

CHAPTER 4
ACTUARIAL SERVICES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subchapter 32, Valuation of Life Insurance Policies, was adopted as new rules by R.1999 d.442, effective December 20, 1999 (operative

January 1, 2000, except as provided in N.J.A.C. 11:4-32.6). See: 31 N.J.R. 2845(a), 31 N.J.R. 4268(c).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.2001 d.7, effective November 30, 2000. See: Source and Effective Date.

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

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SUBCHAPTER 1. NEW JERSEY INSOLVENT HEALTH MAINTENANCE ORGANIZATION ASSISTANCE ASSOCIATION

Authority

N.J.S.A. 17:1-8.1; 17:1-15e; and 17B:32B-1 et seq.

Source and Effective Date

R.2001 d.122, effective April 2, 2001.
See: 32 N.J.R. 3907(a), 33 N.J.R. 1109(a).

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
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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

Law Reviews and Journal Commentaries

Long-Term Care Insurance: Bear Trap or Safety Net? Marilyn Askin, 172 N.J.L.J. 34 (1995).

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

11:4-34.4 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.

(f) No policy shall be delivered or issued for delivery in this State as long-term care insurance, if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except in the case of the following:

1. Preexisting conditions or diseases, in accordance with (b) above and N.J.A.C. 11:4-34.8(d);
2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or any other organic brain disease such as senile dementia;
3. Alcoholism and drug addiction;
4. Illness, treatment or medical condition arising out of:
 - i. War or act of war (whether declared or undeclared);
 - ii. Participation in a felony, riot or insurrection;
 - iii. Service in the armed forces or units auxiliary thereto;
 - iv. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
 - v. Aviation (this exclusion applies only to non-fare-paying passengers); or
5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
6. This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(g) Termination of long-term care insurance shall be without prejudice to any benefits payable for continuous loss which commenced while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be predicated upon the continuous disability of the covered person and limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(h) No policy may be advertised, marketed or offered as long-term care or nursing home insurance unless it complies with the provisions of these rules.

(i) A cash value or premium refund benefit may only be included in a long-term care policy if the following conditions are met:

1. The insurer shall submit copies of sales or advertising literature and a statement of the class or type of insureds to whom the policy will be sold;
2. The benefit payable is not reduced by an amount greater than the aggregate of the claims paid under the policy; and
3. If the cash value or premium refund benefit depends on the policy being in force for a given term, and if the insured dies or otherwise terminates coverage prior to the end of the term, an appropriate benefit is provided. The benefit should be related to the number of years the cash value or the premium refund provision has been in force and to the cash value or premium refund which would have been provided at the end of the given term. Some variation by issue age may be allowed.

(j) An insurer has the option to offer nonforfeiture benefits or home health care services in a long-term care policy.

Administrative Correction to (g)2.

See: 21 N.J.R. 3777(c).

Amended by R.1996 d.180, effective April 1, 1996.

See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

Rewrote section.

11:4-34.7 Continuation or conversion of group coverage

(a) Group long-term care insurance issued in this State on or after the effective date of these rules shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

(c) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of this group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) For the purposes of this section, "converted policy" means a policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the policy from which conversion is made restricts

provision of benefits and services to named providers or facilities, and the circumstances of termination make continued use of these providers or facilities impossible or impractical, the converted policy shall provide coverage on an indemnity or expense incurred basis with benefits determined by the Commissioner to be substantially equivalent to the reasonable cost of services provided by the named providers or facilities, and shall not restrict provision of benefits and services to any named providers or facilities.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

1. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

2. The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

- i. Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

- ii. The premium for which is calculated in a manner consistent with the requirements of subsection (f).

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11:4-34.8 Required disclosure provisions

(a) Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(b) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

(c) A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(e) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited by these rules, shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(f) If disability is a criterion for payment of benefits under a policy, the policy must include a definition of disability.

