17, eff. February 1, 1982 (Operative June 1, 1982).

See: 13 N.J.R. 36(a), 14 N.J.R. 159(a).

(e) added.

11:4-11.6 General provisions

(a) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.

(b) An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(c) Terms such as estate planner, financial planner, investment advisor, financial consultant, or financial counseling shall not be used in such a way as to imply that the insurance agent is generally engaged in an advisory business in which compensation is unrelated to sale unless such is actually the case.

(d) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(e) A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash-flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

(f) A presentation of benefits shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately in close proximity thereto.

(g) A statement regarding the use of the life insurance cost indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

(h) A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the company's current dividend scale and is not guaranteed.

(i) For the purposes of this regulation, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

(j) All sales proposals and sales presentations of individual life insurance products which fail to fully and fairly inform an applicant or prospective insured as to future premium changes, benefits and related options constitute a misrepresentation as to material facts.

(k) With respect to life insurance products which require an additional first year premium, for which there are no comparable additional first year insurance benefits, and which also contain partial endowment benefits or their cash value equivalent, any statement or illustration in any advertisement, sales material, or sales presentation which uses such terms as "deposit," "accumulation," "interest at x percent," "double your money" and similar terms associated with fund accumulations and investment contracts is prohibited unless the insurer can demonstrate that all major characteristics customarily associated with such contracts are present; the name given to such products shall not include any term that implies a "deposit" or any similar term; and no statement may be made or implied which purports to show that the partial endowment or cash value equivalent arises solely from the additional first year premium.

(l) If the policy contains a provision permitting the making of voluntary deposits which will accumulate at interest, the nature thereof shall be disclosed, and such disclosure shall distinguish such deposit provision and the insured's rights thereunder from any other premiums for the basic policy and riders.

As amended, R.1982 d.17, eff. September 1, 1982 (operative June 1, 1982).

See: 13 N.J.R. 36(a), 14 N.J.R. 159(a).

(j), (k) and (l) added.

11:4-11.7 Failure to comply

Failure of an insurer to provide or deliver a buyer's guide or a policy summary as provided in N.J.A.C. 11:4-11.5, shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy.

11:4-11.8 Effective date

With respect to the buyer's guide, this rule shall apply to all solicitations of life insurance which commence on or after February 1, 1977; otherwise, this rule shall apply to all solicitations of life insurance which commence on or after January 1, 1978.

As amended, R.1977 d.187, eff. May 25, 1977.

See: 9 N.J.R. 283(a).

APPENDIX**LIFE INSURANCE BUYER'S GUIDE**

The face page of the buyer's guide shall read as follows:
LIFE INSURANCE BUYER'S GUIDE

This guide can show you how to save money when you shop for life insurance. It helps you to:

Decide how much life insurance you should buy;

Decide what kind of life insurance policy you need; and

Compare the cost of similar life insurance policies.

11:4-18.6 Annual review of calendar year experience data on filed individual health insurance policy forms

(a) Each insurer shall maintain records of premiums, claims, and reserves on each policy form as required for the accident and health policy experience exhibit.

(b) If the incurred/earned loss ratios for a particular policy form, based on a substantial volume of reasonably mature business, do not meet the standards set forth in section 5 of this subchapter, the insurer will be required to explain why the premiums should not be regarded as unreasonably high in relation to the benefits provided. After consideration of the explanation and any additional information furnished by the insurer, the department will inform the insurer if the benefits provided are considered unreasonable *in relation to the premiums charged*. If within 90 days thereafter the insurer does not reduce the premiums or increase the benefits provided in the policy such that the standards set forth in section 5 of this subchapter are met, the department may commence proceedings as provided by law for withdrawal of the filing of the form.

Amended by R.1995 d.327, effective June 19, 1995.
See: 27 N.J.R. 1513(a), 27 N.J.R. 2407(a).
Deleted (b) and relettered former (c) as (b).

11:4-18.7 Rate manual

(a) Each insurer shall maintain on file with the department an up-to-date rate manual for all individual health insurance policies, riders, and endorsements currently available for sale in New Jersey. Such manual shall include:

1. Name of the insurer on each page;
2. Table of contents or index; and
3. Identification by form number of each policy, rider, and endorsement to which the rates apply.

11:4-18.8 Separability

If any provisions of this regulation or the application thereof to any person or circumstance shall be held invalid, the invalidity shall not affect the provisions or application of this regulation which can be given effect without the invalid provision or application, and for this purpose, the provisions of this regulation are separable.

11:4-18.9 Penalties

If, after notice and hearing the commissioner finds that a person has violated this regulation a penalty, in addition to any other penalty, not exceeding \$2,000 for each violation may be imposed and shall be collected and enforced pursuant to N.J.S.A. 2A:58-1 et seq.

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-18.10 Compliance

All policies of insurance previously filed with the Commissioner which are not in compliance with this subchapter as of the operative date shall be deemed to be withdrawn from filing and disapproved. No new policy of insurance shall be delivered or issued for delivery in this State until the policy has been filed with the Commissioner.

Amended by R.1988 d.473, effective October 3, 1988 (operative January 3, 1989).
See: 19 N.J.R. 1620(b), 20 N.J.R. 2457(c).
Deleted old text and substituted new.

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS**11:4-19.1 Purpose**

The purpose of this subchapter is to prevent the exclusion of pregnancy-related surgery and sterilization procedures from certain second surgical opinion programs and to make maternity coverage available to insureds.

11:4-19.2 Scope

This subchapter shall apply to all group and individual health insurance policies as well as hospital and medical service corporation contracts delivered or issued for delivery in this State. This subchapter shall not apply to health service corporation contracts.

11:4-19.3 Second surgical opinions

Every health insurer and medical service corporation offering individual and group policies in this State, with the exception of hospital service corporations, shall include in its programs for second surgical opinions, coverage for pregnancy-related surgery and sterilization procedures.

11:4-19.4 Maternity benefits option

(a) Each insurer shall make available benefits coverage for maternity care without regard to the marital status of its policyholders, subscribers or other persons thereunder covered for expenses incurred in pregnancy and childbirth.

(b) The amount of or type of benefit coverage for maternity care expenses incurred in pregnancy and childbirth shall be provided to the same extent as benefits coverage is provided in policies and contracts for any other covered illness. Where a fixed amount of benefit coverage for surgery is prescribed by a policy or contract, benefit coverage for pregnancy-related surgical procedures shall be commensurate to that for surgery of comparable difficulty and severity.

(c) Policies which provide normal pregnancy and childbirth benefits shall cover pregnancy if conception occurs after the effective date of coverage or after a probationary

period of not more than 30 days after the effective date of the coverage.

(d) Each insurer is required to give a single notice of the option to select maternity benefits coverage to its policyholders or subscribers. While no notice of the availability of such coverage is required to be made at every renewal of a policy, the coverage itself must be made available at renewal, for the option of selection by the insured.

2. Assure that limited death policies are not sold by agents in preference to full death benefit policies and that the applicant understands that he or she may qualify for a full death benefit policy;

3. Reduce through disclosure the likelihood of misunderstanding arising where the sales presentation emphasizes the underwriting feature while minimizing or ignoring the limitation on death benefits at early durations; and

4. Set standards for the advertising of limited death benefit policy forms so as to eliminate unfair, misleading or deceptive advertising practices.

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

11:4-20.1 Purpose

The purpose of this subchapter is to eliminate unfair discrimination in the underwriting, insuring and rating of individuals who are normal insurance risks in spite of blindness, partial blindness, or other physical or mental impairments.

11:4-20.2 Unfair discriminatory acts or practices

(a) The following are hereby identified as acts or practices which constitute unfair discrimination between individuals of the same class:

1. Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness, partial blindness or other physical or mental impairments, except where the refusal, limitation or rate differential is based on sound, actuarial principles or is related to actual or reasonably anticipated experience.

Case Notes

Statute proscribing discrimination in terms and conditions of employee's health insurance policy regulated insurance within meaning of ERISA's savings clause. *PAS v. Travelers Ins. Co.*, C.A.3 (N.J.)1993, 7 F.3d 349.

SUBCHAPTER 21. LIMITED DEATH BENEFITS FORMS

11:4-21.1 Purpose; scope

(a) The purpose of this subchapter is to establish guidelines for the filing and review of limited death benefit policy forms which will:

1. Make life insurance available to people who are otherwise uninsurable;

(b) This subchapter shall apply to all life insurance policy forms delivered or issued for delivery after the operative date hereof that limit death benefits during a period following the inception of the policy as an alternative to underwriting. This subchapter shall also apply to those single pay and limited pay life insurance policy forms where, at any issue age, the premium or premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy exceed the guaranteed death benefit during the limited death benefit period defined at N.J.A.C. 11:4-21.3(g), regardless of whether the form is underwritten. The requirements in this subchapter apply to all previously filed forms as well as any forms submitted in the future. Previously filed forms which do not comply with these requirements are considered withdrawn as of August 20, 1996.

Amended by R.1996 d.82, effective February 20, 1996.
See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).

Added single pay and limited pay life insurance policy forms.

11:4-21.2 Definitions

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

“Advertising” means any advertising materials and sales presentations in the following categories:

1. Printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, billboards and similar displays;

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters;

3. Material used for the recruitment, training and education of an insurer's sales personnel, agents, solicitors, and brokers which is designed to be used or used to induce the public to purchase, increase, modify, reinstate, or retain a policy; and

4. Prepared sales talks, presentations and material for use by sales personnel, agents, solicitors and brokers.

“Department” means the New Jersey Department of Insurance.

“Full death benefit policy” means any individual life insurance policy, group life insurance policy, group life insurance certificate, or fraternal benefit society certificate delivered or issued for delivery in this State which provides the full face amount as the death benefit at all times following the inception date of the policy and which provides a death benefit greater than premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy during the limited death benefit period defined at N.J.A.C. 11:4-21.3(g).

“Limited death benefit policy” means any individual life insurance policy, group life insurance policy, group life insurance certificate, or fraternal benefit society certificate delivered or issued for delivery in this State which limits death benefits during a period following the inception date of the policy as an alternative to underwriting. Limited death benefit policies include those single pay and limited pay life insurance policy forms where, at any issue age, the premium or premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy are equal to or in excess of the guaranteed death benefit during the limited death benefit period defined at N.J.A.C. 11:4-21.3(g), regardless of whether the form is underwritten. Limited death benefit policies also include those funeral insurance policies as defined at N.J.S.A. 17B:17-5.1a that meet the requirements set forth in N.J.A.C. 11:4-21.1(b).

Amended by R.1996 d.82, effective February 20, 1996.
See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).

Amended “Full death benefit policy” and “Limited death benefit policy”.

11:4-21.3 General requirements

(a) No limited death benefit policy shall be issued in this State unless the insurer has, at the time of application, obtained from the applicant a signed and dated statement attesting that the applicant understands that he or she may qualify for a full death benefit policy which provides full benefits from inception. A copy of this statement must be submitted to the Department for review prior to its use.

(b) All advertising of a limited death benefit policy and any revisions to the advertising must be submitted to the Department prior to use. The material submitted must include a narrative statement of the method by which the policy will be sold.

(c) All advertising for a limited death benefit policy shall prominently explain the nature of the limited death benefit policy and state the duration of the limited death benefit period.

(d) Any advertising of a limited death benefit policy which makes reference to a specific premium rate must provide:

1. For other than radio and television, a listing of the rates and benefits for all available ages (male and female); and
2. For radio and television, instructions in the procedure to be followed by the applicant to learn what benefits and rates are available.

(e) When sold by agents, the commission may not be greater on the sale of limited death benefit policies than on the sale of full death benefit policies.

(f) The limited death benefit shall not be less than the amount of premiums paid with interest at the rate used to determine nonforfeiture values under the policy.

(g) The period during which a limited death benefit applies shall not exceed 25 percent of life expectancy at the issue age, as determined by the mortality table used for nonforfeiture values under the policy, or two years, whichever is shorter.

(h) The policy shall include a provision allowing for the return of the policy for a full refund of premiums within 30 days after delivery.

Amended by R.1996 d.82, effective February 20, 1996.
See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).
Eliminated amount and issue age limitations.

11:4-21.4 Severability

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

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

11:4-22.1 Purpose

The purpose of this subchapter is to permit individual life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is intended by these rules.

11:4-22.2 Definitions

The following words and terms when used in this subchapter shall have the following meanings:

"1980 CSO Table, with or without Ten Year Select Mortality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 National Association of Insurance Commissioners (NAIC) Amendments to the Model Standard Valuation Law and Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioner's 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors.

"1980 CSO Table (M), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

"1980 CSO Table (F), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

"1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioner's 1980 Extended Term Insurance Table.

"1980 CET Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

"1980 CET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

"1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" mean the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO and 1980 CET Mortality Tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the NAIC in December 1983.

"Non-Norris market" means all employer-based plans not included within the definition of "Norris market" set forth in this subchapter.

"Norris market" means all employer-based plans subject to the holding of the 1983 *Arizona Governing Committee v. Norris* United States Supreme Court decision (463 U.S. 1073).

Amended by R.1987 d.394, effective October 5, 1987.
See: 19 N.J.R. 1399(a), 19 N.J.R. 1814(a).

Added definition "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables".
Amended by R.1996 d.148, effective March 18, 1996.
See: 27 N.J.R. 3717(a), 28 N.J.R. 1545(a).
Added "Norris market" and "Non-Norris market".

11:4-22.3 Construction of gender blended tables for use in the determination of minimum nonforfeiture benefits and minimum reserves

(a) For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this State after September 11, 1981, a life insurer which has elected or which elects an operative date under N.J.S.A. 17B:25-19h(xi) may file with the Department of Insurance for use as part of the policy form, the approved gender blended mortality tables as described in (b) below and attached as the Appendix to this subchapter, or a description thereof, to determine minimum cash surrender values and minimum amounts and minimum periods of paid-up nonforfeiture benefits.

1. An approved mortality table which is a blend of the 1980 CSO Table (M) and the 1980 CSO Table (F) with or without Ten-Year Select Mortality Factors may at the option of the company be substituted for the 1980 CSO Table, with or without our Ten-Year Select Mortality Factors; and

2. A mortality table which is of the same blend as used in (a)1 above but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) may at the option of the company be substituted for the 1980 CET Table.

(b) The following describes the gender blended tables approved for use pursuant to N.J.S.A. 17B:25-19h(viii). These tables are contained in the Appendix to this subchapter and are part of this subchapter:

1. 100 percent Male 0 percent Female for tables to be designated as the "1980 CSO-A" and "1980 CET-A" tables;

2. 80 percent Male 20 percent Female for tables to be designated as the "1980 CSO-B" and "1980 CET-B" tables;

3. 60 percent Male 40 percent Female for tables to be designated as the "1980 CSO-C" and "1980 CET-C" tables;

4. 50 percent Male 50 percent Female for tables to be designated as the "1980 CSO-D" and "1980 CET-D" tables;

5. 40 percent Male 60 percent Female for tables to be designated as the "1980 CSO-E" and "1980 CET-E" tables;

6. 20 percent Male 80 percent Female for tables to be designated as the "1980 CSO-F" and "1980 CET-F" tables;

vii. The distribution of expected policy issues by policy and rider benefits by issue age and sex;

viii. The percentage of policies expected to be issued with extra premiums for any physical, mental or medical conditions which result in substandard morbidity; and

ix. A summary statement of the underwriting standards (for example: short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market for the policy form (that is, the segment(s) of the general public to which the form will be marketed: middle income based on predetermined ZIP code selections for example);

6. The cell and cell weights, when a model office is used in the calculation of the anticipated loss ratio;

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the recognition or nonrecognition or the homogenization of the elements of any insurance construct will not result in an anticipated loss ratio which would differ by more than 10 percent from the anticipated loss ratio of any element of the construct if the elements of the construct were not recognized or separately recognized, as the case may be.

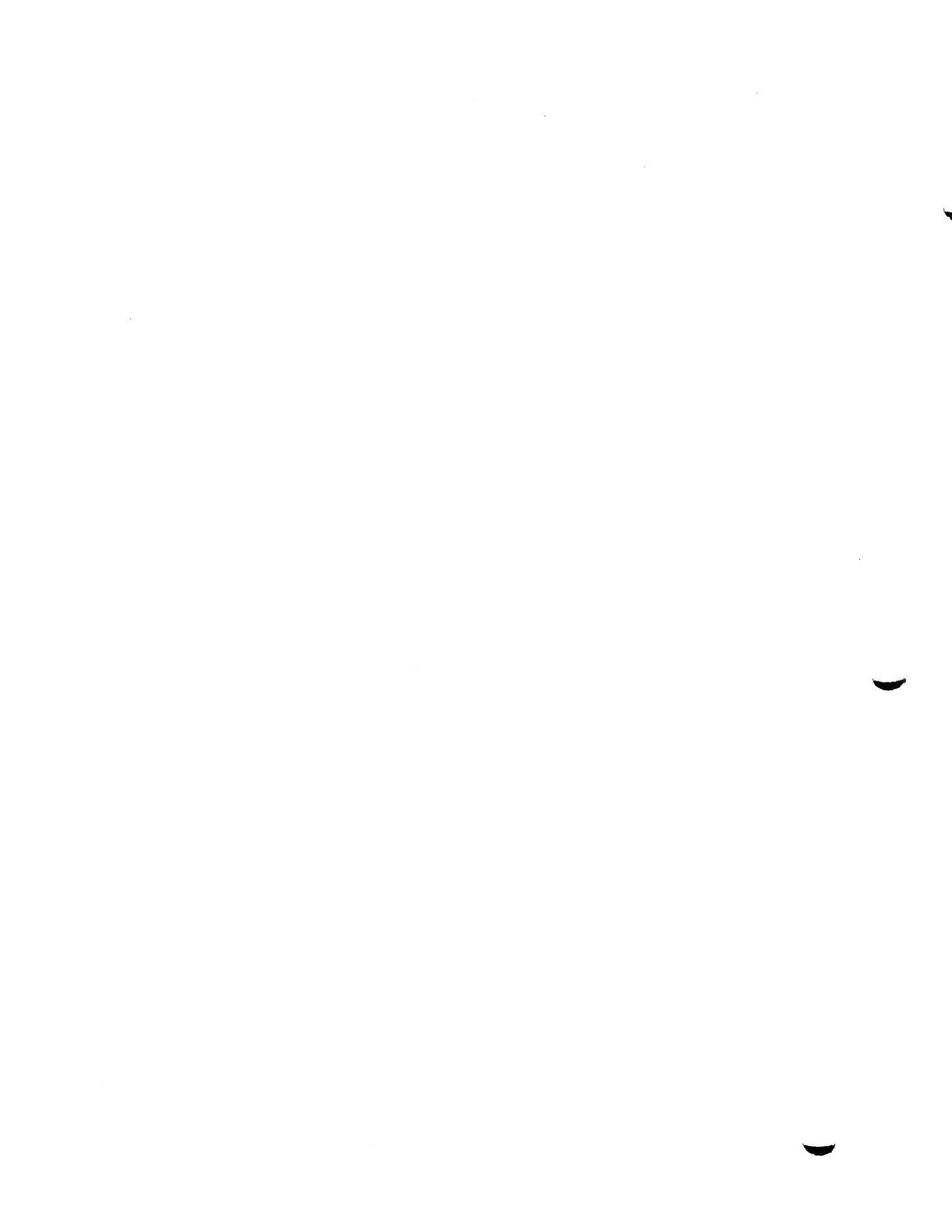
ii. For the purpose of this paragraph, construct shall mean the risk variables which significantly affect the

cost of the coverage. For example, age could be a construct wherein its elements would be age 65, age 66, age 67 and so forth. (Of particular concern are anticipated loss ratios by issue age or issue age groupings.); and

8. A certification signed by an actuary who must be a member of the Society of Actuaries or Casualty Actuarial Society, stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

(c) Every carrier shall submit annually for filing by the Commissioner its rates. Supporting documentation, including ratios of incurred losses to earned premiums by policy duration shall be submitted annually with the rates. Any revision of rates is subject to the requirements of (d) below. The supporting documentation shall demonstrate, using reasonable assumptions, that the anticipated and aggregate loss ratio are at least as great as the originally anticipated loss ratio. Such demonstration shall exclude active life reserves.

(d) Carriers shall submit for filing by the Commissioner in accordance with N.J.A.C. 11:4-23.12 all rate revisions. No carrier shall implement any rate revision until such rate revision has been filed. Submission of rate revisions for filing shall demonstrate that both the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage and the aggregate loss ratio are at least as great as the originally anticipated loss ratio.



1. For policies issued prior to January 4, 1993, expected claims in relation to premiums shall meet:

i. The originally filed loss ratio when combined with the actual experience since inception;

ii. The appropriate loss ratio requirement from (a)1 and 2 above when combined with actual experience beginning with July 1, 1996 to date; and

iii. The appropriate loss ratio requirement from (a)1 and 2 above over the entire future period for which the rates are computed to provide coverage.

2. In meeting the tests in (d)1i, ii and iii above and for purposes of attaining credibility, an insurer may combine experience under policy forms which provide substantially similar coverage subject to the approval of the Commissioner. Once a combined form is adopted, the insurer may not separate the experience except with the approval of the Commissioner. The Commissioner shall permit pooling in plans having less than 10,000 employee/policyholder months on an annual basis.

3. Prior to the effective date of enhancements in Medicare benefits, carriers shall:

i. Submit for filing appropriate premium adjustments required to produce loss ratios commensurate with the loss ratios anticipated for the current premium for the applicable policies or certificates, with accompanying documentation sufficient to justify the adjustment, in the opinion of the Commissioner; and

ii. Make premium adjustments to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards of (a) above, and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the carrier for the policies and certificates. No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described herein, shall be made at any time other than upon the policy renewal or anniversary date.

4. Every carrier shall submit for filing by the Commissioner a rate reduction whenever the expected aggregate loss ratio reported for a policy or certificate is less than the anticipated loss ratio for that policy or certificate, and the requirements of (c) above may not be met.

5. When a rate adjustment is requested pursuant to a change in the policy or certificate necessary to eliminate benefit duplication with Medicare, the submission for a rate change shall include any riders, endorsements, policy and certificate forms needed to accomplish the Medicare supplement coverage modification necessary to eliminate benefit duplications with Medicare. The forms shall result in a clear description of the Medicare supplement benefits provided by the policy.

6. If a carrier does not make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the appropriate loss ratio.

(e) Carriers shall submit for filing with the Commissioner annually on or before May 31 reports in accordance with the applicable reporting form contained in the Appendix to subchapters 16 and 23 of this chapter, Exhibit F, completed for each type in a standard Medicare supplement benefit plan.

1. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), a refund or credit calculation shall be required.

i. The refund calculation shall be done on a State-wide basis for each type in a standard Medicare supplement benefit plan.

ii. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

iii. For purposes of this section, for policies or certificates issued prior to January 4, 1993, the carrier shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after May 31, 1996. The first report shall be due by May 31, 1998.

2. A refund or credit shall be made by carriers whenever the benchmark loss ratio exceeds the adjusted experience loss ratio, and the amount to be refunded or credited exceeds a de minimis level.

i. A refund or credit against premiums due shall be made no later than September 30 following the experience year upon which the refund or credit is based.

ii. The refunds and credits shall include interest accruing from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of the United States Department of Health and Human Services, which in no event shall be less than the average rate of interest for 13-week Treasury notes.

(f) The Commissioner may conduct a public hearing, in his or her discretion, to gather information regarding a request by a carrier for an increase in a rate for a policy or certificate form, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard of (a) above. The determination of compliance shall be made without consideration of any refund or credit for such reporting period. Public notices of the hearing shall be in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(g) For purposes of complying with (c) and (d) above, premiums and claims shall refer to premiums and claims for insured residents of this State under a specific policy form. However, if the experience is based on fewer than 1,000 life years of exposure for residents of this State, then the premiums and claims shall be a weighted average of the premiums and claims for this State and national experience, where the weighting factor applied to the State experience is the square root of the ratio of "a" to 1,000 ("a" being the number of the life years of exposure).

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.7.

Added "and policies issued as conversions from group policies" in (a)1.

Substituted old text with new text in (b).

Added (b)1, 2; (c); (d); (e).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on required disclosure provisions recodified to 23.14; rule on loss ratio standards recodified from 23.8; standards for refunds and credit added.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

11:4-23.12 Guaranteed issue for eligible persons

(a) Eligible persons are those individuals described in (c) below who apply to enroll under the policy not later than 63 days after the date of the termination of enrollment described in (c) below, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(b) With respect to eligible persons, a carrier shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in (d) below that is offered and is available for issuance to new enrollees by the carrier, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(c) An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

2. The individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

3. The individual is enrolled with a Medicare + Choice organization under a Medicare + Choice plan under Part C of Medicare, and any of the following circumstances apply:

i. The organization's or plan's certification under Part C of Medicare has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

ii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the Federal Social Security Act (42 U.S.C. § 1395w-21) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856 (42 U.S.C. § 1395w-26)), or the plan is terminated for all individuals within a residence area;

iii. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(1) The organization offering the plan substantially violated a material provision of the organization's contract under Part C of Medicare in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(2) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

iv. The individual meets such other exceptional conditions as the Secretary may provide;

4. The individual is enrolled with any of the following, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under (c)3 above:

i. An eligible organization under a contract under Section 1876 (42 U.S.C. § 1395mm) (Medicare risk or cost);

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. An organization under an agreement under Section 1833(a)(1)(A) (42 U.S.C. § 1395) (health care prepayment plan); or

iv. An organization under a Medicare Select policy;

5. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because of the following:

i. Either the insolvency of the carrier or bankruptcy of the noncarrier organization, or other involuntary termination of coverage or enrollment under the policy;

ii. The carrier substantially violated a material provision of the policy; or

iii. The carrier, or an agent or other entity acting on the carrier's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

6. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under Section 1876 (42 U.S.C. § 1395mm) (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under Section 1833(a)(1)(A) (42 U.S.C. § 1395) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) (42 U.S.C. § 1395w-2) of the Federal Social Security Act); or

7. The individual, upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(d) The Medicare supplement policy to which eligible persons are entitled under (c)1, 2, 3, 4 and 5 above is a Medicare supplement policy which has a benefit package classified as Plan A, B, C or F offered by any carrier. The Medicare supplement policy to which eligible persons are entitled under (c)6 above is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same carrier, or, if not so available, a policy described in the preceding sentence. The Medicare supplement policy to which eligible persons are entitled under (c)7 above shall include any Medicare supplement policy offered by any carrier.

(e) At the time of an event described in (c) above because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy or plan, the organization that terminates the contract or agreement, the carrier terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of carriers issuing Medicare supplement policies under (a) and (b) above. Such notice shall be communicated contemporaneously with the notification of termination.

(f) At the time of an event described in (c) above because of which an individual ceases enrollment under a contract or agreement, policy or plan, the organization that offers the contract or agreement, regardless of the basis for the cessa-

tion of enrollment, the carrier offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of carriers issuing Medicare supplement policies under (a) and (b) above. Such notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

Emergency Rule, R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.12, Filing requirements for policies, certificates and premium rates, recodified to N.J.A.C. 11:4-23.13.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

11:4-23.13 Filing requirements for policies, certificates and premium rates

(a) No carrier shall deliver or issue for delivery in this State any Medicare supplement policy or certificate, any written application therefor, or any printed rider or endorsements to be applied thereto, unless the forms thereof have been submitted to and filed by the Commissioner.

1. At the expiration of 30 days after submission, the form shall be deemed filed unless affirmatively disapproved for filing by the Commissioner prior thereto.

2. If any such form is disapproved for filing by the Commissioner during the said 30-day period, it may not be delivered or issued for delivery unless and until such disapproval for filing is withdrawn. Such disapproval shall be subject to review in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

3. The Commissioner may extend the 30-day period no more than another 30 days if written notice is provided to the insurer before the expiration of the initial 30 day period, in which event all but this paragraph shall apply to the extended period.

4. Forms filed by or deemed filed by the Commissioner may subsequently be withdrawn from filing. Insurers shall have the right to a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. An insurer may continue to deliver or issue for delivery such forms until a final decision in accordance with the withdrawal is rendered, following the request for a hearing, or, if no hearing is requested, delivery or issuance for delivery of such forms may continue no later than 30 days following notice of the withdrawal of that form.

(b) Disapproval for filing, or withdrawals of approval of the filing of any form, must be stated in writing with the grounds therefor included in the statement, in accordance with the rules of this State.

(c) No carrier shall use or revise premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been submitted to and filed by the Commissioner in accordance with (a) and (b) above.

(d) The Commissioner shall not file, and carriers shall not submit for filing, more than one Medicare supplement policy or certificate form of each type for each standard Medicare supplement benefit plan, except as the Commissioner may otherwise approve in accordance with (d)2 below.

1. For the purposes of this subchapter, "type" shall mean an individual policy, and a group policy, and at such time as a Medicare Select program shall become effective in this State, an individual Medicare Select policy, and a group Medicare Select policy.

2. The Commissioner may approve carriers, individually, to offer up to four additional policy or certificate forms of the same type for the same standard Medicare supplement benefit plan. Such forms shall be subject to the filing requirements of this section. The four additional policy or certificate forms of the same type shall be limited to one additional form of the same type for:

- i. The inclusion of Innovative Benefits;
- ii. The addition of either a direct response or an agent marketing method;
- iii. The addition of either guaranteed issue or underwritten coverage; and
- iv. The offering of Medicare supplement coverage to persons eligible for Medicare by reason of disability.

(e) A carrier shall not discontinue offering any policy or certificate form filed by the Commissioner on or after the effective date of this subchapter unless such form has been withdrawn from filing pursuant to (a)4 above, or the carrier provides notice of discontinuance of offer to the Commissioner at least 30 days prior to such discontinuance, in writing.

1. Discontinuance subject to notice to the Commissioner shall include the following:

- i. Failure to actively offer for sale a policy or certificate form for more than 12 consecutive months;
- ii. Sale or transfer of Medicare supplement policies or certificates to another carrier; and
- iii. Revisions in the rating structure or methodology applicable to a Medicare supplement policy or certificate form which has not been otherwise submitted to and filed by the Commissioner in accordance with N.J.S.A. 11:4-23.11.

2. Carriers shall not submit for filing a new form for any Medicare supplement plan of the same type for which the carrier has discontinued issue of a policy or certificate for a period of five years following the notice of discontinuance to the Commissioner. The Commissioner may waive some or all of the five year period, in his or her discretion.

(f) Except for policies or certificates assumed under an assumption reinsurance agreement, the experience of all policy or certificate forms of the same type for a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation set forth at N.J.S.A. 11:4-23.11(d).

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.9, Requirements for replacement recodified to 23.12. Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on application forms and replacement coverage recodified to 3.15; rule on filing requirements recodified from 23.9; (c) through (f) added.

Recodified from N.J.A.C. 11:4-23.12 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.13, Compensation arrangements, recodified to N.J.A.C. 11:4-23.14.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

11:4-23.14 Compensation arrangements

(a) No carrier or other entity shall provide to any producer a first year commission or first year compensation for the sale of Medicare supplement policies or certificates in an amount which exceeds 200 percent of the commission or compensation to be provided by that insurer or other entity for the selling or servicing of that policy or certificate in the second year or period of that policy or certificate.

(b) The commission or other compensation which may be provided in subsequent renewal years shall be, for no fewer than five renewal years, the same as that commission or compensation provided in the second year or period.

(c) No carrier or other entity shall provide compensation or commission to any producer, nor shall any producer receive commission or other compensation greater than the renewal commission or compensation payable by the replacing carrier on renewal policies or certificates when an existing policy or certificate is replaced.

(d) For purposes of this section, "compensation" means a pecuniary or nonpecuniary remuneration of any kind relating to the sale of a policy or certificate, including, but not limited to:

1. Bonuses;
2. Gifts;
3. Prizes;

(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 non-smokers.

“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, and minimum reserve liabilities 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, 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, and minimum reserve liabilities 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, 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.

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).

11:4-25.1 Purpose; scope

(a) The purpose of this subchapter is to establish rules for the filing and review of funeral insurance policies pursuant to N.J.S.A. 17B:17-5.1.

(b) This subchapter shall apply to all life insurance policy or annuity contract forms delivered or issued for delivery, marketed, used or designated as intended for use, as funeral insurance policies after the operative date hereof.

(c) Any insurance policy or annuity contract used as a funeral insurance policy in this State on or after December 21, 1993, whether issued within this State or outside of this State, whether on a group or individual basis, and any certificates, policies, contracts, applications, forms and related material, shall be subject to all the laws and regulations of this State and the terms and conditions of the Department of Insurance, as though issued in this State, and shall at the time of submission and filing be designated as being intended for use as a funeral insurance policy.

11:4-25.2 Definitions

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

“Funeral insurance policy” means any insurance policy or annuity contract (other than “credit life insurance” as defined at N.J.S.A. 45:7-82) that at the time of issue, was intended to provide or which was explicitly marketed for the purpose of providing funds to the provider, whether directly or indirectly, at the time of the insured’s death in connection with a prepaid funeral agreement.

“Funeral trust” means a commingled or non-commingled account held in a pooled trust or “P.O.D.” account, established in accordance with N.J.S.A. 2A:102-13 et seq. or N.J.S.A. 3B:11-16 et seq., which is intended as the depository for cash payments connected with a prepaid funeral agreement.

“Insurance adjusted premium fund” at the end of any policy year means the quantity (E) times the following quantity: (A) plus (B), the sum multiplied by (C), less (D), where:

(A) is the insurance adjusted premium fund at the end of the previous year (or zero at policy inception);

(B) is the insurance adjusted premium fund consideration for the policy year;

(C) is 1 plus the premium fund interest rate;

(D) is the premium fund mortality rate times the death benefit during the policy year (including any increases to the initial death benefit as provided by this formula); and

(E) is 1 divided by the quantity: 1 minus the premium fund mortality rate.

“Insurance adjusted premium fund consideration” means:

1. In the case of a single premium policy, 90 percent of the actual gross premium less \$75.00; and

2. In the case of multiple premium policies, 65 percent of the first year gross premium and 87.5 percent of any renewal gross premium, less the smaller of \$30.00 and 10 percent of the gross premium.

“Premium fund interest rate” means the interest rate specified at N.J.S.A. 17B:25-20 for calculating the minimum nonforfeiture values for deferred annuities.

“Premium fund mortality rate” means the mortality rate used in calculating the minimum cash values required by law. This mortality rate is based on the 1980 CSO Table (with or without smoker differentiation, as applicable).

“Preneed funeral arrangements” means funeral arrangements made with an intended funeral recipient or his or her guardian, agent or next of kin, for the funeral of the intended funeral recipient.

“Prepaid funeral agreement” means a written agreement and all documents related thereto made by a purchaser with a provider prior to the death of the intended funeral recipient, with which there is connected a provisional means of paying for preneed funeral arrangements upon the death of the intended funeral recipient by the use of a funeral trust or funeral insurance policy, made payable to a provider and in return for which the provider promises to furnish, make available or provide the prepaid funeral goods or services, or both, specified in the agreement, the delivery of which occurs after the death of the intended funeral recipient.

“Provider” means a person, firm or corporation duly licensed and registered pursuant to the “Mortuary Science Act,” N.J.S.A. 45:7-32 et seq., to engage in the business and practice of funeral directing or mortuary science, or an individual serving as an agent thereof and so licensed:

1. Operating a duly registered mortuary in accordance with N.J.S.A. 45:7-32 et seq. and the regulations promulgated thereunder;

2. Having his, her or its business and practice based within the physical confines of the registered mortuary; and

3. Engaging in the practice of making preneed funeral arrangements, including, but not limited to, offering the opportunity to purchase or enroll in prepaid funeral agreements.

11:4-25.3 Forms submission requirements

(a) No insurer shall deliver or issue for delivery any funeral insurance policy in this State that has not been filed pursuant to law on or after December 21, 1993, or as otherwise permitted under this subchapter.

(b) The requirements of this subchapter apply to all previously filed forms as well as any forms submitted in the future. Previously filed forms which do not comply with these requirements shall be deemed withdrawn as of July 15, 1996.

(c) By November 12, 1996, each issuer shall submit to the Life Bureau of the Department of Insurance a list of all funeral insurance policy forms currently filed which meet the requirements contained herein. An executive officer of the company shall certify that the forms listed comply with these rules. Any previously filed form not listed shall be deemed withdrawn.

11:4-25.4 Disclosure requirements

(a) The submission for the filing of any funeral insurance policy shall be accompanied by a copy of the prepaid funeral agreement to which the policy is related. The prepaid funeral agreement shall provide that:

1. Cancellation of the funeral arrangements will not cancel or otherwise invalidate the funeral insurance policy;

2. Cancellation, withdrawal of, or loans made against, the proceeds or cash value of the policy shall void any price guarantees and indicate, therefore, the likelihood that inadequate funds will exist to pay for the original arrangements as intended; and

3. Cancellation of the prepaid funeral agreement will not result in the refund of premiums paid.

(b) Subsequent amendments to or any replacement of the prepaid funeral agreement, or any new or additional prepaid funeral agreement or agreements to be used with a filed funeral insurance policy, shall be submitted to the Department of Insurance for prior review and approval to assure compliance with the requirements of (a) above.

11:4-25.5 Loss ratio standard

(a) A funeral insurance policy shall be identified in the policy form as a life insurance policy or annuity contract.

(b) Funeral insurance policies identified as life insurance shall provide, at a minimum, the following benefits in relation to premiums:

1. The guaranteed death benefit shall not be less than the death benefit required by the limited death benefits forms rule at N.J.A.C. 11:4-21;

2. During the first seven policy years, the guaranteed death benefit shall not be less than the insurance adjusted premium fund;

3. The guaranteed death benefit in any policy year after the limited death benefit period defined at N.J.A.C. 11:4-21 shall not be less than the death benefit required at the end of that period by (b)1 above, and the death benefit for any policy year after the first seven policy years shall not be less than the death benefit required at the end of the seventh policy year by (b)2 above;

4. The minimum nonforfeiture benefits shall be those specified by the standard nonforfeiture law for life insurance at N.J.S.A. 17B:25-19, except that if the provision of the guaranteed death benefits required by (b)1, 2 and 3 above would cause a policy to be disqualified as life insurance for purposes of federal income tax treatment, a smaller nonforfeiture benefit, consisting of the maximum benefit possible while still maintaining qualification, may be provided. The actuarial memorandum certifying compliance with N.J.S.A. 17B:25-19 shall demonstrate that lower values are required and that the values provided are the maximum possible; and

5. A funeral insurance policy not meeting the standards of (b)1 to 4 above shall be considered an annuity contract and shall be so designated. It will be subject to the standards of (c) below.

(c) A funeral insurance policy designated as an annuity contract shall provide a death and surrender benefit. The benefit payable on death or surrender shall not be less than the amount required by the standard nonforfeiture law for individual deferred annuities at N.J.S.A. 17B:25-20.

11:4-25.6 Severability

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

11:4-25.7 Penalties

If after notice and an opportunity for hearing, the Commissioner of Insurance finds that a person has violated this regulation or the enabling legislation, a penalty, in addition to any other penalty, not exceeding \$2,000 for each violation, may be imposed and shall be collected and enforced pursuant to law including, but not limited to, N.J.S.A. 2A:58-1 et seq.

SUBCHAPTER 26. ANNUITY MORTALITY TABLES

11:4-26.1 Purpose

The purpose of the new subchapter is to recognize new mortality tables, the 1983 Table "a" and the 1983 GAM Table, for use in determining the minimum standard of valuation for annuity and pure endowment contracts.

11:4-26.2 Definitions

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

"1983 Table 'a'" means that mortality table adopted as a recognized mortality table for annuities in June, 1982 by the National Association of Insurance Commissioners.

“1983 GAM Table” means that mortality table adopted as a recognized mortality table for annuities in December, 1983 by the National Association of Insurance Commissioners.

11:4-26.3 Individual annuity or pure endowment contracts

(a) The 1983 Table “a” is approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual or pure endowment contract issued on or after September 11, 1981.

(b) The 1983 Table “a” shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1987.

11:4-26.4 Group annuity or pure endowment contracts

(a) The 1983 GAM Table and the 1983 Table “a” are approved as group annuity mortality tables for valuation and, at the option of the company either table may be used for purposes of valuation for any annuity or pure endowment purchased on or after September 11, 1981 under a group annuity or pure endowment contract.

(b) The 1983 GAM Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987 under a group annuity or pure endowment contract.

11:4-26.5 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.

SUBCHAPTER 27. REPORTING A LIQUOR LAW LIABILITY LOSS EXPERIENCE STATISTICS

11:4-27.1 Purpose

The purpose of this subchapter is to implement the statutory intent on N.J.S.A. 17:23-16, 17 and 18.

11:4-27.2 Scope

This subchapter shall apply to all insurers authorized to do business in New Jersey who issue policies covering liquor law liability for insureds in New Jersey.

11:4-27.3 Definitions

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

“Calendar-accident year” means the premiums earned during a 12-month period, and the paid and outstanding losses and claims resulting from accidents that occurred during the same period.

“Earned premium” means the portion of the written premium applicable to the expired or used part of the period for which the premium has been charged.

“Incurred losses outstanding” means the total amount of unpaid losses for claims for which the insurer is liable as of a specific date.

“Incurred losses paid” means all money paid to claimants or policyholders in direct settlement of a loss covered by the policies, including allocated claim expenses.

“Written premiums” means the total amount of premiums for all policies, plus additional premiums from endorsements and audits, but less return premiums from endorsements and cancellations. Reinsurance premiums are not to be considered either for reinsurance ceded or accepted.

11:4-27.4 Schedule and procedures for reporting liquor law liability loss experience statistics

(a) Each insurer authorized to do business in New Jersey, which issues policies covering liquor law liability for insureds in New Jersey, shall provide the Commissioner of Insurance with liquor law liability premium, loss and claim experience data, on an annual basis, for three calendar-accident years, 1984, 1985 and 1986 in accordance with the following schedule; for calendar-accident year 1984, losses valued as of March 31, 1985 shall be due on June 10, 1986; for calendar-accident years 1984 and 1985, losses valued as of March 31, 1986 shall be due on June 10, 1986; for calendar-accident years 1984, 1985 and 1986, losses valued as of March 31, 1987 shall be due on June 10, 1987.

(b) Each insurer authorized to do business in New Jersey, which issues policies covering liquor law liability for insureds in New Jersey, shall segregate, for each calendar-accident year, the data required in (a) above for those insureds which have an alcohol breath analyzer machine on their premises from those insureds which do not.

1. The data required by this subchapter shall be indicated on Forms A and B, appended to this subchapter, and shall be submitted to:

Department of Insurance
Property/Liability
20 West State Street
CN 325
Trenton, New Jersey 08625

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (b)1: Revised address.

11:4-27.5 Penalties

Failure to comply with this subchapter shall result in penalties pursuant to the insurance laws of New Jersey.

APPENDIX A

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
LIQUOR LAW LIABILITY INSURANCE
RISKS WITH ALCOHOL BREATH ANALYZER
MACHINES ON PREMISES

FORM A

Company Name _____

Calendar-Accident Year	Losses Valued as of	Premiums		Incurred Losses		Number of Claims †
		Written	Earned	Paid	Outstanding	
1984	3/31/85					
1984	3/31/86					
1984	3/31/87					
1985	3/31/86					
1985	3/31/87					
1986	3/31/87					

†NOTE: Cases to be counted as claims shall be only those in connection with which a loss payment has been made or a loss reserve established. A claim partly paid and partly outstanding shall be counted only once. A claim on which more than one payment is made shall be counted only once.

APPENDIX B

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
LIQUOR LAW LIABILITY INSURANCE
RISKS WITHOUT ALCOHOL BREATH ANALYZER
MACHINES ON PREMISES

FORM B

Company Name _____

Calendar-Accident Year	Losses Valued as of	Premiums		Incurred Losses		Number of Claims †
		Written	Earned	Paid	Outstanding	
1984	3/31/85					
1984	3/31/86					
1984	3/31/87					
1985	3/31/86					
1985	3/31/87					
1986	3/31/87					

†NOTE: Cases to be counted as claims shall be only those in connection with which a loss payment has been made or a loss reserve established. A claim partly paid and partly outstanding shall be counted only once. A claim on which more than one payment is made shall be counted only once.

SUBCHAPTER 28. GROUP COORDINATION OF BENEFITS

11:4-28.1 Purpose; applicability

(a) The purpose of this subchapter is to:

1. Discourage overinsurance and avoid duplication of benefits by permitting a reduction of benefits when a person is covered by more than one plan providing benefits or services for medical, dental, or other care or treatment;
2. Avoid claims payment delays and misunderstandings that result from the use of inconsistent or incompatible nonduplication provisions; and
3. Establish uniformity in the order in which plans pay their claims, and provide the authority for the orderly transfer of information needed to pay claims promptly.

(b) This subchapter applies to group contracts providing health care benefits which are issued, amended, or renewed by health insurers, health service corporations, hospital service corporations, medical service corporations, dental service corporations, dental plan corporations and all similar organizations.

11:4-28.2 Definitions

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

“Allowable expense” means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

1. Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expenses to like items of expense.

2. When a plan provides benefits in the form of services, the reasonable monetary value of each service shall be considered as both an allowable expense and a benefit paid.

3. The difference between the cost of a private hospital room and the cost of a semi-private hospital room shall not be considered an allowable expense under the above definition unless the patient’s stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

4. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense shall include only the corresponding expenses or services to which COB applies.

“Claim” means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

1. Services (including supplies);

11:4-30.13 Severability

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

11:4-30.14 (Reserved)

Repealed by R.2000 d.170, effective April 17, 2000.

See: 32 N.J.R. 167(a), 32 N.J.R. 1396(a).

Section was "Effect on previously filed forms".

SUBCHAPTER 31. TERM LIFE INSURANCE COMPARISON SURVEY

11:4-31.1 Purpose and scope

(a) This subchapter requires annual submission of data by insurers to the Department of Insurance, relevant to premium information on annual, renewable, convertible term life insurance policies so that the Department may compile an annual Term Life Insurance Comparison Guide for use by the general public.

(b) This subchapter applies to every insurer authorized to provide and sell life insurance policies in the State of New Jersey.

(c) This subchapter applies to all policies for annual, renewable, convertible term life insurance which were issued on or after January 1, 1988.

11:4-31.2 Definitions

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

"Annual, renewable, convertible term life insurance" means term insurance issued which provides renewal privileges, which has conversion privileges, and which provides premium increases on an attained age basis. This definition does not apply to indeterminate premium contracts, wherein the premium may be changed by the company subject to contractual maximums, nor does it apply to term contracts with re-entry options, wherein the insured may qualify for reduced premiums upon submission of satisfactory evidence of insurability.

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

"Department" means the Department of Insurance of the State of New Jersey.

"Insurer" means any legal entity authorized to write life insurance in the State of New Jersey who issues individual term life insurance in this State.

"Standard risk," means a usual and customary underwriting classification assigned to those insureds who do not smoke and who are expected to experience normal rates of mortality.

11:4-31.3 Coverage option survey

(a) Every insurer shall complete and file with the Department a premium survey requesting information on annual, renewable, convertible individual term life insurance policies with a face amount of \$100,000 as set forth below:

1. Insurers shall use the forms prescribed and provided by the Commissioner, which appear as Appendices A, B, and C of this subchapter, and are incorporated herein by reference as part of this subchapter.

2. The insurer shall provide the total number of individual annual term life insurance policies containing renewal and conversion privileges issued between January 1 through December 31 of the calendar year for which the survey is being conducted, inclusive of those dates.

i. The requested aggregate information shall include policies which become available for purchase by proposed insureds during the reported survey period.

ii. The requested aggregate information shall include policies which become unavailable to proposed insureds during the reported survey period.

3. The insurer shall provide the premium rates which apply to male and female insureds in age groups of 25, 35, 45 and 50 years, only for policies which are current and available for purchase by proposed insureds as of December 31st of the survey period being reported.

4. The insurer shall provide the annual dividend rate, if any, which applies to male and female insureds in each age group only for policies which are current and available for purchase by proposed insureds as of December 31st of the survey period being reported.

5. The insurer shall provide the projected premium and dividend rates which apply to male and female insureds in each age group for the sixth and eleventh policy year of the individual policy, but only for those policies which are current and available for purchase by proposed insureds as of December 31st of the survey period being reported.

6. Information for each current policy for which premium and/or dividend rates are to be reported for a particular survey period is to be submitted on separate sets of forms (Appendices A, B and C), and identified by its policy plan number.

(b) Survey forms shall be filed with the Department not later than the 31st day of March next following the survey period, which shall be that calendar year immediately preceding that March 31st. Completed coverage option survey forms shall be submitted to:

Division of Public Affairs
New Jersey Department of 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).

11:4-31.4 Survey forms

(a) Insurers shall file all requested aggregate information for annual, renewable, convertible term life policies

during the survey period as specified in the upper portion of the form in Appendix A.

(b) Insurers shall file current policy plan information for the first policy year as specified in the lower portion of the form in Appendix A.

(c) Insurers shall file current projected policy plan information for the sixth and eleventh year of the policy, as specified in the forms in Appendices B and C.

APPENDIX A

NJ DEPARTMENT OF INSURANCE TERM LIFE QUESTIONNAIRE

CHARGES AND REFLECT THE EXACT PREMIUM AS PAID BY A CONSUMER. DO NOT LIST RATES PER \$1,000. POLICY PLAN (FORM) NUMBER _____

COMPANY _____

PERSON FILING FORM (TITLE) _____

PHONE _____

NUMBER OF INDIVIDUAL ANNUAL RENEWABLE TERM POLICIES IN FORCE IN NJ (AS OF DECEMBER 31, 19__) _____

TOTAL INDIVIDUAL ANNUAL RENEWABLE TERM PREMIUM WRITTEN 19__ (INCLUDE ONLY NEW BUSINESS, NOT RENEWAL, ON AN ANNUALIZED BASIS) IN NJ? _____

DOES COMPANY PAY ANNUAL DIVIDENDS? _____

HOW IS THE POLICY SOLD? AGENTS _____ DIRECT MAIL _____ OTHER (EXPLAIN) _____

A.M. BEST CO. RATING _____

(FOR THE ABOVE DATA, PLEASE PROVIDE COMPANY AGGREGATES FOR THE TERM JAN. 1 TO DEC. 31 OF THE REPORTING YEAR.)

PLEASE PROVIDE PREMIUM RATES FOR A \$100,000 FACE AMOUNT, ANNUAL, RENEWABLE, CONVERTIBLE TERM LIFE POLICY FOR THE FIRST POLICY YEAR. RATES SHOULD INCLUDE EXPENSE

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

* PLEASE ANSWER BY USING APPROPRIATE LETTER
(A) MEDICAL EXAM _____ (B) QUESTIONNAIRE _____
(C) OTHER, EXPLAIN _____

(For data above and on forms B & C, please provide data for only those policy plans still in effect on Dec. 31 of the reporting year. Use a separate set of forms for each policy plan.)

PLEASE RETURN TO:

DIVISION OF PUBLIC AFFAIRS

NEW JERSEY DEPARTMENT OF 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).

APPENDIX B

NJ DEPARTMENT OF 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		FEMALE STANDARD	
		Premium	Dividend	Premium	Dividend
25					
35					
45					
50					

* PLEASE ANSWER BY USING APPROPRIATE LETTER
 (A) MEDICAL EXAM ____ (B) QUESTIONNAIRE ____
 (C) OTHER, EXPLAIN _____

PLEASE RETURN TO:

DIVISION OF PUBLIC AFFAIRS

NEW JERSEY DEPARTMENT OF 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).

APPENDIX C

NJ DEPARTMENT OF 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		FEMALE STANDARD	
		Premium	Dividend	Premium	Dividend
25					
35					
45					
50					

* PLEASE ANSWER BY USING APPROPRIATE LETTER
 (A) MEDICAL EXAM _____ (B) QUESTIONNAIRE _____
 (C) OTHER, EXPLAIN _____

PLEASE RETURN TO:

DIVISION OF PUBLIC AFFAIRS
 NEW JERSEY DEPARTMENT OF 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).

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.

(e) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined at N.J.A.C. 11:4-32.3(b)2, 3 and 4 may not be used to calculate the one-year valuation premiums.

(f) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

(g) Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined at N.J.A.C. 11:4-32.2.

(h) Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described at N.J.A.C. 11:4-32.4(b) with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

(i) The minimum reserves during the secondary guarantee period are the greater of:

1. The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or
2. The minimum reserves required by other rules governing universal life plans.

(j) Any contract provision that keeps the death benefit in force beyond the period using the guaranteed terms of the contract that would cause the policy values to be zero must be valued consistently with the principles underlying this subchapter. The methods of valuation, if other than those required by this subchapter, must be submitted to the Commissioner for approval.

Administrative correction.
See: 32 N.J.R. 477(a).

11:4-32.6 Operative date

This subchapter shall become operative January 1, 2000, except that insurers meeting the requirements of N.J.A.C. 11:4-32.1(c)6 and obtaining the approval of the Commissioner to calculate reserves for policies issued prior to January 1, 2000 using the methods and assumptions described in this subchapter may elect an operative date of December 31, 1999 for reporting purposes.

APPENDIX

SELECT MORTALITY FACTORS

The six tables of select mortality factors contained herein include: (1) male aggregate, (2) male nonsmoker, (3) male smoker, (4) female aggregate, (5) female nonsmoker, and (6) female smoker.

These tables apply to both age last birthday and age nearest birthday mortality tables.

For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are 80 percent of the appropriate male table in this Appendix, plus 20 percent of the appropriate female table in this Appendix.

SELECT MORTALITY FACTORS

Issue Age	Male, Aggregate																			
	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	76	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	92	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	65	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	88	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	53	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	82	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
67	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
68	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
69	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
70	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
71	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
72	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
73	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
74	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
75	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
76	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
77	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
78	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
79	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
80	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
81	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
82	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
83	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
84	18	24	32	36	40	41	42	42	42	45	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Issue Age	Male, Smoker																			
	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	75	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	53	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	85	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Issue Age	Female, Aggregate Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	51	47	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	45	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Issue Age	Female, Smoker Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100

Issue Age	Duration																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SUBCHAPTER 33. EXCESS INTEREST RESERVE ADJUSTMENT

11:4-33.1 Purpose

This subchapter establishes procedures for modifying the calculation of excess interest reserves when a life insurer guarantees to credit policy values with interest which exceeds the maximum valuation rate prescribed in N.J.S.A. 17B:19-8. This subchapter does not limit or restrict any other requirement of law.

11:4-33.2 Applicability and scope

This subchapter applies to all life insurance policies, pure endowment and annuity contracts issued by an insurer transacting business in this State in which the insurer has committed to crediting interest to policy values for any period that extends beyond the valuation date at a rate that exceeds the maximum valuation rate as specified and defined in N.J.S.A. 17B:19-8.

11:4-33.3 Requirements

(a) In addition to the basic policy reserve required under N.J.S.A. 17B:19-8, a life insurer is also required by N.J.S.A. 17B:19-8 to establish an excess interest reserve whenever the insurer has committed to crediting interest to policy values for any period of time that extends beyond the valuation date at a rate that exceeds the maximum valuation interest rate.

(b) The amount of the excess interest reserve required equals the total amount of the excess interest commitment, discounted to the valuation date using an interest rate not greater than the maximum rate prescribed under N.J.S.A. 17B:19-8.

(c) Upon written request by an insurer to the Commissioner, the Commissioner may determine that the excess interest reserve calculated on that portion of the policy value encumbered by a policy loan is not required. In making such determination, the Commissioner shall consider the following:

1. The relationship between any minimum guaranteed interest rate, the maximum valuation interest rate and interest rate commitment; and
2. Such other information which the Commissioner deems necessary to make a determination.

11:4-33.4 Separability

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 to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 34. LONG-TERM CARE INSURANCE

11:4-34.1 Purpose

The purpose of this subchapter is to implement the insurance laws of this State, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

11:4-34.2 Applicability and scope

Except as otherwise specifically provided, this subchapter applies to all long-term care insurance policies delivered or issued for delivery in this State on or after the effective date hereof, by insurers; fraternal benefit societies, nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

11:4-34.3 Definitions

Unless the context requires otherwise, the definitions in this section shall apply throughout this subchapter.

“Applicant” means:

1. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and
2. In the case of a group long-term care insurance policy, the proposed certificate holder.

“Certificate” means, for the purposes of these rules, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.

“Commissioner” means the Commissioner of Insurance.

“Guaranteed renewable” means long-term care insurance coverage which grants an insured the right to continue the policy in force by the timely payment of premiums and in which the insurer has no right to unilaterally change any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

“Group long-term care insurance” means a long-term care insurance policy which is delivered or issued for delivery in this State and issued to:

1. A group conforming to one of the descriptions set forth in N.J.S.A. 17B:27-2 to N.J.S.A. 17B:27-8 inclusive or N.J.S.A. 17B:27-27.
2. A group other than as described in paragraph 1, subject to a finding by the Commissioner that:
 - i. The issuance of the group policy is not contrary to the best interests of the public;
 - ii. The issuance of the group policy would result in economies of acquisition or administration; and
 - iii. The benefits are reasonable in relation to the premiums charged.

“Long-term care insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide benefits for not less than 24 consecutive months either over the life of the policy or per occurrence for such covered person on an expense incurred, indemnity, prepaid

or other basis; for one or more medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. Long-term care insurance shall not include any insurance policy or rider which is offered primarily to provide life insurance coverage, term of care coverage of less than 24 months either over the life of the policy or per occurrence, basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, mental health or substance abuse coverage, or limited benefit health coverage.

“Noncancellable” means long-term care insurance coverage which gives the insured the right to continue the insurance in force by the timely payment of premiums set forth in the policy and in which the insurer has no right to unilaterally change any provision of the policy while the policy is in force.

“Policy” means, for the purposes of these rules, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

Amended by R.1996 d.180, effective April 1, 1996.
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

Added “guaranteed renewable” and “noncancellable” and amended “long-term care insurance”.

11:4-34.4 Filing requirement

No group long-term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in paragraph 2 of the definition of “group long-term care insurance” (N.J.A.C. 11:4-34.3), unless the group policy or certificate thereunder has been submitted to and filed by the Commissioner in accordance with the laws and regulations of this State.

11:4-34.5 Policy definitions

(a) No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements.

1. “Medicare” shall be defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as

Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

2. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder.

3. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

4. "All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition shall require that the provider be appropriately licensed or certified.

11:4-34.6 Policy practices, provisions and prohibitions

(a) No long-term care insurance policy shall:

1. Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

3. Provide coverage for skilled nursing care only, or provide coverage for skilled care in a facility which is more than double the coverage for lower levels of care in a facility, or provide coverage that conditions eligibility for benefits for levels of care on the receipt of higher levels of care; or

4. Require prior institutionalization to condition, limit or restrict eligibility for benefits; or

5. Require for purposes of a restoration of benefits provision that the period between confinements be more than six months; or

6. Contain a mandatory case management provision; or

7. Contain renewal provisions other than guaranteed renewable or noncancellable.

(b) Preexisting condition limitations in long-term care insurance policies or certificates shall not exclude coverage for more than six months after the effective date of coverage under the policy for a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. Nothing, however, shall prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

(c) The loss ratio standards set forth in N.J.A.C. 11:4-18.5; the minimum standards provisions set forth in N.J.S.A. 17B:26-45 and N.J.A.C. 11:4-16, 17 and 18; and the reserve requirements set forth in N.J.S.A. 17B:19-5 and N.J.A.C. 11:4-6 are hereby incorporated by reference and shall apply to long-term care insurance, to the extent that such standards, provisions and requirements are not inconsistent with these rules.

(d) Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within 30 days of its delivery and to have the premium refunded, if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(e) A certificate issued pursuant to a group long-term care insurance policy delivered or issued for delivery in this State shall include:

1. A description of the principal benefits and coverage provided in the policy;

2. A statement of the principal exclusions, reductions and limitations contained in the policy; and

3. A statement that the group master policy determines governing contractual provisions.

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the loss ratio of any element of any insurance construct will not differ by more than 10 percent from the anticipated loss ratio for the policy.

ii. For the purpose of this paragraph, "construct" means the risk variables which significantly affect the cost of the coverage. For example, age could be a construct wherein its elements would be age 20, age 21 and so forth. The Department of Insurance is particularly concerned with anticipated loss ratios by issue age or issue age groupings;

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

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

Repeal and New Rule, R.1996 d.180, effective April 1, 1996.
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

Section was "Compliance".

Public Notice: Alternate interest rates for rate submissions.
See: 31 N.J.R. 1642(b).

Public Notice: Alternate interest rates for rate submissions.
See: 32 N.J.R. 2959(a).

11:4-34.14 Loss ratio standards for individual long-term care insurance

(a) Long-term care insurance is subject to the loss ratio requirements set forth at N.J.A.C. 11:4-18.5.

(b) When a long-term care policy is funded by a level premium payable over the life of an insured whose issue age is under 65, the anticipated loss ratio cannot be less than:

$$(A-B-C)/A$$

where: A=the present value at policy issue of one dollar of annualized premium;

B=the present value at policy issue of the product of R and one dollar of annualized premium payable for policy years from policy issue to attained age 65;

C=the present value at policy issue of the product of .35 and one dollar of annualized premium payable for policy years after attained age 64;

and where R=the complement of the applicable loss ratio factor for coverage before attained age 65, with complements of .50 for noncancellable insurance and .45 for guaranteed renewable insurance.

New Rule, R.1996 d.180, effective April 1, 1996.
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

11:4-34.15 Spousal discount

(a) A spousal discount is permitted in individual long-term care insurance when the following conditions are met:

1. The objective basis of the rate differential is included in the actuarial memorandum as required by N.J.A.C. 11:4-18.4(a)1iv;

2. All conditions required to be satisfied in order to receive and retain the discount shall be disclosed and shall be related to the objective basis of the rate differential. When improved morbidity is the objective basis for a spousal discount, insurers shall extend the discount to all married individuals regardless of whether the insured's spouse is covered under a long-term care policy; and

3. When a husband and wife both apply for and are issued a long-term care policy offering a spousal discount, both individuals shall receive the discount.

New Rule, R.1996 d.180, effective April 1, 1996.
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

SUBCHAPTERS 35 THROUGH 36. (RESERVED)

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

11:4-37.1 Purpose and scope

(a) The purpose of this subchapter is to set forth standards and procedures whereby a carrier shall obtain approval from the Commissioner of its offering of health benefits plans utilizing selective contracting arrangements that promote health care cost containment while adequately preserving quality of care.

(b) This subchapter applies to all carriers operating pursuant to Title 17B of the New Jersey statutes, and issuing health benefits plans utilizing selective contracting arrangements in this State or which cover New Jersey residents. This subchapter shall not apply to the following: 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.; hospital and medical service corporations operating pursuant to N.J.S.A. 17:48B-1 et seq.; dental service corporations operating pursuant to N.J.S.A. 17:48C-1 et seq.; dental plan organizations operating pursuant to N.J.S.A. 17:48D-1 et seq.; or health service corporations operating pursuant to N.J.S.A. 17:48E-1 et seq.

(c) The provisions of these rules shall apply except where in conflict with any policy or contract issued pursuant to the New Jersey Individual Health Coverage Act at N.J.S.A. 17B:27A-1 et seq. or the New Jersey Small Employer Health Coverage Act at N.J.S.A. 17B:27A-17 et seq. If such a conflict exists, all remaining provisions of these rules determined not to be in conflict shall remain in effect.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Added (c).

11:4-37.2 Definitions

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

“Allowable expense” means the usual, customary and reasonable item of expense for a covered service when the item of expense is covered at least in part by the health benefits plan.

“Carrier” means any insurance company operating pursuant to Title 17B of the New Jersey statutes and authorized to issue health benefits plans in this State.

“Coinsurance” means the percentage of the allowable expenses payable by the covered person.

“Coinsurance differential” means the difference in the coinsurance percentage applicable to in-network and out-of-network benefits.

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

“Copayment” means a specified dollar amount a covered person must pay for specified covered services.

“Covered person” means a person on whose behalf the carrier is obligated to pay benefits pursuant to the health benefits plan.

“Covered service” means a service provided to a covered person under a health benefits plan for which a carrier is obligated to pay benefits.

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

“Emergency care” means covered services that are provided by any health care provider for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that absence of immediate attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

“Evidence of coverage” means any certificate, agreement or contract which includes a statement of the essential benefits, limitations, exclusions and services of the health benefits plan, and which is issued to the covered person by the carrier.

“Formulary” means a list of prescription medications that are preferred for use by a health plan.

“Health benefits plan” means a policy, contract or evidence of coverage delivered or issued for delivery in this State that pays benefits and/or arranges for the provision of covered healthcare services and supplies. For purposes of this regulation, health benefits plan shall not include accident only, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services provided pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers’ compensation or similar law, automobile medical payment insurance, and personal injury protection issued pursuant to N.J.S.A. 39:6A-1 et seq.

“Health care provider” means any physician, hospital, facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

“Preferred provider” means a health care provider or group of health care providers who have entered into selective contracting arrangements with a carrier or a preferred provider organization.

“Preferred provider organization” or “PPO” means an entity other than a carrier that contracts with preferred providers to establish selective contracting arrangements.

“Selective contracting arrangement” or “SCA” means an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations.

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

Rewrote “Emergency care”, “Evidence of coverage”, “Health benefits plan” and “Health care provider”; and inserted “Formulary”.

11:4-37.3 Standards for selective contracting arrangements

(a) For purposes of paying for covered services under a health benefits plan, a selective contracting arrangement entered into by a carrier shall meet the following criteria:

1. The selective contracting arrangement shall include a mechanism for the review or control of utilization of covered services;
2. The selective contracting arrangement shall provide for an adequate number of preferred providers by specialty to render covered services in the geographic service area(s) where it functions;

11:4-37.4 Selective contracting arrangement approval and amendment procedures

(a) No carrier shall issue health benefits plans utilizing selective contracting arrangements unless the carrier has entered into such arrangements directly with preferred providers or has contracted with preferred provider organizations.

(b) For purposes of obtaining the Commissioner's approval under this subchapter, a carrier issuing health benefits plans utilizing a selective contracting arrangement shall submit four copies of a complete selective contracting arrangement approval application on a form to be provided by the Department. The items set forth at (c) 14 and 15 below shall be set forth separately from the remainder of the items to be included in the approval application.

1. Two copies of the entire application shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Managed Care Bureau, 11th Floor
Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

2. Two copies of the entire application, together with the appropriate filing fee set forth at N.J.A.C. 11:4-37.8, shall be submitted to the Department of Health and Senior Services at the following address:

New Jersey Department of Health and Senior Services
Office of Managed Care
John Fitch Plaza, Room 600
PO Box 360
Warren and Market Streets
Trenton, NJ 08625-0360

(c) A complete selective contracting arrangement approval or amendment application shall include the following:

1. A narrative description of the health benefits plan(s) to be offered, including, but not limited to, the nature of the plan, the market for the plan and a description of the geographic areas to be served.

2. A statement that the carrier is either entering into a selective contracting arrangement directly with preferred providers, or is contracting with a PPO. In the latter case, the carrier shall include the following:

i. The identity and a description of the PPO that will operate and/or administer the selective contracting arrangement;

ii. A description of the relationship between the carrier and the PPO, and a copy of the contract between the carrier and the PPO; and

iii. A certification signed by a senior officer of the PPO that the PPO does not engage in the business of insurance in this State, and in no way assumes risk in the provision of services for the treatment of injury or illness or preventative care for any person or on behalf of any person other than its own employees;

3. A description and map of the geographic area to be served, identified by county. If sub-areas of counties are to be proposed as boundaries of the service area, the map should also include zip codes;

4. A description of the procedures by which covered services and other benefits may be obtained by covered persons using the selective contracting arrangement;

5. If the carrier is contracting directly with the preferred providers, a narrative description of the financial arrangements between the carrier and the preferred providers. If the carrier is contracting with the PPO, a narrative description of the financial arrangements between the carrier and the PPO, including the manner in which the PPO compensates its providers, a flow diagram of the complete billing and payment cycle that includes all intermediary steps for each method of reimbursement used (for example, capitation, fee for service) from the time services are rendered until the provider is paid;

6. A copy of every standard agreement, including all versions of variable text, establishing the selective contracting arrangements that will be utilized in the health benefits plan, including the agreement(s) the carrier or PPO has entered into with health care providers, classes of health care providers or any other entity for the provision of administrative or health care services. The agreement(s) shall include a description of the responsibilities of the contracting parties as they relate to the administration, financing and delivery of health care services;

7. Evidence that providers shall maintain licensure, certification and adequate malpractice coverage.

i. With respect to physicians and dentists, malpractice insurance shall be at least \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year;

ii. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year.

iii. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year.

8. A description of the criteria and method used to select preferred providers, including any credentialing plan;

9. The names and addresses of preferred providers by specialty, county, municipality and zip code, accompanied by maps of the geographic service areas identifying the location of these providers, and a copy of the provider directory to be distributed to covered persons;

10. A description of any provisions which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;

11. A description of the utilization review program, including:

i. A description of the criteria and methods to be used in utilization control, particularly the criteria for determining over- and under-utilization; and

ii. A description of the mechanisms for evaluating the success or failure of the utilization review program;

12. A description of the quality assurance program. At a minimum, this shall include:

i. A clear description of how quality of care will be monitored and controlled;

ii. The criteria used to define and measure quality;

iii. The criteria used to determine the success or failure of the quality assurance program; and

iv. A description of the staff and their qualifications that will be responsible for the quality assurance program;

13. A description of the complaint and grievance system available to covered persons, including procedures for the registration and resolution of grievances;

14. A copy of every standard form policy or contract, including all variations of variable text, to be issued by the carrier to the contractholders of health benefits plans, which shall include the requirements set forth at N.J.A.C. 11:4-37.3(b)1, 2 and 3;

15. A copy of every standard form of evidence of coverage to be issued by the carrier to covered persons, setting forth the carrier's contractual obligations to pay for covered services provided to covered persons, which shall include the requirements set forth at N.J.A.C. 11:4-37.3(b)1, 2 and 3;

16. A description of the incentives for covered persons to use the services of preferred providers;

17. A provider agreement of the PPO or carrier stating in substance that:

Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, payment by the health carrier or intermediary that is other than what the provider believed to be in accordance with the reimbursement provision of the provider agreement or is otherwise inadequate, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services;

18. An organizational chart of the carrier or PPO depicting the area responsible for managing selective contracting arrangements;

19. A listing and biographical affidavit of the officers and directors (NAIC Form #280), if any, of the carrier or PPO responsible for managing the selective contracting arrangement;

20. The address of the office of the carrier or PPO responsible for managing the selective contracting arrangement;

21. A copy of the basic organization documents of the PPO if the carrier is contracting with a PPO, including the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto, together with a copy of the bylaws, rules and policies or similar documents regulating the conduct of the internal affairs of the PPO;

22. A copy of the PPO's audited financial statement most recent to the time of application if the carrier is contracting with a PPO; and

23. The following three-year pro-forma information:

i. Enrollment projections indicating the number of covered persons by rating status (that is, single, husband/wife, parent/child and family) and number of covered persons for each county. This data is to be provided quarterly for the first year, and annually for the remaining two years; and

ii. Financial projections for the PPO if the carrier is contracting with a PPO, including balance sheet, revenue and expense statement and a cash-flow statement limited to the selective contracting arrangement business only.

(d) Any changes in the items listed at N.J.A.C. 11:4-37.3 and this section made either during the approval process or at any time after the arrangement has been approved shall be reported in writing to the Department within 30 days, at the following address:

New Jersey Department of Banking and Insurance
 Managed Care Bureau, 11th Floor
 Life and Health Division
 20 West State Street
 PO Box 325
 Trenton, NJ 08625-0325

(e) The Commissioner, in consultation with the Commissioner of Health and Senior Services as necessary, shall review these documents and grant approval, within 60 days of the carrier's filing its complete application or a complete amendment to its application pursuant to this section to those carriers whose selective contracting arrangements are determined to meet the criteria set forth in this subchapter. The Commissioner may extend the 60-day time frame an additional 30 days for good cause shown and shall provide notice to the carrier of such extension. A decision to deny approval shall be accompanied by a written explanation by the Department of the reasons for denial. A carrier whose selective contracting arrangement has been denied approval may request an administrative hearing pursuant to the procedures at N.J.A.C. 11:4-37.6.

(f) The approval of a selective contracting arrangement issued under this subchapter by the Commissioner, in consultation with the Commissioner of Health and Senior Services shall remain in force for a period of three years excepting suspension or revocation pursuant to this subchapter.

(g) A carrier shall apply for triennial renewal of the Department's approval of its selective contracting arrangement on forms provided by the Department at least 60 days prior to the expiration of the previous three-year approved period. Applications for renewal of the Department's approval shall be subject to the filing fee set forth at N.J.A.C. 11:4-37.8. If the Department has not issued a written notice of disapproval within 60 days of receipt of a complete renewal application, which clearly sets forth the reasons for disapproval of the renewal application, the renewal application shall be deemed approved.

Amended by R.1998 d.302, effective June 15, 1998.
 See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
 Rewrote the section.

11:4-37.5 Confidentiality

(a) The following data or information submitted to the Department under this subchapter shall not be confidential and may be released by the Department and the Department of Health and Senior Services, but only upon written, specified request:

1. The carrier's narrative description of the health benefits plan(s) to be offered;

2. The identity of the PPO that will operate or administer the SCA;

3. The certification signed by a senior officer of the PPO that the PPO does not engage in the business of insurance in this State, and in no way assumes risk;

4. The description and map of the geographic area to be served;

5. The description of the procedures by which covered services and other benefits may be obtained by covered persons;

6. The standard agreements establishing the selective contracting arrangements that will be used in the health benefits plan, not including the agreement(s) the carrier or PPO has entered into with health care providers, classes of health care providers or any other entity for the provision of administrative or health care services;

7. The evidence that providers maintain the required licensure, certification and malpractice coverage;

8. The names and addresses of preferred providers by specialty, county, municipality and zip code; maps of the geographic service areas identifying the location of the providers; and provider directories to be distributed to covered persons;

9. The description of any provisions which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;

10. The description of the complaint and grievance system available to covered persons, including procedures for the registration and resolution of grievances;

11. The standard form policies and contracts, including variables, to be issued by the carrier to the contractholders of health benefits plans;

12. The standard evidence of coverage forms to be issued by the carrier to covered persons setting forth the carrier's contractual obligations to pay for covered services provided to covered persons;

13. The description of the incentives for covered persons to use the services of preferred providers;

14. The provisions within the health benefits plan for holding covered persons financially harmless for payment denials by or on behalf of the carrier for improper utilization of covered services caused by preferred providers;

15. The organizational chart of the carrier or PPO depicting the area responsible for managing selective contracting arrangements;

16. The listing and biographical affidavit of the officers and/or directors (NAIC Form #280) responsible for managing the SCA; and

17. The PPO's most recent audited financial statement if the carrier is contracting with a PPO.

(b) All data or information submitted to the Department under this subchapter, except for those items included in (a) above, is confidential and shall not be disclosed by the Department to any person other than employees and representatives of the Department and the Department of Health and Senior Services.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Rewrote (a).

11:4-37.6 Denial, suspension and revocation

(a) The approval of a selective contracting arrangement issued by the Department under this subchapter may be denied, suspended or revoked if the Commissioner determines that:

1. The selective contracting arrangement criteria set forth in this subchapter are not being met;
2. Payment for covered services provided under the selective contracting arrangement is not in accordance with the terms of the approved arrangement;
3. The arrangement for the payment of covered services fails to meet the requirements of these rules; or
4. Any false or misleading information is submitted by the carrier seeking approval.

(b) If the Commissioner believes that any of the conditions set forth in subsection (a) above exist, the Commissioner shall notify the carrier by directing a notice by certified mail or personal delivery to the last known business or mailing address of the carrier. The notice shall include:

1. A description of the condition(s) in (a) above alleged to exist;
2. A statement that the carrier may within 20 days correct the condition(s) alleged to exist; and
3. A statement advising the carrier of the procedure for requesting a hearing.

(c) A carrier requesting a hearing pursuant to (b)3 above shall submit the hearing request to the Department at the following address:

New Jersey Department of Banking and Insurance
Managed Care Bureau, 11th Floor
Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

The hearing request shall include:

1. The name, address and telephone number of a contact person familiar with the matter;
2. A copy of the Commissioner's written allegations;
3. A statement requesting a hearing; and
4. A concise statement describing the factual and legal bases for which the carrier believes that the Commissioner's allegations are erroneous; and
5. All relevant documents in support of the hearing request.

(d) The Commissioner may, after receipt of a properly completed request for a hearing, provide an informal conference between the carrier and such personnel of the Department or Department of Health and Senior Services as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

(e) 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.

1. If the Commissioner concludes 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.

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

(f) In addition, or as an alternative to suspension or revocation, the Commissioner may impose such other penalties as provided by law.

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.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
In (c), changed names and address.

11:4-37.7 Monitoring; auditing

(a) The Commissioner, in consultation with the Commissioner of Health and Senior Services, as necessary shall monitor and conduct periodic audits or examinations of the carrier's selective contracting arrangements at the expense of the carrier as necessary to ensure compliance with the approval criteria set forth in this subchapter.

(b) All records of the carrier relating to selective contracting arrangements shall be disclosed upon request of and in a format acceptable to the Commissioner. If such records are maintained in a coded or semi-coded manner, a legend for the codes shall be provided to the Commissioner.

Amended by R.1998 d.302, effective June 15, 1998.

See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).

In (a), inserted "at the expense of the carrier" following "arrangements".

11:4-37.8 Filing and review fees

(a) Every carrier shall pay a \$1,500 filing fee for filing each of the following with the Department:

1. A selective contracting arrangement approval application pursuant to N.J.A.C. 11:4-37.4; and

2. A triennial renewal application of a selective contracting arrangement pursuant to N.J.A.C. 11:4-37.4(g).

(b) The approval application and renewal application fees of \$1,500 shall be payable to the "New Jersey Department of Health and Senior Services."

(c) Every carrier, in addition to complying with the filing and review fee requirements set forth in this section, shall be subject to any fees that may be applicable as set forth in N.J.A.C. 11:1-32.

Amended by R.1998 d.302, effective June 15, 1998.

See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).

In (a), decreased filing fees from \$3,000 to \$1,500, inserted "approval application" in 1, deleted a former 2, and recodified former 3 as 2; and rewrote (b).

11:4-37.9 Penalties

Carriers failing to comply with the requirements of this subchapter may be subject to penalties authorized by law.

New Rule, R.1998 d.302, effective June 15, 1998.

See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).

APPENDIX

		APPENDIX—Actuarial Justification of Benefit Differentials (SCA) or (HMO)							
		In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network
IN-NETWORK BENEFITS (IN)									
	Hospital Copay/Day								
	Doctor's Office Visit Copay								
OUT-OF-NETWORK BENEFITS (OON)									
	Coinsurance								
	Deductible								
	Out-of-Pocket Limit								
(1)	Starting Claim Cost (per member per month)								
- (2)	Adjustment for Hospital Copay								
- (3)	Adjustment for Doctor Copay								
= (4)	Adjusted Claim Cost								
(5)	Value of Deductible								
x (6)	Impact of 3x Family Deductible								
= (7)	Adjusted Value of Deductible								
(8)	Adjusted Claim Cost = (4) - (7)								
x (9)	Coinsurance								
= (10)	Adjusted Claim Cost								
+ (11)	Impact of Out-of-Pocket Limit								
= (12)	Adjusted Claim Cost								
(13)	Provider Discount								
(14)	Net Claim Cost (Line 12: 100% - Line 13)								
(15)	Benefit Ratio (Line 14/Line 1)								
(16)	Benefit Differential (Line 15 IN - Line 15 OON) (as a %)								

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

SUBCHAPTERS 38 THROUGH 39. (RESERVED)

SUBCHAPTER 40. LIFE/HEALTH/ANNUITY
FORMS

11:4-40.1 Purpose and scope

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

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

11:4-40.2 Definitions

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

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

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

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

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

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

11:4-40.4 General requirements

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

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

New Jersey Department of 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 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.

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

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

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

1. A properly completed Initial Submission Data Form as set forth at Exhibit A in the Appendix to this subchapter, incorporated herein by reference;
2. A specimen copy of the form in duplicate;
3. A cover letter in duplicate, which shall include the following:
 - i. The insurer's identity;
 - ii. The form number(s) of the form(s) being submitted. If several forms are being submitted, the form numbers may be included as an attachment to the cover letter;
 - iii. A general description of the nature of the form(s), including, but not limited to, the specific market and issue ages;
 - iv. The identity of one individual authorized as the insurer's contact person for the form(s) being filed;
 - v. A statement as to whether the form was previously submitted to the Department, including the date and status of any such submission; and
 - vi. For rider forms or endorsements, an explanation of the manner in which the rider or endorsement affects the mortality basis or premiums for the base policy;
4. A certification signed by a responsible officer of the insurer that the forms comply with all laws, rules, bulletins and published guidelines applicable to the particular type of form. The certification may be included in the text of the cover letter described in (b)3 above if the cover letter is signed by a responsible officer of the insurer;
5. A readability certification if required pursuant to N.J.S.A. 17B:17-21d;
6. An actuarial memorandum which complies with the requirements of any applicable statutes, rules or published guidelines, and premium rates if required by this subchap-

ter or other law or rule, for the particular type of form being submitted;

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

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

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

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

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

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

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

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

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

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

1. A properly completed Resubmission Data Form;
2. A cover letter in duplicate, which shall include all the information required to be included in the initial submission cover letter as set forth at (b) above, in addition to the Department submission number;
3. The revised form(s) or page(s) only, if practicable, of the disapproved form(s). One copy shall be marked to

show the changes from the prior submission, and one copy shall be unmarked. The resubmission shall also include a marked copy of any revised support material (for example, a periodic report);

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

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

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

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

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

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

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

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

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

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

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

1. If the interest rate and/or non-forfeiture values appearing on the form change as a result of the new interest rate, the submission shall include the new page(s) bearing distinct identifying form numbers for filing;
2. A revised actuarial memorandum reflecting the change in interest rate or a statement that the new rate does not affect the memorandum currently on file;
3. Pursuant to N.J.S.A. 17B:25-19h(x), an insurer is not required to refile other provisions of the form to file the changes described in (a)1 and 2 above; and
4. The interest rate and non-forfeiture values may be filed as variable to the extent they are equal to or determinable from the maximum interest rate, and cash values calculated using that rate, as described in N.J.S.A. 17B:25-19. Insurers shall place variable brackets around the appropriate item(s) on the revised policy page(s).

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

11:4-40.8 Certificate of assumption form approval procedures

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

1. A clear indication whether the assuming and ceding insurers are authorized in this State for the lines of business being assumed;
2. A general description of the type of business being assumed;
3. A list of the forms and filing dates with which the certificate will be used, together with a copy of the Department's filing letters applicable to these forms;
4. For forms intended for use with group business, the provisions of the form must be consistent with both the group contract and certificate form;
5. Evidence of approval of both the transaction and the forms, if required, by the state of domicile of the assuming and ceding insurers;

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 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 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.

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.

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 Insurance.

"Department" means the New Jersey Department of Insurance.

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

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

“Minimum guarantee premium” means the minimum premium as established by the insurer to maintain coverage in force and avoid lapse.

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

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

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

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

11:4-47.3 General requirements

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

11:4-47.4 Pricing assumptions—actuarial certification

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

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

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

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

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

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

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

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

may be decreased, on a non-guaranteed basis, in the future.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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