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

11:4-34.9 Requirements for replacement

(a) Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and health or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(b) Upon determining that a sale will involve replacement, an insurer (other than an insurer using direct response solicitation methods, or its agent) shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and health or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND HEALTH OR LONG-TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and health or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest, to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage,

be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

(c) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and health or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH OR LONG-TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and health or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under this new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to

[company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

11:4-34.10 Discretionary powers of the Commissioner

(a) The Commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of these rules, with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds; and
2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
3. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

11:4-34.11 Outline of coverage

(a) An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage 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;
3. A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and
4. A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

(b) The outline of coverage shall be a free-standing document, using no smaller than ten point type.

(c) The outline of coverage shall contain no material of an advertising nature.

(d) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

(e) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(f) The format for the outline coverage shall be as follows:

[COMPANY NAME]

[ADDRESS—CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

1. This policy is [an individual policy of insurance] ([group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

i. [Provide a brief description of the right to return—"free look" provision of the policy.]

ii. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

i. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

ii. [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

5. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. **BENEFITS PROVIDED BY THIS POLICY.**

i. [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

ii. [Institutional benefits, by skill level.]

iii. [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. **LIMITATIONS AND EXCLUSIONS.**

[Describe:

i. Preexisting conditions;

ii. Non-eligible facilities/provider;

iii. Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

iv. Exclusions/exceptions;

v. Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

i. That the benefit level will *not increase over time*;

ii. Any automatic benefit adjustment provisions;

iii. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

iv. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

v. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. **TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

[i. Describe the policy renewability provisions;

ii. For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;

iii. Describe waiver of premium provisions or state that there are not such provisions;

iv. State whether or not the company has a right to change premium and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.**

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. **PREMIUM.**

[i. State the total annual premium for the policy;

ii. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. **ADDITIONAL FEATURES.**

[i. Indicate if medical underwriting is used;

ii. Describe other important features.]

11:4-34.12 Severability

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

11:4-34.13 Actuarial requirements for rate submissions

(a) Pursuant to N.J.A.C. 11:4-18.4(a)1, insurers are required to include with each submission of new or revised rates for individual health insurance not subject to N.J.S.A. 17B:27A-1 et seq. an actuarial memorandum which includes anticipated loss ratio, methodology for calculating gross premium, an explanation and documentation supporting the premium assumptions and the objective basis for any rate differentials. The following information shall be included in the actuarial memorandum for individual long-term care policies to comply with N.J.A.C. 11:4-18.4(a)1:

1. The number of years for which the policy is expected to be delivered or issued for delivery in this State, and the number of policies expected to be delivered or issued for delivery in this State for each form in each such year;

2. The anticipated loss ratio calculated over the life of the policy form, with separate disclosures of the present value of future paid benefits and the present value of future paid or written premiums utilized in the calculation of the anticipated loss ratio, when any statutorily required additional actuarial active life reserves are neither reflected in the future benefits nor the future premiums in the calculation;

3. The future benefits on both a paid and incurred basis and the future premiums on both a written and earned basis for each of the years recognized in the calculation of the anticipated loss ratio, when neither the future benefits nor the future premiums include, or are adjusted for, any statutorily required additional actuarial active life reserves;

4. The expected incurred/earned loss ratio for each of the years recognized in the calculation of the anticipated loss ratio, wherein:

i. The expected incurred claims shall equal expected paid claims adjusted for changes in the expected claim liabilities and claim reserves and in any expected statutorily required additional actuarial active life reserves for each such year; and

ii. The expected earned premiums shall equal premiums expected to be received adjusted for any changes in expected advance premiums and in expected unearned premium reserves for each such year, but changes in any expected statutorily required additional actuarial active life reserves shall not be included in the adjustment of premiums expected to be received;

5. The assumptions used in the calculation of the loss ratios for each benefit provision wherein the premiums are determined separately including the following:

i. The annual claim costs (ultimate) by attained age and sex;

ii. The select and/or anti-select morbidity factors by policy duration (year) by issue age and sex;

iii. The lapse and mortality rates, or total termination rates, by policy duration by issue age and sex, and any skewing of those rates occurring within a policy year resulting from modal premium payments;

iv. The secular trend factors by policy duration by issue age and sex, which secular trend factors, when used in the calculation of the anticipated loss ratio, shall not be applied for a period greater than the number of years for which trending is reflected in the calculation of premiums;

v. The interest rates by policy duration, which rates shall equal an insurer's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes). Alternatively, the Department will permit the use of a seven percent interest rate graded linearly to five percent over 10 years and five percent thereafter or a six percent level interest rate. The Commissioner shall review annually the alternate interest rate and adjust those rates based on corporate bond yields for Aaa and Baa bonds as reported in U.S. Financial Data which is published by the Research and Public Information Division of the Federal Reserve Bank of St. Louis. The Commissioner shall provide public notice of new alternate rates by publication in the New Jersey Register;

vi. Expenses by policy duration, including commission, override and bonus rates; other marketing expense rates; other maintenance expense rates; any new-market expense rates; other acquisition expense rates; and the explicit profit margin or risk charge; on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable bases;

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

viii. A summary statement of the underwriting standards (such as short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market (that is, the segment(s) of the general public for example, middle income based on predetermined zip code selections) for the policy form;

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 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).

Public Notice: Alternate interest rates for rate submissions.

See: 35 N.J.R. 3967(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).

SUBCHAPTER 35. VIATICAL SETTLEMENTS

Authority

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

Source and Effective Date

R.2001 d.226, effective July 2, 2001.
See: 33 N.J.R. 162(a), 33 N.J.R. 2300(a).

11:4-35.1 Purpose and scope

(a) The purpose of this subchapter is to implement N.J.S.A. 17B:30A-1 et seq. governing viatical settlements.

(b) This subchapter applies to persons who enter into agreements with New Jersey residents to purchase their life insurance policies for less than the current death benefit.

11:4-35.2 Definitions

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

"Act" means an Act concerning life insurance viatical settlements approved September 17, 1999, N.J.S.A. 17B:30A-1 et seq.

"Commissioner," unless otherwise stated, means the Commissioner of the Department of Banking and Insurance.

“Department” means the Department of Banking and Insurance.

“Financing entity” means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person who may be a party to a viatical settlement contract and who has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

“Financing transaction” means a transaction in which a licensed viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction or any securities offering either registered or exempt from registration under Federal and State securities law, or any direct purchase of interests in a certificate, if the financing transaction complies with Federal and State securities law.

“Insured” means the person covered under the policy being considered for viatication.

“Mean life expectancy” means the mean number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider, considering medical records and appropriate experiential data.

“Net death benefit” means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

“Patient identifying information” means an insured’s address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

“Person” means any individual, corporation, organization, firm, association, partnership or other legal entity.

“Resident (of New Jersey)” means a person who either resides in New Jersey or maintains an office in New Jersey where business is transacted.

“Terminally ill” means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

“Viatical settlement broker” means a person who on behalf of a viator and for a fee, commission or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers. Irrespective of the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator’s instructions and in the best interest of the viator. The term does not include an attorney, accountant or financial planner retained to represent the viator whose compensation is paid directly by or at the direction of the viator.

“Viatical settlement contract” means a written agreement entered into between a viatical settlement provider and a viator. The agreement shall establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator’s assignment, transfer, sale, devise or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurer pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

“Viatical settlement provider” means a person, other than a viator, who enters into a viatical settlement contract. Viatical settlement provider also means a person who obtains financing from a financing entity for the purchase, acquisition, transfer or other assignment of one or more viatical settlement contracts, viaticated policies or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates or otherwise disposes of one or more viatical settlement contracts, viaticated policies or interests therein. Viatical settlement provider does not include:

1. A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;
2. The issuer of a life insurance policy providing accelerated benefits pursuant to N.J.A.C. 11:4-30 and pursuant to the policy; or
3. A natural person who enters into no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit.

“Viatical settlement representative” means a person who is an authorized agent of a licensed viatical settlement provider or viatical settlement broker, as applicable, who acts or aids in any manner in the solicitation of a viatical settlement. Viatical settlement representative shall not include: