Customer Care Center Claims Manual

As of August 2, 2000

Customer Care Center
Claims Manual

UNUMPROVIDENT

Aug. 2, 2000

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Customer Care Center Philosophy

UnumProvident's Customer Care Center is committed to providing superior claims handling and customer service to all its customers. To deliver on this commitment, the Customer Care Center has established the following guiding philosophy:

Conduct a thorough, fair and objective evaluation on each claim. Our claims professionals will gather all appropriate and necessary information to evaluate every claim thoroughly, and make fair, factual and contractually-based claims decisions.

Pay all claims promptly with a high level of customer service. Once we have determined that a claim is payable, we will pay our claimants the benefits that they are due in a timely manner and in accordance with the contract. We will be courteous, responsive, timely and accurate in all of our customer interactions, including but not limited to those with our claimants.

Assist claimants' efforts in returning to work and productive lives. It is our goal, where appropriate, to help our claimants engage in rehabilitation and other efforts that will enable them to return to work and productive lives. To achieve this goal, we will utilize our best in class vocational, rehabilitation and case management expertise and resources to build partnerships with our claimants to support their efforts.

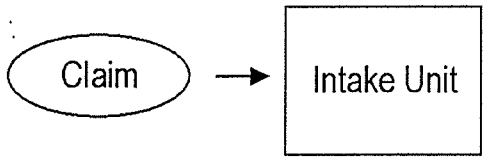
Defend against non-compensable and fraudulent claims. We will honor completely the commitments and promises we have made to our customers as set forth in our contracts with them. As part of our obligation to our policyholders and insureds, we will take all necessary and appropriate steps to ensure that those claims which either are not payable under the terms of our contracts, or are fraudulent, are identified and not approved. We will defend these decisions fully.

Claim Consultant Role

The essential function of the consultant role is to provide high level technical expertise and guide the Customer Care Specialist in arriving at the appropriate claim determination. It is also the responsibility of the Customer Care Consultant to review adverse claim determinations made by the Customer Care Specialists.

Integrated Claim Management

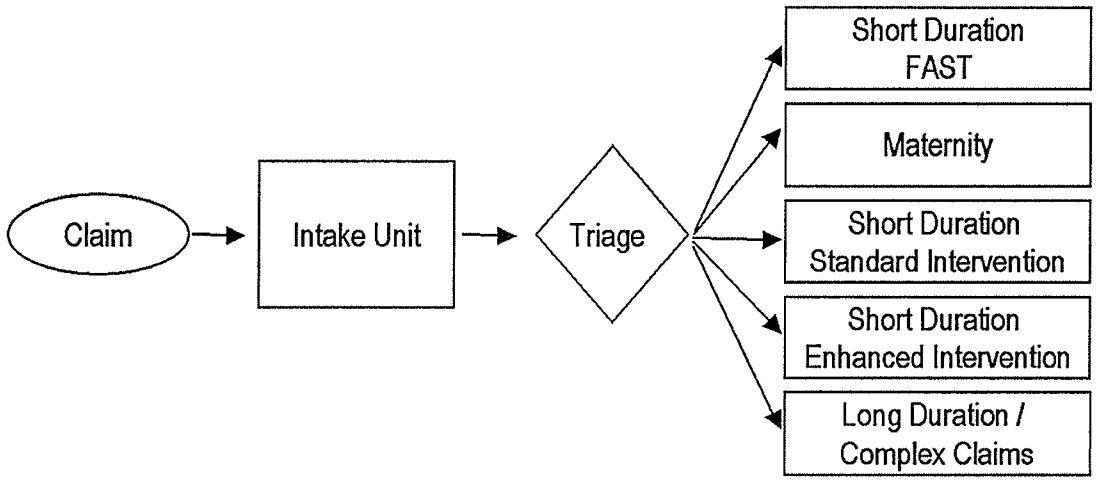
Process for Any Disability Claim



- Common intake
  - One intake point for all claims for a single insured
  - Facilitates unified administration
  - Ultimately, one claim form to one location with one Customer Care Specialist handling

Integrated Claim Management

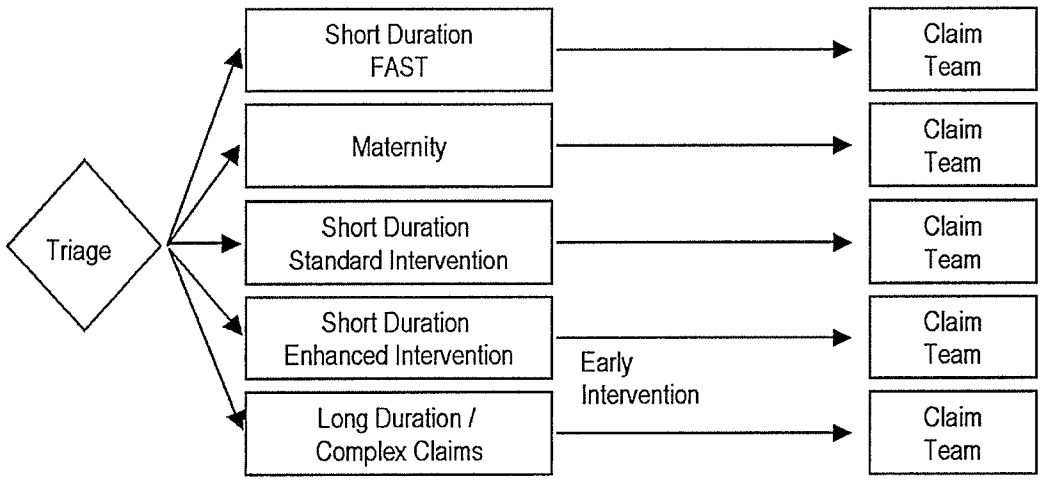
Process for Any Disability Claim



- Triage
  - Match resources with specific requirements of the claim
  - Not product-specific

Integrated Claim Management

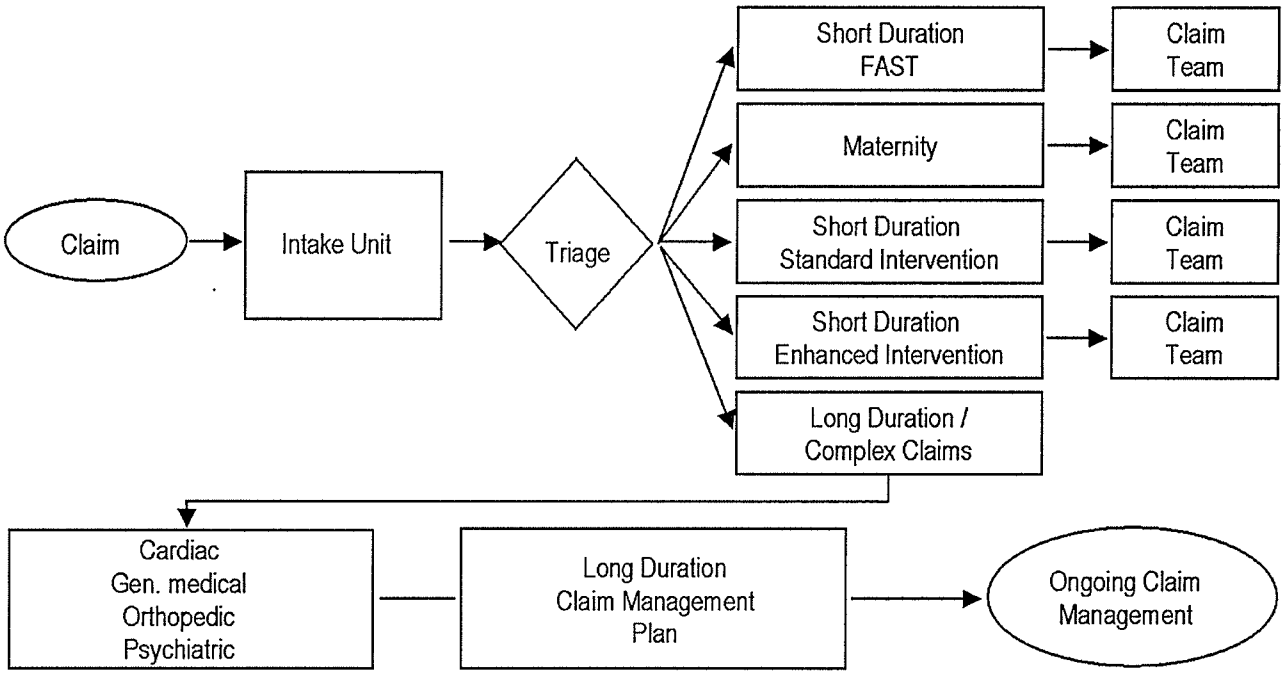
Process for Any Disability Claim



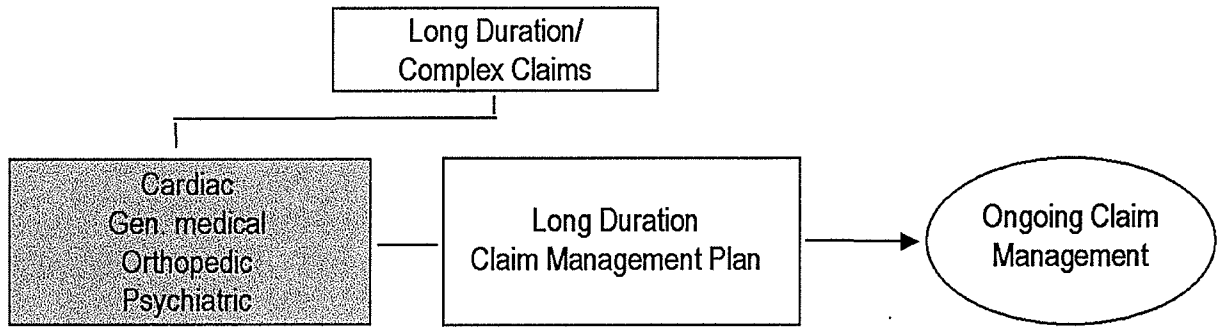
- **Early intervention/Short Duration**
  - **Critical to RTW success**
  - **3 point contact initiated within 48 hours - Early Intervention nurse assignment**
  - **Establish Medical Management Pathway**

Integrated Claim Management

Process for Any Disability Claim

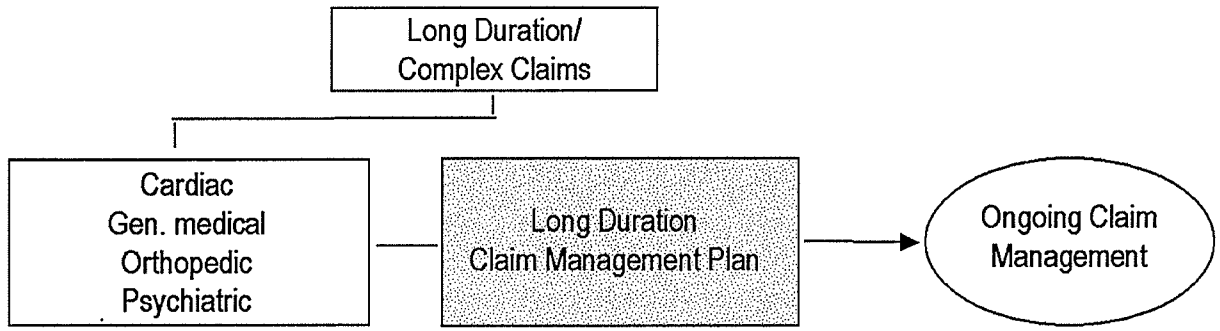


Integrated Claim Management



- **Impairment based management of longer duration claims**
  - **Structure supports process**
  - **Facilitates depth of knowledge, alignment of specialty resources, professional service**

Integrated Claim Management



- **Claim Management Plan**
  - **Consultants**
  - **Milestone Signoff**
  - **Multi-disciplinary effort**

Introduction to the Claims Manual

This is the first Claims Manual created for UnumProvident Corporation's Customer Care Center. It is designed and intended to be a reference guide to claims professionals and others in the Customer Care Center on the handling of claims under the contracts that UnumProvident sells and administers. In effectuating that intent, the following key points apply to this Claims Manual:

1. Every claim submitted to UnumProvident is different and must be decided on its own unique and individual facts. Accordingly, this manual generally contains guidelines, rather than definitive, "hard and fast" rules on the handling, evaluation and determination of claims. These guidelines do not offer a prescribed answer to each claim situation. Rather, such answers must be arrived at based on the specific and particular facts of the claim, as noted above. This claims manual is not meant to replace independent thought and analysis by the Customer Care Representative. Depending on the unique facts of a claim, one or more of the guidelines contained in this Manual may or may not be applicable.

2. In the handling of each claim, the Customer Care Center will strive to comply with all applicable laws. In support of that goal, this Manual contains overviews of a variety of legal rules and guidelines that may apply to specific claims. The absence of any other applicable requirements from the Manual does not signify in any way noncompliance with such laws. In the event of any inadvertent conflict between any guidelines in this Manual and applicable law, the applicable law shall govern the situation.

3. In this first Manual, UnumProvident does not intend to cover every single claim practice and procedural topic. Rather, this Manual is and shall be a dynamic, interactive document to which procedural and practice guidelines on additional topics will be added over time, as appropriate.

4. This Manual will not include, at this point, guidelines with regard to the Colonial Life & Accident claims operation.

5. Once created, this Manual will be distributed to all Customer Care Centers and claim operations, as will additions and updates.

Occupation/Job Analysis Guidelines

Most UnumProvident policies condition entitlement to benefits (at least for some period of time) on an individual's inability to perform some or all of the material and substantial duties of his "own occupation" due to sickness or injury. For some claimants the degree of medical impairment is so severe that entitlement to benefits can be determined without an extensive analysis of their occupation, but for most, an understanding of their pre-disability occupation is critical to evaluating their entitlement to benefits.

Questions may arise in interpreting "occupation" as defined in the policy. Some policies, such as the LTD CXC contract, provide a more detailed description of the term "occupation" than others do. The following guidelines have been developed for identifying and evaluating the appropriate "occupation" for a claimant.

NOTE: Certain state or federal courts may have made or may make interpretations that will take place over this general guideline. If you receive a memorandum, concerning a specific state or federal district court's interpretation of policy language, follow the recommendations in the memorandum.

This guideline applies to all contracts that determine disability with reference to the inability to perform one's own or regular occupation.

If the contract includes a specialty definition, please be certain to keep the details of that definition in mind during the course of this evaluation. We may want to consider review of the Underwriting file for additional occupation information.

Prior to approaching the claim as a "job vs. occ" situation, we should have reached a determination that a person is actually working or capable of working. The capability to work must be looked at from a practical and realistic standpoint based on an analysis of all the facts. Our decision should be based on the claimant's ability to work on a reasonably continuous basis.

In determining the insured's occupation, we must develop a thorough understanding of the work the claimant was performing immediately prior to disability. This must be compared to the work that the claimant is now capable of performing.

The essence of the "job vs. occ" analysis is a comparison of the "old" and "new" work situations to determine how similar or different they are. Some of the factors that might be considered are:

- **Physical and mental requirements**: What capabilities, from a physical and mental standpoint, are necessary for the successful performance of each work situation?
- **Employer**: Is the "new" work being performed or could it be performed with the same employer or an affiliate of that employer?
- **Title**: Does the "new" work involve the same or very similar organizational title (such as, "Vice President of Marketing") as the former work?
- **Income level**: What are the financial parameters (average income, maximum income) of the two work situations?
- **Hours worked**: What are the daily and weekly schedules required for the two work situations?
- **Educational/degree requirements** (and whether the claimant met those requirements): What kind of minimum educational requirements are involved with each work situation? (If the claimant was successful in his prior work without the educational requirements typically necessary for that work, can he be equally successful in the "new" work without the typical educational requirements?)
- **Professional or other license or accreditation**: Does either work situation require a particular license from the state or federal government, or other special credentials such

as certification by a professional organization?
- **Customers/patients/clients**: In the "new" work situation, would the claimant be dealing with the same types of people as he did in the former position?
- **Skills**: What are the particular skills that are necessary for the successful performance of each work situation?
- **Industry**: Are the two work situations within the same industries (chemical industry, insurance industry, and health care industry)?
- **Day-to-day setting/location**: Where does the person actually "go to work" for each work situation (office building, hospital, university, etc.)?

This is not an exhaustive list—sound judgment should be used to determine any additional factors that should be considered for a particular claim.

There is no magic formula for reaching this determination. Sound judgment must be applied in the final analysis. Generally, the more of these factors that can be said to be the same, the more likely it is that the "new" work will be considered to involve the same occupation. If the new work involves only a different employer or different job title, but the other factors are the same; a conclusion that the "new" work is within the person's occupation would likely be appropriate.

If there are material differences in several key factors, although the new work is within the same industry and perhaps even for the same employer, the likely conclusion is that this other work will not be found to be the same occupation as the claimant was employed in prior to disability.

The income comparison can be particularly important, and our general guideline is that work which cannot produce 80% or more of a person's pre-disability income may be considered to be a different occupation (for purposes of this evaluation).

We should be careful to fully explain to the claimant how we evaluated both his occupation and the "new work", why we reached the conclusion that they both constituted the "same occupation," and why we believe the claimant is not disabled from that occupation. The more information that can be provided, the better.

Establishing Occupation

In determining what an insured's own occupation should be, consider the following:
- what were the material and substantial duties the claimant performed?
- how did the insured spend his time?
- from what activities was his income generated?

The insured's "own occupation" or "regular occupation" is the occupation which the insured was engaged in at the time of the disabling injury or sickness.

The following sources can be used in establishing the insured's occupation:
- appointment books, calendars, schedules (including surgical schedules), or other evidence of how the insured spent his time prior to disability;
- billings;
- job description, personnel file, etc., if the insured is an employee of a firm that generates such materials;
- evidence of earned income W-2s, tax returns, etc.;
- authored works such as reports, memoranda, publications, etc.; and
- timesheets.

Occupation must be determined using fair and reasonable standards of review. If an occupation, as broadly defined, includes a particular procedure, but the insured has not performed such procedures in the past to a material and substantial degree, the inability to perform that procedure should not result in a finding of disability.

Occupation does not include the unique environment in which the insured was performing his occupational duties prior to disability. For example, if an insured was a bookkeeper in an old building that, because of its unique structure, contained only a narrow flight of stairs that the insured cannot now negotiate, this does not render him unable to perform his occupational duties as a bookkeeper.

Certain state or federal courts may have interpreted the term "occupation" in prior cases. Each such holding is based on the unique facts of the case. Florida, however, appears to have adopted a more narrow definition of "own occupation." Refer to the Legal Department if you have questions regarding the law of any state regarding "occupation."

Ongoing Claimant Certification of Disability

Background

During the active management of a claim we frequently ask for information supporting ongoing payment and calculation of benefits. One tool used to obtain data is the supplemental claim statement. This form requests information from the claimant and the attending physician.

To ensure that we are requesting the appropriate information at the right time and to establish a consistent approach to claims management, we should adhere to the following guidelines.

Applicability

Group LDU, IDI, Life
This does not apply to SDU claims due to limited duration.

Attending Physician Statement

We should request updated medical information as needed to support continued payment of a claim. This information can be obtained through various sources including office notes, attending physician statements, Independent Medical Examinations, etc.

When we are actively managing an LTD claim, we should be requesting a completed Attending Physician Statement at least quarterly. Some impairments may warrant more frequent attending physician statements. Actively managed IDI claims will usually require monthly attending physician statements.

Claimant Statement

When we are actively evaluating a claim, the fully completed claimant statement must be requested minimally on a quarterly basis. For IDI claims, we should consider monthly statements given the lack of a separate employer/employee relationship to assist with verification of information. While we may be using various tools to obtain updated medical data, we need to regularly get updated statements from the claimant.

Rationale

The claimant statement provides ongoing documentation, which will help direct the claim investigation. The claimant is submitting a written document that provides:

- written statement of the claimants activities (including any part-time work)
- updated authorization to release information
- current physical address and telephone number
- other insurance/income status

When we are determining what information is needed, the updated statement will help set our future investigative direction.

Extended Duration Unit

Extended Duration Unit (EDU) will obtain an updated claimant statement for claims every 12-36 months based on the criteria established by the EDU.

Conclusion

The claimant statement is an important tool that will assist in the ongoing management of a claim. The frequency guideline will help ensure that we are getting the updated information necessary to manage a claim.

Reminder: Each claim is unique and should be evaluated on its own merits.

Overpayment Recovery from an Open Claim

Background

A question arose regarding outstanding overpayments and how to recoup them from an open claim.

If the claimant has requested that we withhold federal and/or state income tax from his/her open claim, do we withhold the taxes and apply the balance of the benefit to the overpayment, or do we apply the entire benefit to the overpayment?

Claim Process

We are required by law to withhold FICA taxes. Therefore, we must deduct FICA from the benefit before recouping the overpayment.

We are under no contractual or legal obligation to withhold state or federal income tax. Therefore, we will apply the balance of the benefit (after FICA) to the overpayment with the following exception:

The claimant may request the option of our withholding part of his/her benefit for state and/or federal income tax before we apply the balance of the benefit to the overpayment. We can consider this request if the overpayment can be recovered in full within 12 months. This is an accommodation to the claimant and is not legally required.

What about Garnishments?

If we are recouping an overpayment and subsequently receive a garnishment notice, we will advise that we are not currently paying a benefit and, therefore, cannot make garnishment payment.

If we are making payments from the open claim for some type of garnishment (e.g., IRS levy, child support, etc.) and later determine there is an overpayment, contact Legal to discuss the order and the claim details before honoring the garnishment. If we determine that we will discontinue the garnishment payment, write a letter to the court explaining why payment has been discontinued.

What Happens if the Claimant has Filed Bankruptcy?

If the claimant has filed bankruptcy:

If bankruptcy is filed while we are already recouping an overpayment from an open claim, continue to recoup the overpayment.

If the claimant has an open claim and bankruptcy is filed before the overpayment is discovered, and/or if the claim is closed and bankruptcy has been filed or is in place before we discover the overpayment, we cannot ask the claimant to repay the money due us. Contact Legal for advice.

Conclusion

We should make every attempt to recover money due us as quickly and efficiently as possible. If you have questions regarding a specific claim overpayment and the application of federal taxes/garnishment and/or bankruptcy orders, contact the Legal Department.

What if I Have Additional Questions?

If you have additional questions, please ask your consultant or manager.

Reminder: Each claim is unique and should be evaluated on its individual merits.

Part-time Work and Insurance Continuation

Background

A common claim scenario that occurs is when a claimant works on a part-time basis for an extended period of time and the claimant ultimately becomes totally disabled. The issue becomes:

- Is the person still covered as an active employee?
- Is the reduction in hours the result of disability?
- To what extent do we provide coverage, e.g., what earnings/occupation is used?

This applies to which products?

Group LTD and Group STD Products (this does not apply to IDI Products as the IDI contracts remain in force with no requirement re work/minimum hours).

When is a claimant considered an active employee?

When the claimant meets the "minimum hours for active employment" requirement of the contract s/he is considered an active employee. The standard contract requirement is 30 hours; however, the contract should be checked to ensure we are considering the correct time requirement.

What happens if the claimant's work schedule is below the minimum hour requirement some or all of the time?

The employee's work schedule should be reviewed to determine whether s/he is meeting the time requirements of the policy for active employment. Possible scenarios include:

- the reduced schedule is the result of disability.
- the reduced schedule is a permanent arrangement.

What other factors should be considered?

- Is his/her schedule the normal schedule for that eligible group?
- The decision should be fact specific—why have the hours changed?
- Was the change in hours caused by a medical condition? Is the claimant partially disabled?
- Reasonable circumstances should be considered.

How do I average the hours worked?

Use the information provided on the claim form. If from our claim investigation, we determine that the work schedule appears to fluctuate, we should consider the following:

Does the regular work schedule equal the minimum hours in one month?
In this case the claimant would be covered.

Is it a permanent work schedule, e.g., three weeks at 30 hours, one week at 15? You can immediately average the schedule and determine if the person is covered.

Is it a varied work schedule week to week or month to month? If so, average over a reasonable period of time. Do not apply the rehire provision, because the person was not "terminated from employment."

Is the person working below the minimum hours permanently? S/he would not be covered unless the work schedule reduction is part of medical restrictions/limitations as a result of a medical condition.

How do I look at occupational earnings?

If the reduced schedule is for a limited period of time, consider the claimant's full-time earnings to compute the benefit. If the claimant is working a reduced schedule for an extended period, use that income from the new/modified occupation to compute the benefit.

Is time a factor?

A strict six-month guideline will not be used. Instead, claims will be evaluated on a case-by-case basis.

What if I have additional questions?

Ask your consultant or manager if you have additional questions.

REMINDER: Each claim is unique and should be evaluated based on its individual merits.

Power of Attorney/Incompetency/Guardian & Conservator/Attorney of Record

Overview

This section provides guidelines to help in managing and properly documenting claim files when we receive notice of Power of Attorney, appointment of a guardian or conservator, or are advised that an attorney is representing the claimant.

Important Note

When someone is claiming to have the ability to act on behalf of the claimant, whether it be a power of attorney, attorney of record, guardianship or conservator, written documentation should be obtained to determine what this individual is authorized to do, and whether the individual is acting in addition to the claimant or in lieu of the claimant.

Power of Attorney (POA)

Whenever we are presented with a POA for a claimant, we should request notarized documentation. Review the document to determine the extent of the POA. Each document can differ in what powers are actually granted. For example, someone may have power to transact business for the claimant but not have the right to access medical information. In that situation, we can release the benefit payment in care of the POA, but not discuss/share specific medical information.

Without written documentation, we should not enter into settlement discussions/negotiations with the person claiming to have POA. Any questions on the power/authority level granted in the document should be discussed with Legal.

POA & Incompetency

If the claimant is unable to execute a POA due to incompetence (e.g., due to head injury or psychiatric problems), there must be a court order of guardianship (health/welfare) or conservatorship (financial affairs) for the claimant.

If we receive a POA after the claimant becomes disabled, we should verify the POA with the claimant. If we have reason to doubt competency, we should call the A/P to see if the claimant was competent to execute the POA.

The Customer Care Consultant should read the POA to determine what powers it grants, whether the claimant signed it, and whether it was witnessed and notarized. If there are any questions, contact Legal.

Attorney of Record

At times, the claimant's attorney will act for the claimant in all matters. He officially "becomes of record" by means of a letter indicating it or by other communication, e.g., telephone calls, personal visit, etc. However, a claimant may have an attorney representing him in other matters, such as workers' compensation, and the attorney may not be the authorized representative for the disability claim.

Once an attorney claims he/she is representing the claimant, the file should be clearly noted. If there is any question as to whether or not an attorney is officially representing the claimant for the purposes of our claim, a direct inquiry should be made of the attorney. We should ask the attorney whether it is permissible to continue to deal with the claimant directly, noting that we will copy the lawyer on all correspondence. If we are advised that we may not contact the claimant directly, from that point on, we should not contact the claimant, unless:

- Notice is given by the claimant or the attorney that representation has ceased;
- The claimant calls us. We remind the claimant that by speaking with us directly, he is waiving his right to have us communicate only with the attorney. It should be clearly documented in the claim file that this discussion occurred.
- It appears that the attorney is not conveying important information to the claimant. In this rare situation, contact the attorney before you proceed to contact the claimant.
- The attorney gives us permission to contact the claimant.

If a physical examination is required, the attorney must be notified and arrangements made through his office. If the claim is going to be denied, the denial letter must be addressed to the attorney. We should not call the claimant to advise him of the denial. All contact, both written and verbal, should be through the attorney.

File Documentation

The cover sheet and claim file should clearly indicate when there is an Attorney of Record, Power of Attorney, Guardian or Conservator representing the claimant.

Privacy and Information Practices

Insured's Right to Access File Information
Under ERISA, an insured has the right to obtain the pertinent documents from his or her claim file that we relied upon to deny the claim.

For Non-ERISA cases, providing an insured with pertinent documents, on request, is good customer service and may help the insured to understand the claim decision.

Should litigation ensue, the claimant will usually be able to compel the production of the entire file. Accordingly, while every claim is unique and this question must be decided on a claim by claim basis, it is suggested that UnumProvident produce non-privileged, pertinent documents from the claim file if so requested by the claimant. Following this suggestion, it may often make sense, in response to a claimant's request, for UnumProvident, at the appropriate time, to produce the entire claim file (excepting privileged materials).

There are a few exceptions to this general recommendation:

- Attorney-Client and Attorney Work-Product communications between UnumProvident and its attorneys are privileged and should not be disclosed.
- On rare occasions, files may contain business confidential/trade secret materials to which privilege is claimed. Discuss these instances with the Legal Department. Generally, claim files should not include such materials.
- If a file contains medical information that may be harmful to the claimant if he or she were to view it, that information should be sent to the insured's attending physician.
- California requires that psychiatric information be sent to a qualified professional with treatment responsibility for the condition to which the information relates.

File information may be produced at an appropriate time during the investigation of the claim, or after a decision has been reached, to avoid compromising the claim investigation.

Release of Personal Information
Personal information from an insured's file will not be released to any third party, including the employer, except: 1) pursuant to the insured's prior authorization; 2) pursuant to a court order (subpoena); or 3) within the classes of limited permissible disclosures contained in the NAIC Model Act.

Drug and Alcohol Information, AIDS
UnumProvident will comply with all applicable state and federal laws governing the release of information concerning drug and alcohol information and AIDS. In many cases, drug and alcohol information may not be released except pursuant to a court order or with the insured's specific consent (a general authorization is insufficient). Usually, such records are stamped with a statement prohibiting re-disclosure of those records. State laws similarly may limit the release of AIDS or HIV information.

Please refer questions along these lines to the Legal Department.

Internet Use
Personal information concerning an insured should not be transmitted over the Internet because the security of the information may not be guaranteed.

Reinsurance

The UNUM individual disability claim block is reinsured by other disability carriers.

UNUM's treaties with these carriers are very specific in outlining what information will be provided to them and in what time frame. It becomes increasingly important to be aware of reinsured claims and comply with the obligations. UnumProvident could in fact be denied reimbursement if we fail to meet the treaty provisions. To ensure compliance, Reinsurance Procedures have been developed. These procedures need to be followed on all claims received on UNUM individual disability contracts. Refer to the IDI chapter for details.

Reservation of Rights

Background
As an insurance company, UnumProvident has both a legal and an ethical obligation to treat its customers fairly. This involves many duties and responsibilities, including making accurate liability decisions on claims.

Reservation of Rights
The reason for issuing payments with a "reservation of rights" or on a "without prejudice basis" (Canada), is that we have not obtained sufficient information to determine that a particular payment can be made.

Advising the claimant that payment is being made on a Reservation of Rights basis:
- The claimant is put on notice of our questions about liability; and
- Establishes the right for potential recovery of the payments made under Reservation of Rights.

When should Reservation of Rights be used?
Typically, a claim should be approved or denied without Reservation of Rights and within reasonable timeframes(as are often set forth under state regulations). However when that time has come and the file contains incomplete yet persuasive evidence of disability, ie; there are still some unresolved questions about the medical or other issues which, when resolved, may result in a determination that benefits were in fact not payable, the claim can be paid with a Reservation of Rights.

On integrated STD/LTD claims where we have not made an LTD initial liability decision within 45 days from receipt of the claim, the file should be reviewed with a consultant to determine if payment under reservation of rights is warranted based on the specific facts of the file.

If we have substantial question of liability and we have insufficient information to reasonably support payment, no payment should be made until the investigation is completed.

Payment of Benefits
It is not necessary that the payment include all past due amounts. It may be appropriate to pay benefits for only the current month depending on the facts of the claim. Generally, a reservation of rights should be imposed for 90 days, but special circumstances may exist to warrant extension of the period of time.

All decisions to use, remove or extend Reservations of Rights beyond 90 days require Claim Consultant sign-off.

Recovery of Payments
The use of Reservation of Rights should allow us to assert recovery for payments made. As each claim is unique, the specific facts of the case should be considered when determining our actions. If we are unsuccessful in seeking recover of money, refer the file to the collections unit.

Any decision to waive recovery of an overpayment requires Consultant or Manager approval.

Notice to Claimants
Written notice of our decision with an explanation of the reservation of rights should be provided to the claimant. We should explain that we have outstanding questions and explain what steps we will take to complete our investigation. The letter should include the following paragraph:

"This payment and any possible future payments, until we advise you otherwise, are being made under Reservation of Rights. This means that the payment cannot be construed as an admission of present or future liability and we reserve our right to enforce any and all provisions of the policy, and to claim repayment of the benefits that were made to you."

If we determine that we have ongoing liability, a letter should be sent to the claimant advising that we are no longer paying under Reservation of Rights.

For Group Policies we should generally notify the Employer of our Reservation of Rights decision.

Conclusion

Reservation of Rights places the claimant on notice of our continued investigation while making a good faith payment on the claim. Since each claim is unique, the case specific facts will determine whether use of Reservation of Rights is appropriate. Consultant sign-off is required to use/remove this notice from a claim..

Salary Continuation for Public School Teachers in Louisiana

Background

The State of Louisiana has specific laws regarding salary continuation/sick leave for public school teachers. Each of the six (6) laws addresses the benefits an employee may be receiving from the employer.

This document will outline each law, as well as which contractual offset language is applicable when a claimant is receiving benefits from the employer under one of these laws.

Effective Date

All of the laws outlined below have been in effect for many years with the exception of Extended Sick Leave. That law became effective on January 1, 2000.

Applicability

This applies to all group policies that include offset language.

Who is covered?

The laws outlined below cover teachers and teaching staff as defined:

For Regular Sick Leave and Occupational Injury Law 17:1201:

"Teacher or teaching staff shall include any person employed by the city or parish school board in the State of Louisiana who holds a valid teaching certificate issued by the state Department of Education and any social worker or school psychologist employed by a local school board in the state who holds a valid professional ancillary certificate in school social work or school psychology issued by the state Department of Education."

For Extended Sick Leave Law 17:1202:

"Teacher or teaching staff shall include any member of the teaching staff of a public school in the State of Louisiana and any social worker or school psychologist employed by a local school board in the state who holds a valid professional ancillary certificate in school social work or school psychology issued by the state Department of Education."

For Medical Sabbatical law 17:46 will also include:

"Teacher or teaching staff shall include any person employed by a city or parish school board in the State of Louisiana who holds a valid teaching certificate issued by the state Department of Education and any social worker or school psychologist employed by a local school board in the state who holds a valid professional ancillary certificate in school social work or school psychology issued by the state Department of Education."

For occupational injuries, law 17:47 also includes secretaries, paraprofessionals, school aides and superintendents that work in special schools.

Special schools are defined as, "Special schools for the blind, deaf, and spastic students, and the special schools comprising Special School District Number One, operated and maintained as part of the public educational system by the State Board of Elementary and Secondary Education under the provisions of Section 3, Article VIII, Louisiana Constitution of 1974."

Regular Sick Leave LA R.S. 17:1201A

Specifics regarding the benefits payable under this law are: 10 days per year; Can accumulate without limitation; and 100% rate of pay.

We can offset benefits paid under this law if our policy contains any of the folowing offsets: State Compulsory; Salary Continuation; and/or Sick Leave/Accumulated Sick Leave

NOTE: If Salary Continuation or Accumulated Sick Leave are listed under "What Are Not Deductible Sources of Income" in the contract, you may not use any of the above listed offsets.

Extended Sick Leave LA R.S. 17:1202

Specifics regarding benefits payable under this law are: Available when accumulated sick leave has been exhausted; Can be used for the employee's own illness or to care for an ill family member; 90 days in a six (6) year period (the school board can extend); Cannot accumulate; 65% rate of pay; and Can be gainfully employed if working less than 20 hours per week and had been working on the job for at least four (4) months prior to the leave.

We can offset benefits paid under this law if our policy contains either of the following offsets: State Compulsory; and/or Salary Continuation.

NOTE: If Salary Continuation is listed under "What Are Not Deductible Sources of Income" in the contract, you may not use any of the above listed offsets.

Medical Sabbattical LA R.S. 17:46

Specifics regarding benefits payable under this law are: Available if sick leave balance is reduced to 25 days; 65% rate of pay; and Can take-off two (2) semesters after working 12 consecutive semesters; or one (1) semester after working six (6) consecutive semesters.

We can offset benefits paid under this law if our policy contains any of the following offsets: State Compulsory; Salary Continuation; and/or Sabbatical Leave or a similar leave of absence plan.

NOTE: If Sabbatical Leave or similar leave of absence plan is listed under "What Are Not Deductible Sources of Income" in the contract, you may not use any of the above listed offsets.

Occupational Injury LA R.S. 17:1201C(1)(a)

This law applies if the teacher is disabled or injured by a student committing assault and battery. Specifics regarding benefits payable under this law: Not required to use accumulated sick leave first; and 100% rate of pay.

We can offset benefits paid under this law if our policy contains either of the following offsets: Workers' Compensation, occupational disease law, or other act or law of similar intent; and/or Assault leave plan.

We can deny benefits if the policy contains the following exclusion:
Occupational injury.

Occupational Injury LA R.S. 17:1201C(1)(b)

This law applies if the teacher is disabled or injured as a result of physical contact in trying to help a student not get harmed.

Specifics regarding benefits payable under this law are: Not required to use accumulated sick leave first; 100% rate of pay; and 90 days (school board can extend).

We can offset benefits paid under this law if our policy contains either of the following offsets: Workers' Compensation, occupational disease law, or other act or law of similar intent; and/or Assault leave plan.

We can deny benefits if the policy contains the following exclusion:
Occupational injury.

Occupational Injury LA R.S. 1201D

This law applies if the teacher is disabled or injured in the course of employment.

Specifics regarding benefits payable under this law are: Entitled to weekly wage benefits under Louisiana's Workers' Compensation or entitled to sick leave.

We can offset benefits paid under this law if our policy contains the following offset: Workers' Compensation, occupational disease law, or other act or law of similar intent.

We can deny benefits if the policy contains the following exclusion:
Occupational injury.

Questions?

If you have questions regarding this issue, please direct them to your consultant or manager.

Settlement Procedures

This procedure was developed based on input and direction provided by the Procedure Review Committee.

Background

Settlements are a viable tool in the risk management of a claim. Settlements are an option that can provide value to claimants as well as the Company. This document defines our philosophy and approach to settlements.

Settlement Philosophy

Our philosophy is to selectively settle claims only after evaluating the unique circumstances of that claim. Our settlement practices need to be consistent in how we determine settlement offers, and discuss offers with individual claimants. Our approach will be to use a center of expertise, the Financial Services Unit (FSU) to assist with settlement activity.

Types Of Settlements

Limited Liability Settlements
Settlements where a claimant is expected to receive benefits for a specific period of time. E.g. change in definition of disability and because of specific circumstances with the claim, an advance payment of benefits may be offered in exchange for a Claim and Condition Release Agreement.

Disputed Settlements
Settlements where the claim contains one or more issues in which the Company's position differs from the insured's. This category of settlements is done on an exception basis only and must involve Legal, FSU and the Site Head.

All Other
All other types of settlements including commutations will be reviewed for settlement feasability by FSU.

Settlement Authority Level

To ensure a consistent handling of settlement options, all settlement evaluations must involve the Financial Services Unit (FSU) prior to extending an offer.

NOTE: Limited Liability Settlements equal to six months or less benefit payments can be completed with Consultant and/or Manager signoff and do not require FSU involvement.

Settlement Process

FSU is available via telephone to discuss whether a specific file is appropriate for referral.

Complete the referral form entitled FSU EBFORM.TXT. This form is located on the Corporate Intranet site under Internal Web Connections, Profs Forms.

Send the file to FSU in Portland.

The FSU specialist will evaluate the file and contact the

	CCS/CCC within 10 working days to discuss feasibility; settlement value and who should handle the negotiations. The Manager of FSU should be contacted with any request to accelerate the 10 day review standard. All files not handled by FSU will be promptly returned to the referrer.
What Does This Apply To?	All product lines
Conclusion	When appropriately managed, settlements can be a viable option for both the claimant and the Company. These settlement guidelines must be followed to ensure that a consistent approach to settlements occurs.

Reminder: Each claim is unique and should be evaluated on its own merits.

Shared Claim Procedures

These procedures have been developed for use in all situations where a claimant has multiple lines of coverage with UnumProvident, and claims on these lines of coverage are being handled by different Customer Care Specialists within the UnumProvident organization.

Please note that all claim information can be shared freely, without the exchange of authorizations. The only exception to this is Equitable coverage. Equitable claims are handled separately in our Springfield, MA office. You must exchange an authorization in order to share information with the Equitable. Once you have exchanged an authorization, all other Shared Claim Procedures will apply. The steps for handling Common Claimants are as follows:

Identifying Common Claimants

You may already be aware of other UnumProvident coverage that is in force. Other coverage (with the exception of STD, Colonial, and Special Risk products) may be identified through the recently distributed common claimant report. Soon, managers will have access to this information on their desktops. Additionally, the Common Customer View system, currently in development, will allow our intake unit to identify all common claimants from the outset.

Confirming the Contact Person

Don't wait until a claim issue arises to contact another Customer Care Specialist. As soon as you are made aware of Common Claimant coverage, contact the other Customer Care Specialist to introduce yourself and determine which of you will be the 'point person.'

Defining the Point Person

As you were previously advised, the Customer Care Specialist handling the higher indemnity claim should be the 'point person.' Being the 'point person' means taking responsibility for coordinating the handling. It does NOT mean that the 'point person' does all the work. The two (or more) Customer Care Specialists should work together to decide who will handle which aspects of the claim. If there is a concern about who the 'point person' should be (due to limited benefit periods, etc.), let your manager or consultant know.

Sharing Information

From a legal perspective, if a Customer Care Specialist in Chattanooga receives a piece of information on a claim, the Customer Care Specialist in Portland is assumed to have that information in their possession, even if they have never seen it. Therefore, when you receive information, you should make a copy and share it with your counterpart(s). The two (or more) files should be mirror images of one another.

Making Decisions

Decisions to pay or close claims should be made concurrently, and all of the Customer Care Specialists working on the case should agree on the outcome. If you do not agree with the steps or decision being made in another location, please notify your manager or consultant before further action is taken. They will speak to the manager or consultant in the other location, and work with them to reach a determination that is agreeable. You MUST NOT take independent action on a claim if you know that what you are doing is contrary to what is being done by another employee of UnumProvident. (The only exceptions to this would be if there were differences in

policy type, benefit period, etc., that would justify the actions. All files should be marked accordingly in these instances.)

Advising the Insured

Once a decision is made, the insured should be advised of our decision in a timely manner. The Customer Care Specialists handling the claims should send separate notification from their respective locations, but the notification should be sent at the same time.

Utilizing Resources Effectively

One of the advantages of the Shared Claim Procedures is that we can use our resources more effectively. If a claim requires a medical, financial, vocational rehab, or other review, ONE review should be done and shared between the locations. We should not have a medical review done in Worcester and another review done in Portland at the same time.

Resolving Differences of Opinion

As mentioned above, if you cannot agree on the course of action to be taken, you should involve your manager or consultant before a decision is made. When lack of consensus is due to procedural/training issues, the issues must be resolved before a decision can be made. Questions should be submitted through the site Procedure Review Committee Representative. They, in turn, will submit the issue for a committee evaluation.

Critical Intervention Points

The Common Claimant Team has identified Critical Intervention Points when coordination of handling must be documented in the claim file. These Critical Intervention Points are:

- Initial File Review
- Initial Liability Determination
- Adverse Decision
- Change in Definition of Disability
- Part-time Return to Work
- SHU/CBA Referral
- Settlement

At these Critical Intervention Points, the Action Log or File Plan must be marked to indicate that the Customer Care Specialists in all locations have coordinated their handling.

Other Notes

If you are not sure who is distributing the common claimant reports in your office, check with your manager. The ownership of these reports varies from location to location.

Additionally, most offices are using fluorescent yellow stickers to identify common claimants. (Please check with your manager or consultant to confirm whether these stickers are being used in your area.) These stickers should be completed by the Customer Care Specialists, using information from the Common Claimant Reports. These stickers should be attached to the face sheets/file folders of the claims, and they contain spaces for the following information:

- **Common Claimant w/:** This field should be completed with the other type of UnumProvident coverage identified on the report (Provident LTD, UNUM DI, etc.)
- **Claim #:** The claim number for the common coverage is shown on the report.

- **Contact Person:** The name of the Customer Care Specialist handling the common claim belongs here. This name should be taken from the 'claim rep' field on the reports.
- **Contact Person Phone #:** This information does not appear on the report and should be obtained through the UNUM or Provident directory, or through the phone center.

Please note that the recently distributed Common Claimant Report does not include STD products, Colonial, or Special Risk products. However, if you are aware that your insured also has coverage in those areas, you should utilize these Shared Claim Procedures to exchange information and coordinate handling.

If you have any questions, please contact your Consultant or Manager.

Social Security Administrative Fee

Background
The Social Security Administration is now charging a 6.3% "administrative fee" on all Social Security awards with Attorney fees.

A question has arisen regarding how we will handle this 6.3% administrative fee when calculating social security overpayments.

Effective Date
2/1/00 for all Social Security Awards with approved Attorney fees.

Information
The social security attorney can bill up to 25% of the retroactive social security award to a $4000 maximum.

The Social Security Administration has to approve the Attorney's fee.

The Social Security Administration will now take a 6.3% administrative fee out of the Attorney's fee to a maximum of $252.

Note: The 6.3% administrative fee does not apply to GENEX because they do not charge Attorney fees.

Guidelines
When calculating the Social Security overpayment we will give the insured the full credit for the approved Attorney's fee, which includes the 6.3% administrative fee.

Note: Attorneys may increase their fees in an attempt to recover or retain the 6.3% that the Social Security Administration takes. We cannot prevent this from occurring; however, we only recognize the amount approved by the Social Security Administration when calculating benefits.

Social Security Award Letter Wording
"If we issued your decision after January 31, 2000, we also must charge your lawyer 6.3 percent of what we pay him or her from your past-due benefits. Your lawyer cannot charge or collect this expense from you. We will subtract the charge from the amount payable to the lawyer and send him or her the remainder. If your lawyer disagrees with this, he or she must write to the address shown on this letter. Your lawyer must tell us why he or she disagrees."

Example
Past due Social Security Disability benefits = $1396.00
SS approved $349.00 for Attorney fee (25% of $1396.00)
We will reduce the overpayment by $349 (credit the insured)
SS will reimburse the Attorney $327 (349 less 6.3% or 22.00)

Impact
The 6.3% administrative fee does not substantially change how we calculate our overpayments. This fee primarily affects (reduces) the amount the Attorney will receive.

Questions?
Questions should be directed to your consultant or manager.

Reminder: Each claim is unique and should be evaluated on its own merits.

Social Security Disability Income (SSDI)

Background

A question arose regarding claimant concerns on a taxable income issue.

When a claimant is eligible for a non-taxable benefit from UnumProvident and we require that s/he apply for a taxable benefit (i.e.: Social Security Disability Income—SSDI), the claimant is concerned because s/he now has to pay taxes on the amount that we offset. In the past we have been asked by the claimant to reimburse the amount of the taxes.

Conclusion

Standardly, our group contracts offset Social Security benefits. Contract provisions require that the claimant apply for, and in some cases pursue, those benefits.

As part of the claim management process, we should explain the requirements of the policy and encourage the claimant to apply for Social Security explaining how s/he will benefit if SSDI is awarded. It is our responsibility to calculate and pay benefits according to the terms of our policy—including the offset provisions. Therefore, we will not reimburse the claimant for taxes paid on the SSDI benefit.

Applicability

This applies to Group STD and LTD.

Questions?

If you have questions regarding this issue, please direct them to your manager or consultant.

Special Investigative Unit

The Special Investigative Unit (SIU) is the division of UnumProvident designated to investigate all acts of suspected fraud perpetrated against the Corporation. Its mission is to provide the UnumProvident Corporation and all associated corporate entities with the highest level of investigative services possible in a cost effective and efficient manner.

Investigative services include, but are not limited to:

- Fraud investigations involving employee fraud, agent fraud, applicant fraud and claims fraud
- Internal investigations
- Background investigations
- Liaison with law enforcement agencies
- Liaison with state insurance department fraud units
- Liaison with insurance company SIUs
- Coordination of criminal prosecutions
- Coordination of foreign investigations
- Provide fraud education and training to corporate personnel who are integral to the corporate anti-fraud strategy
- Prepare and disseminate an anti-fraud plan to include a flow chart for handling fraud cases
- Establish and maintain a continuous cooperative relationship between the SIU and all corporate personnel involved in the detection, prevention and resolution of all fraudulent activities committed against UnumProvident Corp.

The Special Investigative Unit is also responsible for complying with all regulations concerning the reporting of suspected fraud to the appropriate state agencies and for filing anti-fraud plans with those states requiring such plans.

In order for the SIU to ensure compliance with these state mandated requirements, whenever fraudulent activity is suspected during routine claim handling, immediate notification must be made to the SIU.

Subpoena Guidelines

Introduction
This section will serve as a reference for individuals responding to subpoenae for production of documents.

Subpoena Duces Tecum/Subpoena for Deposition
A subpoena which not only requires a person to appear as a witness but also requires that person to bring any and all documents which are related to the matter for which the subpoena was issued. Sometimes a subpoena will state that a personal appearance is not necessary if the documents are produced.

If you do not understand the document or at any time in the process have any questions, immediately call your Legal Department representative.

Guidelines

1. **Make a note on the document of the date and time it was received and the means by which it was received (by mail, delivered in person, etc.). If served by mail, retain the envelope and attach to subpoena.**

2. **Carefully read the entire document, giving special attention to the following:**
   A. Is UnumProvident or any subsidiary named as a party in the caption of the case? If so, immediately call your Legal Department representative. If not, proceed with the handling of the subpoena.
   B. What is the document requesting?
   C. What is the date and time on which a response must be made to the request?
   D. Was the subpoena issued in California? California has two specific requirements:
      1. The person issuing the subpoena must serve the insured or his attorney with notice of subpoena.
      2. The subpoena must include a declaration. The declaration often takes the form of an affidavit setting out the reasons the documents are needed.

If either one of these requirements is missing, you will need to call the attorney who issued the subpoena and advise that a notice and a declaration must be issued.

3. **Determine which UnumProvident company is involved (UNUM/America, First UNUM, etc.). Check the subpoena to be sure it is directed to the correct company or whether the company is properly named or spelled.**
   A. If it is, proceed with the handling of the subpoena.
   B. If it is not, place a telephone call to the party issuing the subpoena (see 4 below) and tell him/her the subpoena is not properly issued, give him/her the correct company name, and request that a new subpoena be issued. Confirm telephone conversation by letter. (No records should be released before you have a subpoena that is issued to the proper company. This is necessary in order to provide proper authorization to our company for the release of our records.)

4. **Place a telephone call to the attorney who issued the subpoena.**
   A. Discuss with him/her the matter of a personal appearance. (In most instances, the party issuing the subpoena is interested only in obtaining records and will not require a personal appearance.) If a personal appearance is required, contact Donna Millington Noel (Portland), Jean Phillips (Chattanooga), Susan Schulman (Worcester). If a personal appearance is not required, proceed with the handling of the subpoena.
   B. Ask the attorney if s/he would be satisfied with our sending photocopies of our records

along with an affidavit stating that they are complete and accurate copies of our files. (This is usually satisfactory.) If photocopies are not acceptable, contact your Legal Department representative.

C. Ask the attorney for an extension of time to produce the documents if you project that you cannot have the documents to him/her by the date required.
D. Confirm, in writing, all telephone conversations with the party who issued the subpoena.

5. Gather all files regarding the matter referred to in the request.

6. Carefully review all of the material gathered to determine the following:

Privileged or Confidential Documents
Determine whether there are any documents in the file indicating communications to or from the Legal Department. Also determine if there are any documents that would constitute proprietary business documents. If this material exists, do not release it to the party issuing the subpoena. This material does not have to be produced because of the attorney-client or trade secrets privilege that exempts such correspondence and records from production in response to a subpoena.

Federal Rules require that a person withholding material under a claim of privilege provide a description of the withheld material and the basis for withholding it.

TYPES OF PRIVILEGE:
I. ATTORNEY-CLIENT PRIVILEGE. This privilege is based on the view that protecting lawyer-client communications will facilitate more than it will obstruct the administration of justice. The client might be extremely reluctant to talk freely to his lawyer if he knew he might be called as a witness.

A. Elements:
    1. A communication
    2. Made in confidence
    3. To or by an attorney
    4. By a client or attorney
    5. For the purpose of seeking, obtaining or giving legal advice
B. The Attorney Client Privilege Exists:
    1. Legal Advice: Where the dominant purpose of the communication is of a legal nature.
    2. Exceptions: (Attorney Client Privilege does not exist)
    3. Business Advice: Communications of attorney who is transacting business that could have been transacted by another agent who is not an attorney, e.g., a communication concerning the calculation of a premium refund.

II. WORK PRODUCT. This privilege protects material prepared by an attorney in "anticipation of litigation."

A. Elements:
    1. An attorney's impressions
    2. Conclusions
    3. Opinions
    4. Legal Research
    5. Theories
    6. Strategies
    7. Derived through tangible and intangible means
B. Exception:
    1. Substantial need
    2. Undue hardship

Example: A memo in the claim file from an attorney to the Quality Review Department with legal advice given after an indication that suit would be filed.

If you have questions concerning this privilege, contact the Legal Department.

III. TRADE SECRETS (proprietary information). NOTE: These documents should not be contained in claim files.

This protects disclosure of information that would give a competitor the opportunity to take advantage of information generated and owned by UnumProvident.

A. Elements:

1. A formula
2. pattern
3. device
4. or compilation of information
5. used in one's business

Example:

- Reserve figures
- Premium pricing formulas
- Computer data base
- Claims Manual
- Underwriting Manual
- Internal procedural documents

Substance Abuse Records
Determine whether the materials deal with treatment for alcohol or drug abuse. Pursuant to Federal Law, some alcohol or drug abuse records must be withheld from subpoena production.

Whether or not the patient gives his written consent, in order to disclose protected records with respect to the treatment of drug and/or alcohol abuse, a court order must accompany the subpoena. If you have questions, contact the Legal Department.

AIDS & HIV Test Results
Determine whether any medical records contain information relating to AIDS, AIDS related diseases and/or HIV testing. If you locate any records which disclose the results of an HIV test or mention of AIDS, contact the Legal Department. State laws vary as to whether we are permitted to disclose HIV test results.

Psychiatric Treatment Records
If there are records contained in the claim file which deal with treatment for a psychiatric condition, the subpoena must specifically state a request for psychiatric or psychological records. UnumProvident may produce records in accordance with the court's subpoena.

If the words "psychiatric/psychological record" are not specifically requested on the subpoena, contact the Legal Department. State laws may prohibit us from producing such records.

Settlement Agreements
If you locate any settlement agreements that contain a confidentiality clause, they must be withheld from production.

If any documents fall under the above categories, please pull them from the file. The documents cannot be produced in some circumstances. Contact the Legal Department with questions.

7. Carefully photocopy all requested materials to be produced. The photocopies should be checked to be certain that all original items have been copied and are legible. Pursuant to Federal Rules, the documents must be produced in a manner in which they are kept in the usual course of business. Alternatively, the documents can be labeled to correspond with the categories in the demand. Securely fasten photocopies to ensure that they remain in the proper order during transmittal. (At a later date you may be asked to confirm what you produced. In most cases you will simply be able to go to the original claim file and recreate exactly what you produced. Clearly label and separate from

the rest of the file the documents that you did not produce.)

8. Prepare an affidavit to be sent along with the photocopies stating that the records are true copies of the documents retained at UnumProvident. Contact Legal for a sample affidavit.

9. Prepare cover letter.

10. Prepare invoice (contact Legal for fee schedule for photocopying records and Shipping/Handling charges).

11. Forward letter, fully executed affidavit, invoice and one set of photocopies to the attorney who issued the subpoena. Retain copy of cover letter, subpoena and exhibits in the file.

Taxes

Federal Income Tax
As a service or by federal requirement, UnumProvident will deduct federal withholding tax for the claimant. The claimant indicates on the original application the amount to be withheld for federal tax purposes, or a withholding form can be sent to the claimant. (We need to obtain this in writing from the claimant.)

The tax is considered money paid to the claimant. When doing recalculations, it must be added back into "we paid." The minimum amount we are allowed to withhold for Group LTD is $87.00 per month. The minimum amount we are allowed to withhold for STD is $20 per week. This money is not refundable to the claimant. In order for the claimant to obtain a refund, s/he will need to make an adjustment of his/her income tax.

State Income Tax
The following is a list of the states that do not have state income tax:

Alaska	Tennessee
Florida	South Dakota
New Hampshire	Wyoming
Nevada	Washington
Texas	

FICA (Federal Insurance Contribution Act)

Overview

FICA is a tax that is payable under the Federal Insurance Contributions Act. FICA is taken on the portion of sick pay represented by the percent of employer-paid premium or premiums paid by the employee with pre-tax dollars.

Determining if the Benefit is FICA Taxable

If the premium is totally non-contributory (100% employer paid), we fully tax the net benefit.

If the premium is contributory (employer pays none or a portion of the premium), we tax only the percent paid by the employer.

If the employee pays for the premium with pre-tax dollars, the benefits are taxable. The IRS considers employee payments for sick pay with pre-tax dollars as employer paid premium.

FICA & Government Employees

Governmental groups such as teachers, city, county and state employees may not be subject to FICA/Medicare withholding. Many of these groups contribute to PERS (Public Employee Retirement System) rather than SS.

The employer must tell us whether or not s/he contributes to FICA and Medicare. Some employees may and some may not, and some may contribute just to Medicare.

When to Deduct FICA

FICA tax should be withheld from any checks paid from the last date worked until the end of the time period which is six full calendar months following the last day the employee worked. The check must actually be released during the FICA period.

If the DOD is the first day of the month, that month counts towards the six full calendar months.

Key Points

- The FICA tax is subject to change annually.
- FICA tax is based on the net benefit. (Net = after all offsets have been taken from the benefit.) NOTE: Net is determined before reducing the benefits by state or federal withholding.
- In some cases the claimant may have already paid the maximum amount of FICA tax required for the year. Check with the employer as to whether the claimant has paid the maximum FICA.
- The FICA rate is broken out into two separate payment amounts, one percentage for SS and one percentage for Medicare (the rates are subject to annual change.) If a claimant has maxed out his SS tax for the year, we continue to take Medicare's tax portion, as there is no earnings cap on this portion.
- FICA taxes are taken based on the date of the check's release date, not the benefit period.
- Like Federal Income Tax, FICA is considered money paid to the claimant. When performing recalculations, FICA must be added into the portion that is considered "we paid."
- FICA is deducted on partial disability claims when the claimant returns to work with the same Employer.
- Do not withhold FICA from NDI, BOE, or Buy-Sell claims.

FICA & Recurrent Claims

FICA is taken on most recurrent claim situations. FICA law does not require a new six-month deduction of FICA tax if the claimant returns to work for another employer and then becomes eligible for a recurrent claim under our policy.

If the claimant returns to work for our policyholder, we take FICA on a recurrent claim. The FICA period must be within six months of work with our employer.

FICA Withholding on Partial Disability Claims

Introduction

Once a person is 6 months beyond the "date last worked" for a policyholder, FICA is not required to be withheld. If a person returns to work for the policyholder, there is no "date last worked" as required by the IRS regulation. We are, therefore, required to withhold FICA from the taxable portion of disability benefits for claimants who are partially disabled and have returned to work for the same policyholder.

Effective 1/1/98, on all contract series, claims in which the claimant returns to work with the policyholder, benefits are taxable to the claimant.

Claim Procedure

At the time of a return to work, we need to identify whether the person returned to work for the policyholder.
If no, handle as in the past.
If yes, withhold FICA from the taxable portion of the benefit.

The following are the FICA deduction percentages and maximum salary/wage limits subject to FICA:

Year	FICA %	Maximum Salary/Wage
1993	6.2	$57,600 (SS)
	1.45	$135,000 (Medicare)
1994	6.2	$60,000 (SS)
	1.45	No Wage Limit (Medicare)
1995	6.2	$61,200 (SS)
	1.45	No Wage Limit (Medicare)
1996	6.2	$62,700 (SS)
	1.45	No Wage Limit (Medicare)
1997	6.2	$65,400 (SS)
	1.45	No Wage Limit (Medicare)
1998	6.2	$68,400 (SS)
	1.45	No Wage Limit (Medicare)
1999	6.2	$72,600 (SS)
	1.45	No Wage Limit (Medicare)
2000	6.2	$76,400 (SS)
	1.45	No Wage Limit (Medicare)

Threatening/Suicidal Statements

During the normal course of our claims handling, we may encounter situations where the claimant makes threatening statements to us or to others such as his/her employer, family and/or physician. The claimant may also make suicidal statements. The following procedures should be followed when you encounter these scenarios.

Definition of Threat
A threat is defined as any physical, gestural or verbal action directed against you, or another person(s) which creates a feeling of fear. If you are threatened or witness a threat, be prepared to provide very specific detail regarding:

1. **Who** allegedly made the threat; **When** and **Where** it occurred
2. **What** the details were of the threat
3. **Who else** witnessed the threat
4. **Any other information** that is pertinent to the threat (e.g., activity that may have occurred prior to or after the threat took place)

Threats to UnumProvident Personnel
If a claimant makes statements threatening harm to UnumProvident personnel, we should discontinue the conversation. Immediately notify your manager. They will consider next steps which will include compliance with the Corporate Threat Reporting and Emergency Incident Guidelines. The claim file should clearly document the incident and actions taken.

Threats to Employers
Any threats made towards the policyholder should be immediately shared with the policyholder. These statements are not truly confidential and we are within our rights to share this information out of concern for the parties to the threat. If the threats are notes in the physician's office notes, we can assume that the attending physician made an assessment at that time as to whether the intended victim should be told. The claim file should clearly document all conversations and action steps taken.

Threats of Suicide
When a claimant threatens suicide, we should immediately contact the attending physician and advise of the situation. Even if the AP's office is closed, there is usually an answering service where we can relay this as an emergency message. In the rare situation where we are unable to contact the physician, you should discuss alternatives with your manager. The claim file should be clearly documented regarding all conversations and action steps taken.

Threats to/from Co-workers
Refer to the Corporate Threat Reporting and Emergency Incident Guidelines Policy.

Whenever any of the above situations occur, your manager should be notified and involved in the handling of the situation.

War Exclusion

Background

A question arose regarding how we handle disabilities due to war when the disability begins more than 10 years after the war.

Our various product offerings typically exclude benefits for war related conditions.

Applicability

All Products

Claim Investigation

When evaluating a claim where it appears the condition may be related to a war injury/sickness consider:

- Did claimant apply for or receive Veteran's Disability or Military Pension as a result of condition? There are no time limits to preclude a person from applying or receiving benefits from the government for a war-related disability. **Determine the status of application.**
- Consider the length of time between the war and the date of disability.
- Consider any co-morbid issues, other disability factors not related to war.
- Evaluate specific contract language to determine impact.
- If disability is a result of terrorism consult legal department.

Conclusion

When evaluating a claim to determine whether the disability is the result of a war related condition, we need to consider whether a non-war related condition also exists. If so, would that non-related condition result in disability in the absence of the war related condition.

Claims that may be subject to the war exclusion should be referred to medical/legal for input prior to any final decision.

Questions?

If you have any questions, please direct them to your consultant or manager.

Reminder: Each claim is unique and should be evaluated on its own merits.

Activities of Daily Living (ADL) and Cognitive Impairment

Background

Long Term Care insurance provides payment of benefits when a claimant satisfies the definition of disability as defined in the policy. Disability is defined as loss of Activities of Daily Living (ADLs) and/or Cognitive Impairment. UnumProvident also offers Individual and Group Long Term Disability coverage where the definition of disability is defined as loss of ADLs and/or Cognitive Impairment. The following information will provide a high-level definition of ADL/Cognitive Impairment.

Note: Contract wording can vary in defining ADLs/Cognitive Impairment. When evaluating a claim with this type of definition, you must refer to the specific contract wording.

ADLs

Typically there are six categories of ADLs. The following list defines various ADLs:

Bathing	The ability to wash one's self either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
Dressing	The ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
Toileting	The ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
Transferring	The ability to move in and out of a chair or bed with or without equipment, such as canes, quad canes, walkers, crutches or grab bars or other support devices, including mechanical or motorized devices.
Continence	The ability to either: voluntarily control bowel and bladder function, or if incontinent, be able to maintain a reasonable level of personal hygiene.
Eating	The ability to get nourishment into the body.

A diagnosis alone cannot determine if there is/will be an ADL loss. Also, the ADLs can be regained in some circumstances.

Cognitive Impairment

Typically, Cognitive Impairment is when there is a deterioration or loss in Intellectual Capacity and there is a need of another persons assistance or verbal cueing for the claimant's protection or the protection of others.

Loss of Intellectual Capacity can arise from a variety of medical conditions as well as an accident or injury. Psychiatric claims should rarely result in a cognitive loss that is permanent in nature. Most psychiatric conditions are treatable and may only have short-term memory loss or dysfunction. Depression and Impaired Ability to Concentrate are typically not considered cognitive loss. Cognitive Loss is measurable via testing and information supplied by the physician of record, as well as IMEs.

Advance Pay & Close (AP&C) Procedures

Background

To ensure consistency in our approach to risk management, the Advance Pay and Close procedures have been reviewed and modified.

What is an Advance Pay and Close (AP&C)?

An Advance Pay and Close is a claims management tool designed to help an insured return to work when there is a reasonable and expected return to work date/plan. By offering an alternative payment method, we are providing an option that may assist some claimants in their return to work efforts.

When do we offer this option?

When there is a future recovery/return to work date agreed upon by all parties.

The return to work/recovery period must be reasonable based on the insured's motivation and medical records.

The claimant is motivated and interested in receiving advance payments. This is a voluntary option and rejection of the offer has no impact on future claims management.

How far in advance can we pay benefits?

Maternity Claims

Once we have the actual date of delivery, we can approve an advance payment of up to 6 weeks benefits beyond the delivery date.

Any Occupation Management

We can consider payment of benefits up to 6 months in advance of the any occupation definition change in situations where:

- Maximum Medical Improvement has been reached **and**
- We have clearly identified other gainful occupations that the claimant can perform **and**
- The claimant will not be returning to work with the employer **and**
- The claimant is in agreement with our conclusion that they have work capacity.

Since we have determined that we have a clear/limited liability period, the advance payment of benefits can assist with the insured's financial transition.

Standard Claims Management
In other situations where there is an agreed upon future recovery date (based on the insured's motivation and a review of the medical records), we can advance pay up to 3 months benefits.

How do we calculate the advance payment benefit on a residual/partial claim?

To encourage RTW, we should typically offer the advance payment based on the current net benefit. However, if there is an expected and/or scheduled plan to increase hours/earnings, we need to consider the amount we will offer as advance payment. The following factors should be considered:

- What is the current net benefit?
- Is there a scheduled RTW plan that would allow us to calculate the exact future earnings?

- Can we estimate the expected earnings during the advance pay period?
- Will a payment based on the current net benefit assist with the return to work efforts?

When can't we use the AP&C option?

When the advance payment would be to the maximum duration date, i.e., MN Limit/Self-Reported/Policy maximum duration.

If the claimant is motivated to return to work but it appears, based on a review of the claim file, that they may be unrealistic in their plans. Conflicting information must be resolved before a claim decision can be made.

When there are any ongoing disputes regarding their claim.

Can we offer an advance payment on claims whether the primary disabling condition is mental and nervous?

We cannot provide an advance payment to the maximum duration. However, when the claimant and attending physician are in agreement re: RTW plans, an advance payment is an appropriate option to consider.

Is the claim appeal process included in the correspondence?

Appeal procedures are not included in an advance pay and close because we are not denying further benefits. An advance payment involves agreement from the claimant before we can proceed. Therefore, it is not a claim denial.

What if a claimant's disability continues beyond the AP&C date?

When the claimant contacts us, they have put us on notice of a continued claim for benefits. At this point, we have not formally denied the claim nor have we provided the appeal procedures.

Since the claimant has notified us that s/he is still disabled, we have to consider the file as a pended claim file. This does not mean that we have to do the footwork to obtain medical information for the claimant. We should inform the claimant of the need to provide proof of continued disability before payments can resume. Explain that if we do not receive the information within 30 days, we will consider the file closed.

Do not open the claim on the system. The claim should have a follow-up scheduled for 30 days. If nothing further is received, additional benefits should be denied. A formal denial letter should be sent that includes the Appeal paragraph.

What if the medical information is not clear re: RTW?

Utilize your medical and vocational resources to assist with the evaluation of the Rehab/RTW potential.

Resources

Utilize your manager or consultant to discuss this procedure and application to a particular claim.

Conclusion

- Advance Pay and Close (AP&C) is a claims management tool that offers an alternative payment method.

- We can AP&C 6 weeks beyond a maternity delivery date.
- We can AP&C up to 6 months benefits on an "any occ" claim.
- All other claims are limited to a maximum 3-month AP&C.
- Do not AP&C claims to policy limitation and/or maximum duration periods.
- We can AP&C psychiatric claims when the Attending Physician and Claimant agree to this option.
- If a claimant is motivated but unrealistic in his or her return to work plans, further investigation is needed.
- Medical Resources can be utilized to assist with the evaluation of the reasonableness of RTW or recovery date.
- Do not include the appeal procedures in your AP&C communication, as this is not a formal denial.

Age Discrimination in Employment Act (ADEA)

The Age Discrimination in Employment Act (ADEA), as amended by the Older Workers Benefit Protection Act, is a federal law prohibiting employers from discriminating against employees on the basis of age in all terms, conditions, and privileges of employment. ADEA does permit an employer to discriminate on the basis of age for certain employee benefits so long as the discrimination is actuarially cost justified.

What does this mean for employee benefit plans? The Department of Labor regulations interpreting ADEA state that it is not a violation of ADEA if LTD benefits remain constant until a specified age and then reduce, provided that the reductions for older employees are no greater than is justified by the increased cost of benefits for that employer. ADEA does not permit employers to terminate LTD benefits based on age; an employer is permitted only to reduce benefits based on age.

UnumProvident has structured the benefit reduction schedule in its LTD policies to assist employers in complying with ADEA. Our LTD actuaries have determined that this schedule contains the reductions they can cost justify. In other words, this schedule produces costs for an older employee that are at least as large as costs for any younger employee. And, of course, the schedule does not terminate benefits based on age.

What is a cost justified amount of reduction in LTD benefits under the insurance coverage chosen? UnumProvident has determined—based on its database and actuarial justification—that any insured:

- Employees who are **under 60** years of age as of their date of disability are eligible to receive benefits to age 65 but for not less than 5 years.
- Employees who are **60** years of age as of their date of disability are eligible to receive 60 months of benefits.
- Employees who are **61** years of age as of their date of disability are eligible to receive 48 months of benefits.
- Employees who are **62** years of age as of their date of disability are eligible to receive 42 months of benefits.
- Employees who are **63** years of age as of their date of disability are eligible to receive 36 months of benefits.
- Employees who are **64** years of age as of their date of disability are eligible to receive 30 months of benefits.
- Employees who are **65** years of age as of their date of disability are eligible to receive 24 months of benefits.
- Employees who are **66** years of age as of their date of disability are eligible to receive 21 months of benefits.
- Employees who are **67** years of age as of their date of disability are eligible to receive 18 months of benefits.
- Employees who are **68** years of age as of their date of disability are eligible to receive 15 months of benefits.

Employees of any age must receive at least 12 months of benefits if their disability continues that long.

UnumProvident's position is that it will not sell a LTD policy that may create issues under ADEA because it does not wish its policies to be the cause of ADEA compliance problems for policyholders.

Questions concerning ADEA arise infrequently. If you receive a question on ADEA, contact the Legal Department for assistance in responding.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) established a clear and comprehensive prohibition of discrimination on the basis of disability. The ADA is organized into five titles or sections covering various topics related to Americans with disabilities:

- Employment
- Public service
- Public accommodations and services operated by private entities
- Telecommunications
- Miscellaneous provisions on topics such as prohibition against coercion of or retaliation against an individual who invokes rights under the ADA.

The ADA states that employers can not discriminate against a person with a disability who can perform the essential functions of a job. In addition, employers must make reasonable accommodations to remove barriers that make it difficult for a person with a disability to do the essential functions of a job, unless such accommodation is a hardship to the employer.

Reasonable accommodations need to be made for psychiatric disabilities as well. Employers, when necessary, should consult their HR department or attorney when determining if an accommodation is reasonable under ADA. If a claimant voices a concern over the employer's handling of the ADA, we should encourage communication between the claimant and the employer.

Impact to Claims

We will continue to encourage the return to work of people with disabilities where appropriate. The ADA provides additional support for using return to work strategies to minimize the disability risk for the employer.

Assignment of Benefits

An Assignment of Benefits is a request to pay all or a portion of the benefit to another party. **A court order to pay all or part of the benefit to someone else does not fall into this category.** Many of our insurance contracts state that all benefits are paid to the insured, the loss payee, or the beneficiary.

Occasionally we receive requests to pay all or a portion of the benefit check to entities, e.g., a bank, insurance company or employer. This request must be in writing. Generally we are able to honor the insured's request to assign an entire check. If a request is made for multiple assignments, we should agree on an exception basis only due to system constraints.

If we are agreeing to the assignment request, we need to explain to the insured that the assignment does not affect the taxability of the benefit. For tax purposes, the entire benefit is considered paid to the insured.

We should discourage any request to assign benefits to a 401k plan. If the claimant is insistent, contact the Legal Department. Inappropriate handling has the potential of causing the plan to be disqualified by the IRS.

The assignment may be on a UnumProvident form or one supplied by the insured. The assignment should address clearly how much of the benefit is to be assigned, the duration of the benefits, and whether the assignment is permanent (irrevocable) or may be changed by the insured (revocable).

NOTE: Refer to the Life section of the Manual for Life assignment requests.

Incomplete or Altered Authorizations

Overview

This section outlines our procedures for handling claims when an Authorization has been altered or when the claimant refuses to sign an Authorization.

The Authorization to Release Information was developed to allow us access to information needed to fairly adjudicate claims. Not only does UnumProvident have the responsibility to fairly adjudicate claims, the claimant also has a responsibility to provide necessary information. The claimant has a duty to cooperate in order for UnumProvident to reach a determination on his/her claim.

Initial Claim Form

An initial claim form is considered incomplete if the authorization has been altered in any manner. If the authorization on the initial claim form has been altered, we should contact the claimant and ask that s/he complete an unaltered form. The claimant should be advised that we can not process his/her claim until we receive a new authorization with no changes made to the form. Explain, in writing, that the incomplete authorization will impact our ability to adjudicate the claim. Until we receive an unaltered authorization, we have not been provided with a completed application for benefits.

Refusal to Sign Authorization

During both the initial and ongoing claim investigation, if the claimant refuses to sign an unaltered authorization and as a result we are unable to fully investigate and assess the claim, s/he should be advised that we are unable to investigate/manage the claim. The lack of an authorization has impaired our ability to obtain necessary information. The claimant should be given the opportunity to submit an appropriate authorization and be put on notice that failure to do so could result in denial of the claim. If the claimant does not respond to this request, the claim should be denied (with Consultant approval).

Altered Authorizations

If the authorization is submitted and the insured has altered or limited our right to obtain information in some manner, we should immediately contact the insured and request that s/he sign and return an unaltered authorization.

We should clearly explain our position and explain the consequences. The insured should also be given a written explanation regarding how changing the authorization can impact our ability to adjudicate the claim. If the alteration materially impacts our ability to continue our claim investigation and we cannot obtain the information through any other means, benefits should be suspended pending receipt of an unaltered authorization. If the impact is unclear, we can continue benefits while waiting for a new authorization from the insured.

SS/Tax Return Authorizations

When a claimant refuses to sign a Social Security or Tax Return Authorization form, we should evaluate the reason for our request. What impact does this have on our handling of the claim? We should discuss the situation with the insured. If the Social Security Authorization is to determine the status of the claimant's application for Social Security benefits, we should advise

the insured why the information is needed and the impact his/her refusal will have on his/her claim. Refusal to sign the authorization could result in estimating a Social Security offset.

When a claimant refuses to sign a tax authorization, we need to question why s/he will not sign it. Determine if there are alternative resources to get the information needed. Inability to obtain earnings information can result in denial of benefits.

What if We Have Accepted Altered Authorizations in the Past?

Occasionally, we may have accepted an altered authorization and processed the claim. **This would happen only if the alteration did not impact our ability to appropriately investigate and evaluate the claim.** During the life of the claim, however, circumstances may change and we may need to request an unaltered authorization. We should advise the claimant that we will no longer be able to accept an altered authorization as it impedes our ability to gather information. The absence of adequate proof of loss could result in our inability to continue benefits on the claim.

Important Note

To increase the claimant's comfort with our request for signed/unaltered authorizations, we should advise that we keep all customer files confidential. Any information we gather would be used to evaluate/manage their claim.

Release of California Outpatient Psychotherapy Records

Background

The State of California has added a new section to their Civil Code prohibiting health care providers from releasing medical information regarding a patient's participation in outpatient treatment with a psychotherapist unless the person or entity requesting the information submits a signed written request which includes specific information.

Effective Date

Effective immediately for all claims.

Applicability

Applies to Group Disability, Individual Disability, Group and Individual Long Term Care, and Life.

Impact to the Customer Care Center

When requesting psychotherapy records in California, our letter must include the following paragraph:
"Records relating to [claimant's name] participation in outpatient psychotherapy treatment has been requested. These records are requested as a result of a claim for benefits and will not be used for any purpose other than for a claim for benefits. These records will be destroyed seven years from the date the claim is closed. This request for treatment records is being sent in compliance with Section 56.104 of California's Civil Code concerning the confidentiality of medical records. We will also send a copy of this letter to [claimant's name] in compliance with Section 56.104."

Note: This wording will be added to applicable BAS/PC and Genesis letters; also a new letter will be added to Delta. However, Customer Care Specialists will need to manually add this wording to their "freeform" letters.

The claimant's regular authorization from the claim form must be attached to our request.

Notification to Claimant

We are required to send a copy of the original request to the claimant no later than 30 days after receipt of the requested records.

Note: When using a Medical Records Vendor we must send a separate letter to the claimant advising them of our request.

Using PMSI, MOBILE or Other Medical Records Vendor

We are responsible for:

- Notifying the vendor that we have asked them to request outpatient psychotherapy records in the State of California.
- Advising them that they are required to include specific wording in their request to the medical provider.
- Providing them with the actual wording (specifically as defined above).

Psychotherapist

The definition of "psychotherapist" for these purposes under California law is a:
Clinical social worker, psychologist, family counselor, psychiatrist, (and associates, assistants and trainees of these), school psychologist, registered nurse with a master's degree in psychiatric mental health nursing, or anyone that the patient reasonably believes devotes a substantial portion of his/her time to the practice of psychiatry.

Questions?
If you have questions regarding this ruling, please direct them to your consultant or manager.

Claim Denial Procedures

Background

A denial decision represents the Company's position on a claim. The following information provides guidelines for managing denial decisions.

What Is A Denial?

Any time the claimant does not receive the amount of benefits or extent of benefits that s/he are claiming, in whole or in part, the claimant should be provided with an opportunity to appeal our decision. This includes situations where the claimant does not satisfy the policy elimination period.

Advance Pay & Close and Expected Duraction Claim Decisions

Advance Pay &Close (AP&C) and Expected Duration decisions are not considered claim denials unless the claimant disagrees with our decision.

The AP&C and Expected Duration letters should clearly state that the claimant has 30 days from the end of the approved period to submit additional information. This will ensure that there is an expected timeline in which the claimant must submit proof to have the claim considered.

30-Day Notice To Provide Proof

Frequently we ask claimants to provide proof of disability within an established period of time (30 days). If we do not receive a response within the time period, we are denying benefits. The letter communicating our decision should include appeal rights.

Denial Guidelines

Generally we should obtain medical resource input when our decision is based on an assessment of the medical information in the claim file.

Refer to specific New York DBL and New Jersey TDB denial requirements for DBL/TDB claims.

Denial Notification

During the claim investigation process, we should keep the claimant apprised of the continuing status of his/her file. The claimant should be kept aware of any information we are having difficulty obtaining. In turn, the claimant can clarify any issues/questions that may occur.

When denying benefits, a letter should be sent notifying the claimant of our decision.

We should make a reasonable attempt to call the claimant on adverse claim decisions.

We should make a reasonable attempt to contact the Employer on all Group Policy claims when we are denying initial liability.

Denial Letter

Our denial letters should contain:

- Applicable policy provisions,
- Detailed explanation of our decision including the relevant factual data and how it applies to the policy provisions,
- Appeal Procedures, and
- How to perfect the claim

Conclusion

Denial decisions represent the Company's position on a claim. In keeping with our Customer Care Center Philosophy, the communication of our claim

decisions should reflect our fair evaluation of the claim.

Claim Payment in Alaska

Background

A ruling in the State of Alaska requires that the claimant be provided with an option to receive claim payments made with a negotiable check, payable in cash to the payee upon presentation to a bank located in Alaska. If the check is not drawn on a bank having a physical location in Alaska, it must be payable in cash upon presentation to at least one bank having a physical location in Alaska.

A recent bulletin clarifies that the following are considered to be instruments that are "payable in cash to the payee upon presentation":

- Payment by U.S. Postal Money Order;
- Payment by cashier's check, teller check, certified check, or other negotiable bank check payable in cash on demand at a bank located in Alaska or, if the claimant is out-of-state, at a bank located in the community where the claimant is residing; and
- Payment by electronic fund transfer to any account designated by the claimant.

Applicability

The procedures outlined below apply to STD, LTD and IDI.

Effective

The procedures outlined below are effective immediately.

How will we comply with this ruling?

To comply with this ruling, we must make "immediate cash" an option to the claimant. By making the offer we are in compliance with the law, even if our options are rejected by the claimant.

Where available, Electronic Fund Transfer (EFT) is the method we will use.

The following systems can accommodate EFT:

- BAS – LTD & STD
- Polaris – LTD

The following systems cannot accommodate EFT:

- PACE
- CAPS
- Polaris – STD

Therefore, we will offer wire transfer of funds. A wire transfer of funds places the payment directly into the claimant's bank account and is immediately accessible.

General Claim Procedures

When you have a claim payable to an Alaska resident:

1. During the initial call to the claimant, advise that our usual method of payment is to issue Company checks (whether weekly, monthly, one payment, etc.). Also explain that we have other payment options available—Electronic Fund Transfer (BAS and Polaris) and Wire Transfer (PACE and CAPS)—advising that either choice may impact the timing of payment due to the process involved.
2. If the claimant rejects either EFT or wire transfer, explain that we will pay the claim in the usual method.
3. If the claimant chooses Electronic Fund Transfer, explain that you will send the paperwork that must be completed before EFT can begin. In

the meantime, any claim payments will be made in the usual method.

Claim Settlement Payments

In the event you are making a "lump sum" payment on a claim, you must offer more than one option (when possible). If the claimant rejected EFT, you must offer Wire Transfer.

Electronic Fund Transfer Procedures

If you are going to pay the claim via Electronic Fund Transfer:

- LTD BAS users – follow the established procedures.
- STD BAS users – procedures are in the development/testing phase. Use Wire Transfer or usual payment method until they are finalized. Details regarding finalized procedures will be forthcoming from Financial Support Services.

- Polaris LTD users – follow the established procedures.

Wire Transfer Procedures

If you are going to pay the claim via Wire Transfer:

1. Obtain the following information from the claimant:
   a) The name and address of the receiving bank.
   b) The correct name of the account holder. Tell the claimant that you need the account holder name as it appears on his/her checks (ie: John W. Doe). If the account name is a joint name (ie: John W. Doe and Jane M. Doe), you need both names as they appear on the checks.
   c) The account number. Tell the claimant to look at one of his/her checks. ***It must be a check, not a deposit slip.*** There are two sets of numbers encoded on the bottom line of the check. The second set of numbers is the account number.
   d) The bank routing/ABA number. This is the first set of numbers on the check (9 digits).

Please Note: This information may be obtained via telephone call. However, request that the claimant send written confirmation for the claim file.

2. Complete the Fedwire Request form making sure you complete each field. Incomplete information may result in a delay of the transfer.

Please Note: This form is currently in the development stages. When it is complete, it will be added to the intranet and you will receive notification. In the meantime, you may contact one of the names indicated in #6 below for a copy of the form and they will fax it to you.

Please Note: Only one Fedwire Request form is required per claim. If the claim will require subsequent payments, indicated that this form is for an ongoing claim and regular weekly/monthly payments will be required.

3. Obtain VP signoff. **This must be a physical signature.**

4. The following action must be taken on the claim payment system:
   - **Pace:** Generate a check made payable to the appropriate insuring entity (ie: Provident Life & Accident, Paul Revere, etc.) and forward it to Coleen Martin advising that it is reimbursement to the Company for the wire transfer.

- **Polaris:** Generate a check made payable to the appropriate insuring entity (ie: Provident Life & Accident, Provident Life & Casualty, etc.) and forward it to Trish Kilgore advising that it is reimbursement to the Company for wire transfer.
- **CAPS:** Follow established procedures for coding field drafts.
- **BAS:** Generate a check made payable to the appropriate insuring entity (ie: UNUM Life Insurance Co. of America, First UNUM, etc.) and forward it to Nancy Stanton in Financial Support Services advising that it is reimbursement to the Company for the wire transfer.

5. Send the Fedwire Request form and the benefit check (applicable to all except CAPS users) to the person indicated below. A Walker journal entry must be entered and approved before the Fedwire Request form is sent to the Treasury Department. Once the Walker journal entry is complete, Nancy, Trish or Coleen will enter the journal number on the Fedwire Request form and fax it to the Treasury Department.
   - **Pace:** In Portland and Worcester contact, Coleen Martin; in Chattanooga, contact Trish Kilgore.
   - **Polaris:** Trish Kilgore
   - **CAPS:** Nancy Stanton
   - **BAS:** Nancy Stanton

6. **This step will be completed by Nancy, Trish or Coleen.** The Fedwire Request form must be sent to the Treasury Department in Chattanooga one day prior to the transfer. The fax number is 423.755.3899. Fax it to the attention of Donna Lawrence (423.755.8595) or Bob Datz (423.755.3236). If you are in Chattanooga, you may hand deliver it to the Treasury Department at 6N.

7. For ongoing payments, you must send an email to Bob Datz, Beth Cobb, and Linda Bessman the day before each wire transfer is made. The email must indicate that this is a wire transfer request for an ongoing claim and that the Fedwire request form has already been received by them. It must also include the amount to be transferred, the date of the transfer, the claimant's name, the claim number, the policy number, and the payment from/through dates.

Questions? If you have any questions, please direct them to your consultant or manager.

Reminder: Each claim is unique and should be evaluated on its own merits.

Continuity of Coverage with Recurrent and Elimination Periods

Background

A question arose regarding whether a claimant must satisfy a new elimination period (EP) when there is a change in disability carriers and the claim is recurrent.

This applies to which products?

Group LTD and Group STD products.

Steps to consider

Is claim payable under our plan?

- if no, deny
- if yes, continue with administration of claim in accordance with our contract and in accordance with the following

Determine if prior carrier would have had liability for the claim if their coverage had remained in force.

- if no, continue with administration of claim in accordance with our contract
- if yes, determine if the claimant would have been required to satisfy a new EP under the prior carriers' plan?

If the claimant would not have to satisfy a new EP with the prior carrier we will not require a new EP.

If the claimant would have to satisfy a new EP with the prior carrier, we will require a new EP.

Credit for Elimination period

When a claim is payable under our policy and it would have been recurrent under the prior carrier's plan, we will give credit for the portion of the EP that was previously satisfied, if the prior carrier's EP is equal to or greater than ours. When our EP is longer, we will take the difference.

Conclusion

If the employee would not have had to satisfy a new EP with the prior carrier then the employee will not have to satisfy a new EP with UnumProvident. This process continues to encourage employees to return to work and encourages employers to switch to UnumProvident.

What if I have additional questions?

Ask your consultant or manager if you have additional questions.

Reminder: Each claim is unique and should be evaluated based on its individual merits.

Continuity of Coverage in CXC Contracts

Background

A question has arisen regarding the continuation of coverage during the elimination period in the pre-merger UNUM group CXC contract series and the current group disability product offering.

Current Contract Wording

The contract states that the insurance coverage ends when an employee is no longer in active employment (except as provided under the covered layoff or leave of absence provision).

When a person is disabled due to a pre-existing condition and during the elimination period becomes disabled due to a different condition, the claim would not be payable as coverage has terminated.

New Procedure

We have administratively determined that under all CXC contract series, coverage will continue during the elimination period as long as required premiums are paid.

What Does This Apply To?

All Group CXC contracts.

When Is This Effective?

Immediately.

How Will The Contract Wording Change?

The new contract wording will state: "When does your coverage end? Your coverage under the policy or plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment *(except the coverage will continue:*
  - during the elimination period, as long as required premiums are paid; or
  - while benefits are being paid; or
  - as provided under the covered layoff or leave of absence provision.)

Will Contracts Be Updated To Reflect the New Language?

The new language will be implemented on all future sales.

What if I Have Questions?

Refer to your Consultant or Manager.

Reminder: Each claim is unique and should be evaluated on its individual merits.

Confidential Communications

Internal Attorney-Client Communications & Business Confidential Documents

Overview

This section provides guidance on communications with an attorney for UnumProvident and also describes how to handle business confidential documents.

Key Points

Privileged & confidential information should:

- be clearly noted "privileged & confidential"
- be segregated in the claim file and placed on the left hand side of the claim folder
- not be released to anyone

Privileged and Confidential Information

Privileged and Confidential information should not be released to anyone. If this information is improperly released, we may have waived our rights to keep the document (including conversations) privileged/confidential, to be excluded from evidence or to object to the claimant discovering other documents pertaining to the same issues. Release of this information may also result in the attorney having to testify in court.

Privileged Documents

Assertion of a privilege means that there is a legal basis for refusing to provide a document or other evidence. Although there are several privileges that can be asserted, the attorney-client privilege is the most common privilege asserted in claims handling. The privilege exists when a communication is made, to or from a client, to or from a UnumProvident attorney (or UnumProvident outside counsel), for the purpose of seeking legal advice, and is intended to remain confidential and is not waived. Examples of privileged documents are:

- E-mail or written memos to and from a UnumProvident Attorney/Outside Counsel.
- Formal written opinions given by UnumProvident Attorney/Outside Counsel.
- Written documentation of a conversation (both meeting notes and phone conversation) with a UnumProvident Attorney/Outside Counsel.

Confidential Documents

Confidential documents include trade secrets or other similar information such as research, development or commercial information. A court may allow the claimant to obtain such documents but may not allow its admissibility at trial or will order that the documents not be further disclosed or used in any way ("protected"). Examples of confidential documents are:

- Reserve information.
- LTD policies and procedures, i.e., training documents, underwriting manuals, etc.

File Documentation

To prevent inadvertent disclosure of attorney-client communications, we should clearly mark the document or e-mail with the words "Attorney-Client Communication—Privileged & Confidential." Attorney-client communications should also be segregated from the claim file and maintained on the left-hand side of the claim folder. Do not photocopy or distribute attorney-client communications as this may waive the right to keep the document confidential. Confidential business documents should not be included in claim files.

Contestable Investigations

This policy is currently under review.

Continuity of Coverage in New York

Background

Continuity of Coverage is a policy feature that prevents the loss of coverage for an employee due to a transfer of insurance carriers. The provision outlines the responsibility of both the prior carrier and succeeding carrier in situations involving:

- **not actively at work on the effective date of the new policy, and**
- **pre-existing** conditions

New York Continuity of Coverage

Under New York law, if new coverage is effective within 60 days of the prior coverage, and the level of benefits is similar, then credit must be given for the prior plan period.

Continuity of Coverage will apply to new hires who have changed insurance **due to a change in jobs** as well as situations where employers switch coverage (standard continuity of coverage).

Claim Impact

When evaluating the applicability of pre-existing provision, we give credit to individuals who may have switched insurance coverage due to a change in employers. We will credit the time a claimant served under a PRIOR EMPLOYERS disability plan when applying a pre-existing provision as long as the gap in coverage is 60 days or less.

How Does the New Hire Waiting Period Affect the 60-Day Period?

Most group insurance policies have a period of time following the hire date that must be satisfied before the coverage is effective. This period of time is generally referred to as the waiting period.

When evaluating whether an individual had more than a 60-day gap in coverage, we will include the waiting period days. If the policy has greater than a 60 day waiting period, we can assume that the claimant would not be eligible for Continuity of Coverage.

Claim Investigation Procedures

If the employer has switched carriers, we will apply continuity of coverage and credit for any 60-day gap between carriers.

If the employee has switched employers, we need to determine if the claimant had disability coverage within 60 days of our effective date of coverage.

If there was a gap between coverage of greater than 60 days, continuity of coverage does not apply.

If the prior insurance was less than 60 days, Continuity of Coverage does apply.

How Do We Determine if the Claimant Disability Insurance Coverage with Their Prior Employment?

The claimant must provide proof of the other coverage along with their certification of coverage.

It is reasonable to require that the claimant provide proof of prior insurance coverage. We can facilitate the request however the responsibility is with the claimant.

What Does This Apply To?

All Group STD and LTD Disability Insurance Policies issued (situs) in New York.

What if I Have Additional Questions?

If you have additional questions, please ask your Consultant or Manager.

Reminder: Each claim is unique and should be evaluated based on its individual merits.

Determining Disability

Many issues may arise in processing a claim for benefits under a disability insurance policy (e.g., eligibility, elimination period, waiting period, pre-existing condition, exclusions, actively at work etc.) before a determination of disability is required. This section describes how a determination of disability is made once those preliminary issues are resolved.

Who Determines Disability?

In many instances, the Customer Care Specialist, with the guidance of the appropriate consultant, and applying the appropriate provisions of the policy, is the person who determines if a claimant is disabled. In certain claims, the decision-making approach will be managed by a team of claims professionals and other expert resources. In the non-team setting, the determination of disability is **not** made by a physician, a vocational expert, or other specialty resource. In making the disability determination, however, it is often necessary for the specialist to seek a review by or guidance from a variety of medical, vocational and investigative resources. It is also often appropriate to conduct a roundtable review of the claim.

What is the Basis for the Decision?

The decision as to whether the claimant is disabled is always based on the policy definition. However, all policies generally define disability as an inability to perform a certain occupation due to sickness or injury. In other words, all definitions of disability have three fundamental requirements in common:

1. The claimant must have an illness/sickness or an injury;
2. Illness or injury must result in limitations and restrictions on the claimant's mental or physical functioning; and
3. These limitations and restrictions must result in the claimant being unable to do some or all of the material and substantial duties of the occupation as that term is defined in the policy.

The Disability Analysis

When all other issues surrounding the claim for disability benefits have been resolved and the only question remaining is whether the claimant is disabled, the following four questions should be considered:

1. Does the claimant have a covered illness or injury?
2. Does the illness or injury impair the claimant's mental and physical functioning? If so, what are the claimant's **limitations**—the mental or physical functions he **cannot do**—and what are the claimant's **restrictions**—the mental or physical functions a medical provider states that he **should not do** because it would result in harm to the claimant?
3. What are the material and substantial duties of the occupation defined in the policy (e.g., own occupation, any occupation, etc.) and what are the physical and mental requirements to do those duties?
4. Is the claimant able to do some or all of the material and substantial duties of the occupation **even with** limitations and restrictions?

It is also important to understand that each of the four steps may first require the resolution of other factual and legal issues (e.g., Are the restrictions and limitations medically reasonable? Is the claimant receiving medical care appropriate or reasonable for the condition? What is the claimant's occupation?) and also may require information or resolution of issues unique to that particular claimant or policy.

Changing Diagnosis Codes

Background

As part of our claim processing procedures, we maintain diagnosis codes on our various claim systems. During the initial evaluation of claims and throughout the claim management process the code may not accurately reflect the current primary disabling diagnosis.

Claim Procedure

Our claim system should always reflect the correct primary diagnosis causing disability. The system code should be validated to ensure the appropriate diagnosis code is reflected when:

- evaluating a new claim
- the primary disabling condition changes
- a claim is transferring to a new impairment unit

When a file is referred to Extended Duration Unit

Consultant signoff is required whenever the diagnosis code is changed on any claim systems and the change will result in the claim moving to another impairment unit.

Applicability

All Claim Systems

Questions?

Please see your Consultant or Manager with any questions.

Exclusions and Limitations

Definition
Exclusions: Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Limitations: Specific conditions or circumstances listed in the policy that limit coverage or payment of benefits in a particular area.

Self-Inflicted Injuries
Many contracts state that disabilities due to intentionally self-inflicted injuries are excluded from coverage. The insurer must prove that the self-inflicted injury was intentional and that the resulting disability is subject to this exclusion. Questions that may clarify this issue include:

- Was the claimant's disability the natural or probable consequence of his actions?
- Did the claimant understand the physical nature and consequences of his action?

Consultant review/signoff is required prior to denial based on a self-inflicted injury exclusion.

External E-Mail & Internet Guidelines

Introduction

To ensure that the CCC achieves desired standards and adheres to the appropriate state and federal laws, we developed the following guidelines regarding communication on the Internet. These guidelines supplement the UnumProvident "Internet Security and Usage Policy" and provide direction on CCC specific issues. Everyone should become familiar with the UnumProvident policy since it contains important information that is not included in these guidelines.

External E-mail

The transmission of information is not secure unless encryption technology (security software) is utilized. Also, such correspondence can be easily transferred to large international audiences through distribution lists and chat rooms. Therefore, we should adhere to the following guidelines:

E-Mail communication to claimants is not permitted until a corporate encryption method is implemented and appropriate procedures are in place. In the case of certain unusual business requirements, exceptions may be made through consultation with CCC legal resources and use of a signed consent form obtained from Legal.

Communication to policyholders, insurance companies, intermediaries, attorneys, vendors, and other appropriate parties on the Internet should follow existing privacy and confidentiality guidelines. In no case should private medical or other confidential data be communicated via the Internet since the transmissions are not secure.

All correspondence should meet file documentation standards and be business-like in tone and content.

Do not identify the name of the claimant in the "subject line" as this can breach confidentiality.

Do not refer to UnumProvident's guidelines, procedures, or other proprietary trade secrets.

Information relevant to all claims should be printed and kept in the appropriate file.

Customer Service Standards

To meet our corporate objectives, it is critical that UnumProvident customer service standards are followed regarding this form of correspondence. For example, we will be expected to respond to requests within our published timeframes. This will require work units to develop and implement appropriate "coverage" plans for absent employees.

CCC Internet Research Guidelines

The Internet is an international collection of linked computers and networks that contain a multitude of data and, therefore, presents excellent research possibilities. By the same token, there is no single point of administrative and/or quality control. Considerable inaccurate information exists in databases and extreme caution should be exercised when performing research on the Internet.

The use of the Internet for information should not replace referrals to specialized resources (Medical, Rehab, SIU, etc.). Research should be limited to approved sites, unless you have your

Senior Customer Care Consultants approval, which will be identified by support areas on an ongoing basis.

Examples of approved sites include:

- Services for Independent Living section on UNUM.com
- www.pdr.net (the Physicians Desk Reference site)
- www.healthfinder.com (the Federal Government's gateway to medical sources)
- www.bigyellow.com (telephone numbers and addresses, yellow pages listings)
- www.mapquest.com (mapping and address locator site)

Family and Medical Leave Act of 1993

Introduction

The Family and Medical Leave Act of 1993 (FMLA) is a federal law that requires employers to continue health care coverage during an employee's approved family leave. The law mandates that should coverage lapse during the leave, it will be reinstated at the same level as though coverage had been continued.

UnumProvident

While the law applies to Employers, UnumProvident has developed a position that will meet the Employer's needs. Although federal law requires only that medical and dental insurance and health care reimbursement accounts be continued during FMLA leave, we will allow the Employer to continue any UnumProvident coverage during FMLA leave, as long as premiums are paid and the Employer has approved the employee's leave in writing.

Our newer Group LTD/STD contract series have a specific provision in the policy which states how we will handle FMLA. When investigating a claim with FMLA implications, the contract should be reviewed to determine if the provision is included.

NOTE: An approved FMLA leave is different from the layoff or leave of absence provision. We must determine which leave an employee is on before determining if s/he is still covered under the policy.

Claim File Documentation

In the event of a claim while a person is on leave, proof is required showing written leave approval.

We require written documentation that a FMLA was approved if a claim occurs during the leave or for a pre-existing condition investigation following the leave. We will require a copy of the Employer's human resource policy on family and medical leaves and a written statement that a FMLA leave was approved for the employee.

What if Coverage is Continued?

If an employee's coverage is continued (premiums are paid) through the FMLA leave period, s/he is treated as though disability began while s/he was actively at work.

What if Employee Chooses Not to Continue Coverage?

If an employee is on an approved leave but chooses not to continue coverage (non-payment of premiums), then no claim for disability would be covered should it occur during the leave.

When coverage is not continued and a person returns to work following an approved Family and Medical Leave, the coverage is reinstated as though s/he was never absent. There is no new waiting period, no EOI is required and the pre-existing time period is calculated from the employee's original effective date under the plan.

Change in Carrier to UnumProvident

If the employer's personnel policy allows for continuation of LTD coverage during a FMLA leave, then we will pick the person up on the first day of our coverage.

If the employer's personnel policy excludes LTD coverage during a FMLA, s/he will become covered upon the first day of active employment following our effective date.

If the employer has no written policy, we will extend coverage on the first day of coverage provided the prior carrier extended coverage during a FMLA. If the prior carrier did not extend coverage, UnumProvident will cover them on the first day of active employment following our effective date. (This is a business decision based on the fact that we are attempting to provide continuity and not "new" coverage to those not actively at work on the day our contract takes effect.)

In all the above scenarios, the person must be out on an approved FMLA and the employer must have written documentation that the leave was approved. In the case of a leave due to personal illness, s/he is covered under the COC provision. In addition, premium payments must have continued throughout the leave.

Duration

UnumProvident will support the Employer's obligation by allowing insureds to continue coverage during an approved family leave up to a maximum of 12 weeks per year or the duration required by state law, if longer. The following is a listing as of 11/99 of the states that offer a richer family/medical leave than the 12-week federal mandate.

- *Alabama*: 150 days for sick leave, with 24 additional days for serious illness
- *Alaska*: 18 weeks in 24 months except pregnancy/birth/adoption is 18 weeks in 12 months.
- *Arkansas*: 6 Months
- *California*: 12 weeks in 12 months except paternal leave
- *Colorado*: 520 hours in a fiscal year
- *Connecticut*: 16 weeks in 2 years (private); 24 weeks in 2 years (public)
- *District of Columbia*: 16 weeks in 24 months
- *Florida*: 6 months
- *Kansas*: Reasonable period of time for birth of child
- *Montana*: Reasonable leave for pregnancy
- *Oregon*: 24 weeks in 12 months if for different reasons
- *Rhode Island*: 13 weeks in 2 years
- *Tennessee*: 4 months for birth/adoption/pregnancy

If the issue of state duration versus federal duration occurs on a claim, the legal department should be contacted as there are other state eligibility requirements, such as; length of time employed, number of employees, whether the employer is a public entity and specific types of leave.

NOTE: Our new contract series have a specific provision that states how family medical leaves are handled under the terms of the contract. When processing a claim in which the person has been on family medical leave, refer to the contract to determine impact/claim procedures.

File Documentation

Insurers are required by law to establish, maintain, and retain claim files. File documentation should be fact-based and professionally worded. All communications bearing on the claim should be documented and included in the file, including telephone conversation notes, e-mails, etc. All documents pertinent to the claim should be included in the claim file. All documents should be added in chronological order based on the date they were generated or the date of their receipt, whichever is later. All documents generated by UnumProvident should be legible, and include a date and the name or initials of the author. All documents should be complete.

UnumProvident employees handling claims should not maintain any files concerning a claim other than the claim file itself.

Attorney-client communications contained in the claim file should be designated "Attorney-Client Communication/Privileged and Confidential."

Material should not be removed from a claim file unless it was included by mistake; e.g., documents not related to the claim.

Garnishment Guidelines

A Garnishment is a legal order directing UnumProvident to pay all or a portion of a claimant's benefit to a third party, usually to satisfy a child or spousal support obligation. The order can be issued from a court or a social services agency. The following must be considered when UnumProvident is presented with a garnishment order:

1. Garnishments MUST be directed to a company in the UnumProvident group of companies.
2. Garnishments vary widely state to state and they also differ considerably depending on WHY the garnishment is in place (bad debt, child support, IRS, etc.).
3. State law CAN NEVER BE more severe than federal law with regard to amounts withheld in response to a garnishment. Therefore, if you are in question: comply with the federal guidelines as follows:
    - Federal law dictates that 25% is the maximum withholding for a REGULAR garnishment ("regular" means anything other than support).
    - If the garnishment is for SUPPORT (child support or spousal support) AND THE PERSON HAS A SECOND FAMILY, federal law dictates withholding 50%; 55% if the person is in arrears.
    - If the garnishment is for SUPPORT (child support or spousal support) AND THE PERSON DOES **NOT** HAVE A SECOND FAMILY, federal guidelines dictate withholding 60%; 65% if the person is in arrears.

General Rule: If a Garnishment Order requests withholding anything LESS than the guidelines stated above or allowed by state law, UnumProvident's policy is to withhold the LESSER amount requested. Do not offer to withhold MORE than that amount requested just because the guidelines allow it.

Feel free to contact Donna Millington Noel (Portland), Jean Phillips (Chattanooga), or Susan Schulman (Worcester) with any questions you have. Individual research can be provided on a case by case basis. The above guidelines, however, will adequately serve most circumstances.

Answering Hypothetical Claim/Contractual Questions

In the past, the various pre-merger Customer Care Organizations have received hypothetical claim questions from policyholders, brokers and others. The position regarding responses have varied over time. Our clear policy for responding to hypotheticals is stated below.

Hypothetical Claim Questions
UnumProvident's Customer Care Center will not answer questions that set forth hypothetical claim scenarios, and ask us how we would handle that situation. The reason for this decision is that it has been our experience that such questions are precursors to the filing of an actual claim. Because every claim presents its own unique facts, and because our contractual obligation to our policyholders is to evaluate and decide actual claims, it is not appropriate for us to answer questions about hypothetical claims. If the person is calling about a claim they are going to file, we should advise them to file the claim, and we will handle it in accordance with our normal process.

Contractual Questions Arising in Prospective Sales Situations
In the context of a potential sale of a UnumProvident policy to a customer, questions often arise about the interpretation of specific provisions of the policy. In the event such questions occur, they should be referred to one of the three following places, depending on the nature of the issue:

1. the pertinent sales representative/office, if the question is one that falls within the sales organization's knowledge base;
2. the appropriate account manager in Customer Care, if the question involves a claims issue (e.g., if the customer buys this policy, how would UnumProvident interpret the policy on a claim involving . . .), and the potential customer has more than 2000 lives; or
3. the consultant/senior consultant in the Customer Care site in which the claims under this potential policy will be managed, designated by the site to answer these questions, if the potential customer is less than 2000 lives. For Life, Life Waiver of Premium and Extended Duration Unit claims, the query would be handled by the Director.

In a situation described in (b) or (c), the account manager or consultant (or Director) shall coordinate the response to the potential customer with the pertinent sales representative.

Claim Process Questions
This procedure does not prevent us from answering questions from customers, claimants and others about our claim management and validation process.

Independent Medical Examination (IME) Travel Costs

Background

An Independent Medical Examination (IME) is an examination of the claimant by an external healthcare provider performed at the request of the company.

Occasionally we are asked by the claimant for reimbursement of travel costs associated with attending the examination.

IME Travel Costs

We will consider payment of travel related fees on a claim by claim basis. Factors to consider when determining whether we will assist with the costs include:

- distance we are asking claimant to travel
- whether any special accommodations are needed to allow the claimant to attend the IME

Conclusion

Any decision to pay travel related expenses associated with an IME require Consultant or Manager sign-off.

Reminder: Each claim is unique and should be evaluated on its own merits.

IRS Notice of Levy

We are legally obligated to respond to a Notice of Levy. For assistance in handling claim specific levy issues, contact the Legal Department.

Background

A claimant may have a federal income tax deficit with the IRS. To collect this deficit the IRS may file a levy against a third party. Since we are providing income to the claimant, the IRS may send levy notices to us. UnumProvident's position is that disability insurance benefits are included within the scope of the levy for federal income tax deficits. As a result, we must comply with any levy received. Failure to comply will result in UnumProvident being subject to the tax liability itself. Therefore, it is important that the following procedures are followed.

Types of Levies

There are different types of levies. The most common levies are No.668-W(C) and No. 668-A. If a Notice of Levy is received that differs from the two specifically referred to here, contact the Legal Department for guidance in responding.

LEVY 668-W (C)

Determining Exemptions

A portion of our benefit is exempt from the levy. We need to determine the number of exemptions in order to calculate the benefit, if any, that is payable to the IRS. The reverse side of the levy has a table to calculate the amount exempt from the levy on wages, salary and other income.

If Our Benefit is Below Exemption Amount

If the LTD monthly benefit is less than the exemption amount, there is no benefit available to forward to the IRS. Complete the information on the back of the Levy and forward to the IRS.

If Claim is Closed

Call the IRS and advise that we are not paying monthly disability income benefits to the taxpayer at this time. Follow up with a letter outlining the same information. Do not provide any other information as we may have a confidentiality agreement as part of a lawsuit settlement.

If our Benefit Exceeds Exemption Amount

If there is a benefit in excess of the exemption amount, contact the IRS office that issued the levy and explain that we provide disability income benefits. Ask if their intent is to levy the benefit. If no, request that they send a written release. If it is the intent of the IRS to levy the LTD benefit, complete and return the form. Begin paying the LTD benefits (post-exemptions) to the IRS.

Claimant Acknowledgement of Levy

There is nothing in the levy itself to indicate that the claimant has been notified that the levy has been served on UnumProvident. Regardless, we are obligated to forward to the claimant parts 2, 3, 4, and 5 of the package of forms accompanying the levy. These comprise the "statement of exemption," and should be sent to the claimant immediately. Also include a letter explaining that we have received a Notice of Levy and if we do not receive a completed statement of exemption,

we will be required to forward to the IRS that portion of their monthly benefit in excess of one exemption. The claimant is required to complete the forms and return them to us within 3 working days.

IRS Acknowledgment of Levy

Send a letter to the IRS address shown on the levy. Advise that we received Form 668-W and parts 2, 3, 4 and 5 have been sent to the claimant for completion. Also advise them that the next benefit payment will not be due until xx/xx/xx, and we will forward the first installment prior to that date. Also ask the IRS for a supply of envelopes.

Failure to Provide Exemption Information

If the claimant fails to complete and return the form, we should assume an exemption of one (1).

LEVY 668-A

If the levy is 668-A, contact the IRS and explain that we provide disability income benefits and determine their intent. If it is their intent to levy the benefit, determine the date the levy was received at UnumProvident and calculate the benefit due to the IRS as of the date the levy was received at UnumProvident. Levy 668-A does not provide an exemption allowance to use when calculating the benefit due the IRS.

Calculating the Benefit

Determine whether there is any outstanding benefit due as of the date the levy is received.

Example 1: The benefit period covers the period from 10/7-11/7 and the check is released on the 27th. We receive the levy on 11/3. The claimant has been paid and there is no money payable to the IRS. We have paid the benefit for the period as of the date the levy was received.

Example 2: The benefit period covers the period from 10/7-11/7 and the check is issued on the 27th. We receive the levy on 11/10. We would pay any benefits accrued for the period from 11/7-11/10 to the IRS (based on the amount of the levy) and pay any remaining balance for that period to the claimant.

Future Benefits payable are not subject to this levy because they are not earned money as of the date of the levy.

Late Appeals on Claim Denials

Background

Under ERISA law, the claimant is required to submit an appeal within a certain number of days (not be be less than 60 days) of receipt of a written denial. Similar to the late filing of a claim, the late appeal of a denial decision can impact our ability to manage a claim. Therefore, the following procedures have been developed to ensure a consistent approach to our claim appeal process.

Definition

An appeal will be considered to be "late" if the date of the appeal letter is more than 90 days from the date of our denial letter.

The appeal paragraphs on BAS/PC, Genesis and Delta have been updated to reflect this change.

It is important to note that the 90 day time limit applies to ERISA plans only. Even though we use the same appeal paragraphs on non-ERISA plans, there is no stated time limit to appeal.

Procedures for ERISA Plans

If an appeal is submitted late, it should be referred to Quality Performance Services for review. Prior to the referral, send a letter to the claimant advising that the appeal was submitted late, and you are "forwarding it to QPS for a final decision on the matter". Do not promise the claimant a "review" or "appeal". Quality Performance Services will determine whether or not the appeal should be reviewed or whether it will be declined as being late. The only discussions with the claimant should be through Quality Performance Services.

If you receive a call on a claim and can clearly tell that it is a late appeal, advise the claimant that it appears the appeal is late, yet they can make a written appeal to Quality Performance Services.

Procedures for Non-ERISA Plans

If an appeal is submitted (even if late), it should be referred to Quality Performance Services for review. Prior to the referral, send a letter to the claimant advising that you are forwarding it to QPS for review. The only discussions with the claimant should be through Quality Performance Services.

If you receive a call on a claim and can clearly tell that it is a late appeal, advise the claimant to make a written appeal to Quality Performance Services.

Remember that the time limit does not apply to non-ERISA plans. Therefore, you should not indicate to the claimant that the appeal is "late."

Late Notice Claim Procedures

Background

Our various disability contracts typically contain wording regarding the timely filing of claims. The wording is usually located in the notice and proof of claim section of our policies. The following are guidelines for determining what information is needed when evaluating whether a claim is filed within the legal and contractual requirements.

What Products Does This Apply To?

ALL CLAIMS (LIFE/LTD/STD/IDI/LTC) except New York DBL and New Jersey TDB.

Does This Apply To New York Disability Benefit Law (DBL) And New Jersey Temporary Disability Benefit (TDB) Coverage?

No. DBL and TDB are STD product offerings where we administer the state mandated benefits. We must administer claims filed late in accordance with the provisions that are within these statutory regulations.

What Is The Process For IDI Claims?

Individual Disability policies usually have late notice/proof of claim provisions. The variations of these provisions may impact the payment of a period of benefits due to late filing. However, since the policy remains in force if premiums are paid, we would not automatically deny the full claim for benefits but only the period of time that is late.

How Do We Evaluate The Timeliness Of Claim Filing?

The following procedures should be used to determine impact of late notice.

Strict Time Limit States

For claimants that live in one of the following states, if the claim is submitted after the time limit set forth in the policy, the claim should be appropriately denied as being untimely:

- Arkansas
- District of Columbia
- Georgia
- Idaho
- Mississippi
- Nevada
- South Carolina
- South Dakota
- Wyoming

NOTE: For IDI claims, we would deny only the period of benefits that are outside the contractual limit for timely filing.

Alabama, New York, Colorado

For claimants living in any of these three states, if the claim is submitted after the time limit set forth in the policy, we must evaluate whether the claimant's delay was **unreasonable**. To answer that question, we should take the following steps:

- Ask the claimant to explain the reasons for the delay in submitting the claim; and
- Evaluate whether the reason provided is a justifiable excuse for the delay.
- If the claimant presents a reasonable basis for the delay, we must conduct an analysis to determine if the delay **prejudiced** our ability to investigate or decide the claim.
- If the claimant does not present a reasonable basis for the delay, the claim should be appropriately denied as untimely.

NOTE: For IDI claims, we would deny only the period of benefits that are outside the contractual limit for timely filing if the delay was unreasonable.

All Other States

For claims in which the claimant lives in one of the other states not listed specifically above, if the claim is submitted after the time limit set forth in the policy, we must conduct an analysis to determine if the delay prejudiced our ability to investigate or decide the claim.

NOTE: For IDI claims, we would deny only the period of benefits that are outside the contractual limit for timely filing if we were prejudiced in our ability to investigate or decide the period of time.

What Is Prejudice?

Prejudice means that because of the delay in submission of the claim, we are unable to appropriately determine our liability. If we cannot adequately investigate the material facts of a claim because:

- Pertinent witnesses are not available;
- Pertinent witnesses are unable to provide relevant facts because the original facts or circumstances are not fresh in their minds; or
- We are unable to gather material evidence, such as financial or medical records, including a contemporaneous necessary IME, due to the lapse of time;

then we have been prejudiced by the late submission.

In addition, even if we can make a determination of liability, it is possible that we may still have been prejudiced. We need to establish why a specific action such as investigation or IME at a certain point in time was critical to the evaluation of the claim. Examples of such circumstances would be if we can CLEARLY show that we would have changed or influenced the course or outcome of the disability through:

- rehabilitation;
- directing appropriate care;
- vocational assistance;
- workplace modification; or
- other methods

but we are unable to do so because of the late submission of the claim.

Another factor to consider is the length of delay in filing. Although clear-cut parameters cannot be set, the longer the delay, the more likely we were prejudiced.

When Is This Procedure Effective?

This procedure is effective immediately.

Further Questions

Refer to your consultant and/or manager if you have any further questions.

Reminder: Each claim is unique and should be evaluated based on its own merits.

Lawsuits against UnumProvident

Notice of a lawsuit most often consists of our receipt of documents entitled "Summons" and/or "Complaint." These may be faxed, mailed, or hand-delivered to you.

When a lawsuit has been filed against UnumProvident, you should immediately notify the Legal Department. Immediate notification of the Legal Department is critical when you receive a lawsuit. "Immediate notification" means that a call is placed to the Legal Department within one hour of receiving notice of the lawsuit. Legal will need all of the original documents and envelopes you received in order to make sure that a timely answer is filed to the insured's complaint. The failure to file a timely answer could severely jeopardize the company's ability to defend itself in court, and may result in an automatic victory for the claimant.

If a suit is filed by the claimant against UnumProvident, no communication should occur with the claimant or his attorney unless expressly approved by Quality Review (QR). The majority of lawsuits are filed after benefits have been denied. In those situations, QR will be managing the litigation process with Legal. In the few situations where a lawsuit has been filed while benefits are being paid, discussions should occur with QR regarding the process/extent of communication that should occur on the file.

Medical Information

All information obtained during the claim evaluation process must be considered when making decisions regarding liability. Key components of the evaluation process include but are not limited to consideration of:

- Contractual Provisions
- Claimant Activities
- Occupational Duties
- Financial Information
- Medical Information

As illness or injury is at the foundation of every claim, medical information is fundamental to an understanding of a claimant's restrictions and limitations, opportunity for recovery, and capacity for return to work.

The analysis of medical information drives the success of early intervention and medical case management where we partner with treatment providers to facilitate rehabilitation and return to work in appropriate cases.

During the claims evaluation process, medical information should be assessed for its credibility and relevance. There are a number of avenues, beyond the treating healthcare provider, available for obtaining an assessment of the medical information and/or the claimant's restrictions and limitations including:

- Independent Medical Examination (IME)
- Functional Capacity Evaluation (FCE)
- Internal Medical Personnel

Independent Medical Examination (IME) and Functional Capacity Evaluation (FCE)

An IME and/or FCE is an examination of the claimant by an external healthcare provider performed at the request of the Company.

The IME and/or FCE are reserved as a claim management tool and will only be appropriate in certain situations. As each claim is unique, the specific facts of the claim will determine whether an IME and/or FCE is an appropriate step. If an IME and/or FCE is completed, it is generally appropriate to provide the treating healthcare provider with a copy of the report while proceeding with claims management activities.

Appropriate internal medical resources should be involved in the discussion of claims being considered for denial based on medical grounds.

Customer Care Center Medical Department

Internal healthcare expertise is available to assist with the analysis of medical information. Our physicians, nurses and other allied healthcare professionals are available to:

- Assess medical information from the perspectives of adequacy, consistency and credibility
- Apply current medical knowledge to data regarding diagnosis, treatment, prognosis, and impairment;
- Offer advice regarding obtaining future medical information;
- Attempt to clarify a situation with a peer-to-peer call; and
- Evaluate restrictions and limitations and their expected impact on work capacity.

Internal medical resources are expected to apply an appropriate level of critical scientific analysis to the review of medical information; their analysis will be guided in part by the following principles:

Office notes, test results or other medical records which record findings of the patient's visits are generally more useful than a 'narrative summary' from the attending physician.

More recent medical information is often more informative regarding current status than older data.

An opinion from a healthcare provider with a higher level of expertise, specialization or training is generally more credible or persuasive than the opinion from a provider with a lesser level of expertise, specialization, or training.

A medical opinion based on scientific evidence is frequently more compelling than a medical opinion without such a foundation.

A medical conclusion/opinion founded on detailed specific facts or observations is generally more persuasive than a medical conclusion without such a foundation.

When an attending healthcare provider is recommending restrictions and limitations, we need to consider the basis behind the recommendation and determine whether we have the same information/reports the attending healthcare provider used in making their determination.

From the perspective of the claims adjudication professional:

A generic statement from an attending healthcare provider supporting disability, in most cases, is not sufficient to continue benefit payments. A factual basis behind the opinion should be evident. It may be relevant to evaluate whether the attending healthcare provider considered the claimant's work capacity relative to their occupation setting.

The claim file should reflect the rationale used to reach conclusions when evaluating differing medical opinions.

Conclusion

Medical information is an important component of the claims investigation process. Our medical resources can provide assistance with the evaluation of the information including diagnosis, chart records/diagnostic test results, treatment protocols and prognosis.

Modified Occupation

Background

When the Insured returns to work for his/her employer and begins work in a **modified occupation**, the issue is whether that **modified occupation** should be considered the claimant's occupation when evaluating the claim.

This applies to which products?

Group LTD and Group STD Products.

What are four factors to consider when evaluating whether the modified occupation is really a new occupation?

1. Why is the claimant no longer working in the modified occupation? Is it because:
- **Job Elimination.** Was everyone's job eliminated or is the job elimination connected to the claimant's alleged disabling condition?
- **The Claimant didn't want to do the job any longer?** Did the employer intend this to be an occupation and plans on replacing the claimant?
- **Was this a newly created job?** If a "newly created job," we probably would not consider it to be the person's occupation.
- **Was the company downsizing?** The downsizing may be the driver of the decision to cease work. Clarify the scope of the downsizing and the employer's expectation regarding the future of the modified occupation at the time the claimant began working in that role.
- **Is the reason for the modified occupation related to the alleged disability condition?** Did the medical condition deteriorate, remain static, or was the claimant no longer able to continue working at his regular occupation due to the condition? If the move to the modified occupation is not related to the medical condition, we would consider the modified occupation as the claimant's occupation.

2. Did the claimant and/or the employer intend the modified occupation to be his new occupation on a temporary or permanent basis?

3. What is the nature of the modified occupation? Was it consistent with the claimant's restrictions and limitations, education, training and experience?

4. Is the income of the modified occupation out of proportion to the national economy?

Is time a factor?

Time in the new modified occupation will continue to be a consideration, along with the other factors listed in this memo. The longer the claimant is in the modified occupation, the more it appears that the modified occupation is the claimant's occupation.

To make this claim decision you need to investigate the reason for the job modification. The information obtained should help guide the decision. If the decision is not clear, the file should be reviewed with your manager or consultant. Legal can be consulted as appropriate.

What if I am not clear on how or whether the modified occupation is a new occupation?

To make this claim decision you need to investigate the reason for the job modification. The information obtained should help guide the decision. If the decision is not clear, the file should be reviewed with your manager or consultant. Legal can be consulted as appropriate.

Laws Governing Claims Handling

As an insurer, we are responsible for complying with the appropriate laws that govern our contracts and actions. This section contains many of the laws that will aid you in claims handling. However, this section is not meant to include ALL laws, but those that are state specific or deviate from otherwise normal claims handling. While the difference in laws may affect a specific claim situation, nothing shifts the overall focus from paying claims accurately, fairly and promptly.

These STATES pages should be reviewed when doing the initial review of the claim and at various points in the claim. This chapter (which includes the state-specific regulations listed at left) includes:

- General information on states' Unfair Claim Settlement Practices laws
- General information on ERISA (Employee Retirement Income Security Act)
- Claim handling deadlines for ERISA claims and claims governed by state law
- NAIC (National Association of Insurance Commissioners) model laws
- Family and Medical Leave laws for certain states
- Notice-prejudice rule laws in each state

This document includes information about:

Employee Retirement Income Security Act (ERISA) & State Unfair Claim Settlement Practices Acts

As an insurer, we are responsible for complying with appropriate laws that govern our contracts and actions. If a claim is not governed by federal ERISA laws, it is governed by state law, such as state unfair claims settlement practices laws. Most of our group contracts and some of our individual contracts insure ERISA plans. However, some of our group contracts and the majority of individual contracts are not governed by ERISA. Therefore, it is important to be able to determine what is and is not governed by ERISA so you can apply the proper claims handling requirements and deadlines.

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Employee Retirement Income Security Act of 1974 (ERISA)

The Employee Retirement Income Security Act of 1974 (ERISA) was passed by Congress in response to the rapid growth of employee benefit plans, recognizing that the well-being and security of millions of employees increasingly depended on these plans. ERISA's purpose is to provide minimum and consistent standards for the operation of employee benefit and retirement plans.

ERISA requires that claims be processed promptly; that they be evaluated fully and fairly in accordance with applicable law and the provisions of the plan or policy; that decisions to deny not be made in an arbitrary or capricious manner; and that claimants be informed of the basis for the denial of any claim. To assure these requirements are met, ERISA contemplated the establishment of a claim review/appeal process.

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ERISA Claim Handling
ERISA requires that we notify the claimant of a denial within 90 days of receipt of the claim, unless special circumstances require an extension of time for processing the claim. If more time is required, we must notify the claimant that more time is needed prior to the termination of the 90 day period.

ERISA Denial Letters have very specific requirements. Please refer to the claim denial section for these requirements.

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ERISA Appeals
ERISA has specific requirements governing appeals. Please refer to Appeals section of this manual.

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Elements of an ERISA Plan
The five (5) elements of an employee benefit plan are:
1. Plan/fund or program
2. established or maintained
3. by an employer or employee organization
4. for the purpose of providing welfare benefits,
5. to participants and beneficiaries.

Back to TOC

Factors to Show Whether a Plan Is Established or Maintained
Evidence that a plan is established or maintained may include:
- employer pays some or all of the cost of the insurance
- employer's name is on the policy form/marketing materials
- employer procures the policy
- employees receive a "group" discount
- employer has an active role in plan administration
- employer offers payroll deduction for premiums if more than one employee has coverage
- employee enrollment meetings are conducted by employer and/or during work hours
- the bill for the policy is sent to the employer
- employer selected UnumProvident policy from alternatives
- employer hires a broker to find a carrier
- employer collects/remits premiums, provides information, claim forms, etc.
- and treats premium as a deductible business expense

Back to TOC

Individual Policies That May Be Governed by ERISA
Evidence that an individual claim may be governed by ERISA include:
- The employer contributes towards the premium
- The policy is part of a multi-life case or "list-billing"

☐
- Premiums were discounted because the policy was included in a group

Underwriting guidelines were relaxed because the policy was included in a group; such as guaranteed issue or limited medical underwriting

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Group Plans Not Governed by ERISA
Certain group plans are not governed by ERISA. They are:

- Governments. A plan established or maintained for its employees by any government or political subdivision, agency or instrumentality thereof.
- Church Organizations. The church organization must have tax exempt status under Internal Revenue Code, Chap. 26, Sec. 501. A tax-exempt church can be a corporation.
- Trade Associations. Members of a particular trade can often obtain premium discounts and insurance through their trade association on a plan not sponsored by their employer. This coverage is not governed by ERISA. However, if an employer obtains and sponsors coverage for its employees through a trade association, then it is likely an ERISA plan.
- Some Hospitals or Schools or Colleges/Universities. On some occasions, hospitals can be either governmental entities or church organizations. Schools and Colleges/Universities can be governmental entities or church organizations.
- Partners & Owners. ERISA does not govern plans that cover only the partners or the individual that wholly owns the company along with spouses. However, if the plan also includes other non-partner, non-owner employees, then the claim is governed by ERISA.

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Tips on Group Policies

- Just because the front page of the policy says "this policy is governed by to the extent applicable ERISA," does not mean that this is an ERISA plan.
- If the plan is an ERISA plan, there should be information contained in the summary plan description that advises the claimant of his rights under ERISA. However, this cannot be relied upon with any certainty.
- If the policyholder's name ends with "Inc.," it is probably an ERISA plan. (Exception: Church and government corporations)
- 100% Employee paid is a factor to consider in assessing whether the plan is governed by ERISA.
- If the policyholder is a labor union/association of employees working for what would otherwise be a non-ERISA plan (i.e., governmental entity or church organization), it is possible that the plan is an ERISA plan. Call the Legal Department for guidance.
- Just because the policyholder's name indicates that it may be related to a government or religion, do not assume it is non-ERISA. It may still be an ERISA plan.
- A non-profit organization can be an ERISA plan.
- If you ever have any questions regarding whether the claim may be governed by ERISA, contact the Legal Department.

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State Unfair Claim Settlement Practices Laws

The National Association of Insurance Commissioners (NAIC) developed model laws to govern fair and expeditious claims handling. Most states have enacted some version of this model law. Each State page contains the various claims handling deadlines and other requirements for each state. If your claim is not governed by ERISA, you must comply with these laws. This law section also contains the entire text of the NAIC model act. Typical claim handling deadlines you might find are:

- Acknowledge receipt of notification of claim.
- Provide necessary claim forms.
- Respond to communications from claimant.
- Begin investigation of claim.
- Complete investigation of claim.
- Notify claimant that more time is needed to review claim.
- Send follow-up letters that investigation is incomplete.
- Accept or deny claim after receipt of proofs of loss.
- Pay claimant after acceptance of liability.
- Time to pay after settlement of claim.
- Respond to inquiry from Department of Insurance.

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NAIC Unfair Claim Settlement Practices Laws

The National Association of Insurance Commissioners (NAIC) developed model laws to govern

fair and expeditious claims handling. Some have been adopted in whole or in part by many states. This law section contains the text of the model laws. To summarize those laws, UnumProvident should:

- Accurately represent policy provisions to claimants and insureds.
- Acknowledge with reasonable promptness pertinent communications with respect to claims.
- Adopt and implement reasonable standard for the prompt investigation and payment of claims.
- Require reasonable but complete proof of loss.
- Provide necessary claim forms, instructions and reasonable assistance so the insured can properly comply with company requirements for filing a claim.
- Upon receipt of proof of loss from a claimant, promptly begin any necessary investigation of the claim.
- Conduct a reasonable investigation to determine whether a claimant is entitled to benefits.
- Continuous communication of reasonable frequency to provide the claimant with the status of the claim, or whether additional information is needed.
- Provide reasonable explanation for delays in claim investigation, and explain why more time is needed.
- Affirm or deny coverage of claims within a reasonable time after having completing the investigation of a claim.
- Fully inform a claimant of the basis of a claim approval or denial.
- Maintain claim files so they are accessible and retrievable.
- Maintain detailed claim file documentation in order to permit reconstruction of the activities relative to each claim.

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Massachusetts Extension of Coverage Law

In the state of Massachusetts an employee's coverage is extended for a period of 31 days after the employee's date of termination. Therefore, when conducting a claim review of a Massachusetts employee who has terminated his/her employment, it is extremely important to note the employee's termination date, the employee's first date of medical treatment, and the employee's date of disability. If the date of disability is within 31 days of the employee's termination date (and the claim is otherwise payable), benefits should be extended.

New Mexico Domestic Abuse Insurance Protection Act

Part I: General information and initial claimant contact

Part II: Protected Person claim processing

Overview

Background
The State of New Mexico Insurance Department has created regulations to meet the provisions of the New Mexico Domestic Abuse Insurance Protection Act. The Act and regulations specify how insurance companies are to conduct business with New Mexico victims of domestic abuse. The regulations apply to all product lines in UnumProvident Corporation, and to benefits, underwriting, and customer service functions. *This Act does not apply to self-insured claims.*

With respect to claims, this regulation applies to all New Mexico residents with open claims received on or after 1/1/99, who are either victims of domestic abuse or provide shelter or other forms of support to victims of domestic abuse.

The enclosed procedures and materials address what the Customer Care Center organization will do to comply with the Act.

Impact to the Customer Care Center
We are required to develop a program to "protect" location and abuse information of New Mexico claimants who may be victims of domestic abuse, and to offer them participation in the program. Claimant participation is voluntary; the request must be in writing.

This Act also provides **all** New Mexico claimants, **regardless** of whether or not they are in the Protected Person Program, the right to obtain, review and request changes in confidential abuse information in our claim.

Claimants who **move** to New Mexico during the claim should be immediately notified of our program.

The attached documents provide further details.

What will we call this program?
We will call this program the Unum Customer Care Center Protected Person Program.
"Unum" references the marketing brand of the UnumProvident Corporation.

Initial requirements of the Unum CCC Program
Our overall program contains the following:
- Claimant initial notification of the existence of the Act and our program (referred to as the "short notice" and the "yes" selection form)
- formatted detailed information about the Act and our program (referred to as the "long notice" form), if the claimant provides a written request for this detail
- an easy way for the claimant to enter the "protection" program
- a process for New Mexico abuse claimants to obtain our records, and to request changes in our records
- file reviews and employee corrective actions to insure compliance with the Act
- training for employees who may handle New Mexico claims

What is the role of the Customer Care Specialist?
The Customer Care Specialist:
- sends the short notice letter and "yes" form (number 1016-00) on all New Mexico open claims
- sends the long notice form (number 1014-00), if applicable
- notifies the site Program Administrator, if a claimant elects to be in the Protected Person program
- handles the claim, in accordance with the Act

All Customer Care Specialists will receive Part I of this document.

What is the role of the site Program Administrator?
The Program Administrator:

- will be the subject matter expert, responsible for specific questions and issues about the Act for their site
- will have Parts I and II of this document, as well as copies of the regulations and selected statutes from the Act
- will facilitate on-site training regarding the Act and Program
- will review with the Customer Care Specialist any claim where the claimant elects to be in the Protected Person Program
- will distribute Part II and the regulations to any Customer Care Specialist assigned a Protected Person claim
- communicates to the Customer Care Center of the existence of any Protected Person claim
- maintains and updates the Protected Person "claim list", in coordination with other Program Administrators
- provides ongoing file direction and guidance on Protected Person claims
- coordinates annual site audit of New Mexico and Protected Person claims

What we do after a claimant elects to be in the Protected Person Program?
We must take the following actions:

- send a special authorization to the claimant
- keep records of all disclosures of information to parties outside Unum
- adhere to security procedures to protect the privacy of the claim information and the location of the claimants
- send a notice to any vendor being used in the claim, regarding the Act
- adhere to guidelines on how we store, conceal, and "dispose" of these files
- keep the Program Administrator apprised of any requests, issues, or developments on the claim

What if my Protected Person claimant moves from New Mexico?
We would continue to handle the claim as a Protected Person claim, regardless of the claimant's current residence.

What do we do if a claimant elects not to be in the Protected Person Program, or does not return the "yes" form?
You will follow normal claim handling *unless* you receive written notification from the claimant requesting to be in the Protected Person Program.

What if a claimant later decides to withdraw from the Protected Person program?
We will honor a claimant's *written* request to withdraw from the program, at any time during the claim. If this situation occurs, contact your Program Administrator immediately.

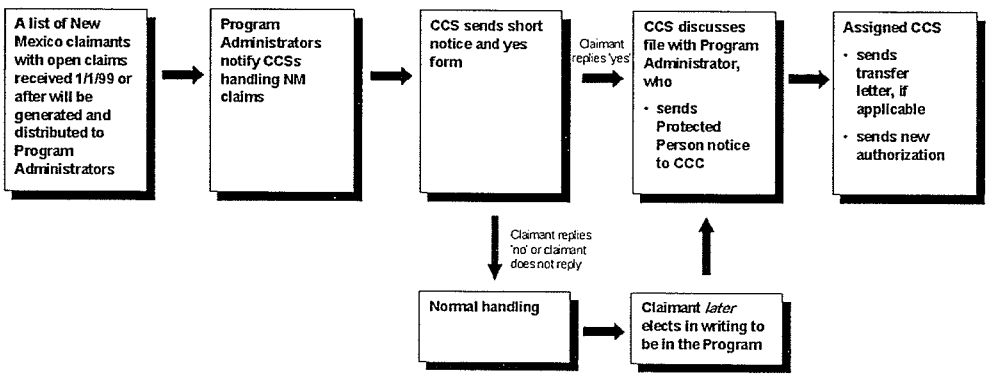
What happens if a Customer Care Specialist does not comply with the provisions of this Act?
The Human Resources Policy and Procedures Guide, and the Code of Conduct, address employee accountability for non-disclosure and other expectations of performance. Based on the level of infraction, violations of confidentiality of abuse claim information "can result in disciplinary action, up to and including termination of employment."

If you have questions on the Human Resources policy, please discuss them with your manager.

Existing claims flow chart

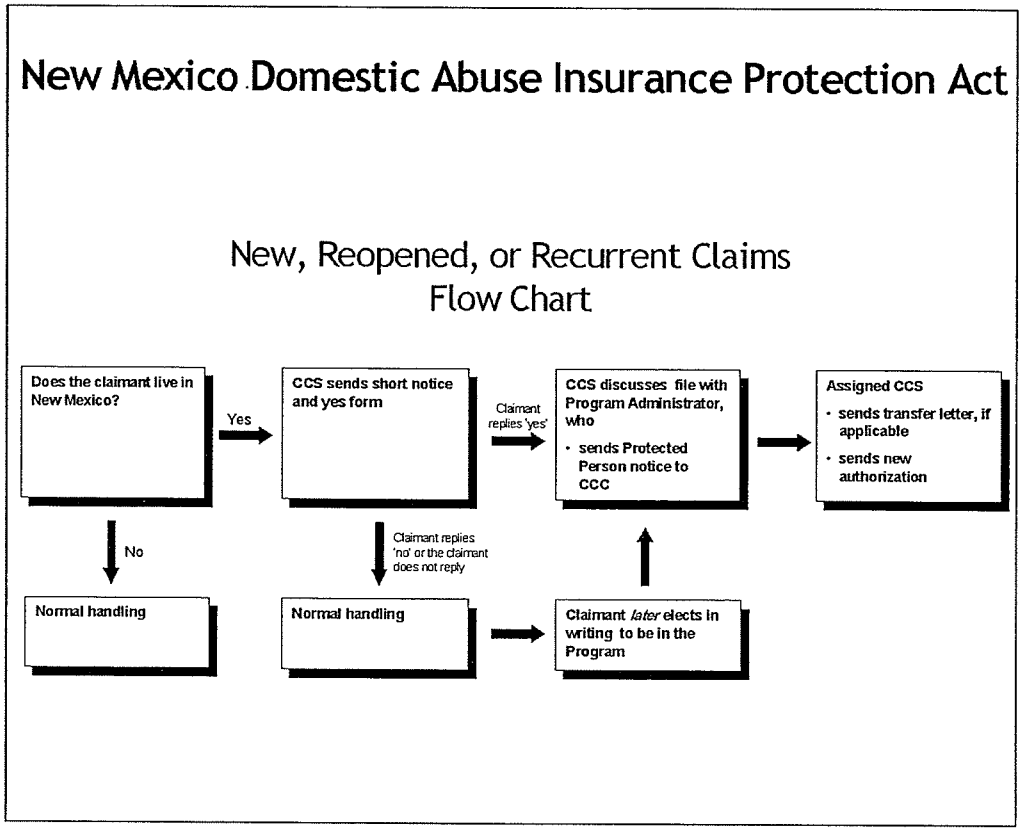
New Mexico Domestic Abuse Insurance Protection Act

Existing Claims Flow Chart



NOTE: This workflow chart addresses the one-time project to notify claimants on existing claims of the existence of the Program.

New, reopened, or recurrent claims flow chart



Initial Notification/Short Notice

Dear :

The State of New Mexico has passed Legislation entitled, "The New Mexico Domestic Abuse Insurance Protection Act." This Act requires that insurance companies, with regards to claims information, offer specific rights of protection, access and confidentiality ***only*** **to New Mexico residents who are either (1) victims of domestic abuse or (2) who provide shelter or other means of support to victims of domestic abuse.** If either of these situations apply to you, you may be covered under this state act as a Protected Person. In accordance with the Act, please note the following:

1. Unum may receive confidential abuse information from persons other than you.
2. Unum is prohibited by law to use your confidential abuse status as a basis for denying your claim or denying you coverage, restricting your benefits or coverage, or charging you more for coverage.
3. As a Protected Person, you would have the right to review or obtain, and to correct, confidential abuse information received by Unum.
4. A longer, more detailed version of your rights and responsibilities, and Unum's rights and responsibilities, is available to you upon written request.

If you are either a victim of domestic abuse or you provide shelter or other means of support to victims of domestic abuse and would like Unum to consider you a Protected Person, please select "yes" on the enclosed form, or send your own written request. If you advise us that you wish to be considered a Protected Person we will send you additional information.

If you do not submit a written request or the enclosed form with "yes" selected, we will assume that you do not wish to be afforded the status of Protected Person and will continue to process your claim accordingly. If at any time you decide to change your Protected Person status, please notify us of your request in writing.

NOTE: We are *required* to send you this offer because you are a resident of New Mexico. Receipt of this letter does not necessarily mean we have domestic abuse information in your claim file.

If you have any questions, please call me at_____, extension _____.

Sincerely,

Claimant "yes" selection form

_____ YES, I want to be considered a Protected Person as defined in the New Mexico Domestic Abuse Insurance Protection Act.

_____ _____
(YOUR NAME – PLEASE PRINT) (YOUR SSN)

_____ _____
(YOUR SIGNATURE) (DATE)

Long Notice Form

The State of New Mexico has passed Legislation entitled, "The New Mexico Domestic Abuse Insurance Protection Act." This Act requires that insurance companies, with regards to claims information, offer specific rights of protection, access and confidentiality ***only*** **to New Mexico residents who are either (1) victims of domestic abuse or (2) who provide shelter or other means of support to victims of domestic abuse.** If either of these situations apply to you, you may be covered under this state act as a Protected Person. In accordance with Title 13, Chapter 7, Part 5, Section 8 of the Administrative Insurance Code of New Mexico, you are entitled to be notified of the following:

1. That Unum may receive confidential abuse information from persons other than you.
2. That Unum may request or receive information from the following sources: any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility, insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation, other organization, institution, or person that has any records or knowledge of you, your health (including any information relating to the use of drugs and alcohol, and any information relating to mental and physical history, condition, advice or treatment), financial or credit information, earnings or other insurance benefits, the Social Security Administration regarding benefits, earnings and employer information, and any award disallowance or termination relating to benefits. Also, reports from the Medical Information Bureau (MIB), and the association of life insurance companies which operates the Health Claims Index (HCI) and the Disability Income Record System (DIRS), (PMSI), and Investigative Vendors.
3. That Unum is prohibited by law to use your confidential abuse status as a basis for denying your claim or denying you coverage, restricting your benefits or coverage, or charging you more for coverage.
4. That Unum may disclose certain information specified in NMSA 1978 Section 59A-16B-4, without prior authorization, under the following circumstances:
    - to a victim of domestic abuse or an individual specifically designated in writing by the victim, and nothing in this section prohibits a victim of domestic abuse from obtaining the victim's own insurance records;
    - to a health care provider for the direct provision of health care services;
    - to a licensed physician identified and designated by the victim of domestic abuse;
    - pursuant to an order of the superintendent or a court of competent jurisdiction, or as otherwise required by law;
    - when necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship or that is relevant to processing a claim, provided the recipient has agreed to be bound by the provisions of the Domestic Abuse Insurance Protection Act [59A-16B-1 to 59A-16B-10 NMSA 1978] in all respects and to be subject to enforcement of that act in the courts of this state, and the information is disclosed or transferred only: 1) to a reinsurer that seeks to indemnify or indemnifies all or part of a policy covering a victim of domestic abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without the information; 2) to a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer; 3) to medical or claims personnel contracting with the insurer, its parent or affiliated companies that have service agreements with the insurer, but only when necessary to process an application or claim, perform the insurer's duties under the policy or protect the safety or privacy of a victim of domestic abuse; or 4) with respect to address and telephone number, to entities with which the insurer transacts business when the business cannot be transacted without the address or telephone number;
    - to an attorney who needs the information to represent the insurer effectively, provided the insurer notifies the attorney of its obligations under the Domestic Abuse Insurance

Protection Act and requires that the attorney exercise due diligence to protect confidential abuse information consistent with the attorney's obligation to represent the insurer;

- to the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or
- to any other entities deemed appropriate by the superintendent;

5. That confidential abuse information used by an insurance support organization to prepare its report to the insurer may be retained by the insurance support organization but may not be disclosed to other persons without the written consent of the protected person except as otherwise permitted by NMSA 1978 Section 59A-16B-4.

6.A That with regards to access to confidential abuse information:

- If any protected person, after proper identification, submits a written request to an insurer for access to confidential abuse information about themselves which is reasonably described by the protected person and reasonably locatable and retrievable by the insurer, the insurer must, within 30 business days from the date the request is received:
- Inform the protected person of the nature and substance of the confidential abuse information in writing, by telephone or by other oral communication, whichever the insurer prefers;
- Permit the protected person to see and copy, in person, such confidential abuse information pertaining to him or her or to obtain a copy by mail, whichever the protected person prefers, unless the information is in coded form, in which case an accurate translation in plain language must be provided in writing;
- Disclose to the protected person the identity, if recorded, of those persons to whom the insurer has disclosed confidential abuse information within two years prior to the request, and if the identity is not recorded, the names of the insurers or other persons to whom the information is normally disclosed; and
- Provide the protected person with a summary of the procedures by which he or she may request correction, amendment or deletion of confidential abuse information.
- Any confidential abuse information provided must identify the person or governmental entity that provided it unless the person who provided it is an agent, the protected person who is the subject of the information, or a natural person acting in a personal capacity rather than in a business or professional capacity;
- An insurer may charge a reasonable fee to cover the costs incurred in providing a copy of confidential abuse information.
- The obligations imposed here upon an insurer may be satisfied by another insurer authorized to act on its behalf. An insurer may make arrangements with an insurance support organization to copy and disclose confidential abuse information on its behalf.
- The rights granted to protected persons by this section extend to all persons to the extent confidential abuse information about them is received and maintained by an insurer in connection with an insurance action. The rights granted to all persons do not extend to information about them that related to and is received in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

6.B That with regards to the correction, amendment or deletion of confidential abuse information:

- You have a right to review or obtain, and to correct, confidential abuse information received by Unum. Within 30 business days from the date of receipt of a written request from a protected person to correct, amend or delete any confidential abuse information about the protected person within its possession, an insurer or insurance support organization shall either:
- Correct, amend or delete the portion of the confidential abuse information in dispute; or
- Notify the protected person of:
  1. its refusal to make the correction, amendment or deletion;
  2. the reasons for the refusal, and
  3. the protected person's right to file a statement as provided in 13 NMAC, 7.5.15.3.
- If the insurer or insurance support organization corrects, amends or deletes confidential abuse information in accordance with 13 NMAC 7.5.15.1.1, the insurer or insurance

support organization shall so notify the protected person in writing and furnish the correction, amendment or fact of deletion to:

1. Any person specifically designated by the protected person who may have, within the preceding two years, received the confidential abuse information;
2. Any insurance support organization whose primary source of confidential abuse information is insurers if the insurance support organization has systematically received such confidential abuse information from the insurer within the preceding three years; provided, however, that the correction, amendment or fact of deletion need not be furnished if the insurance support organization no longer maintains confidential abuse information about the protected person; and
3. Any insurance support organization that furnished the confidential abuse information that has been corrected, amended or deleted.

- Whenever a protected person disagrees with an insurer's or insurance support organization's refusal to correct, amend or delete confidential abuse information, the protected person shall be permitted to file with the insurer or insurance support organization:
  1. A concise statement setting forth what the protected person thinks is the correct, relevant or fair confidential abuse information; and
  2. A concise statement of the reasons why the protected person disagrees with the insurance institution's, agents or insurance support organization's refusal to correct, amend or delete confidential abuse information.
- In the event a protected person files either of the statements described in 13 NMAC 7.5.15.3, the insurer or insurance support organizations shall:
  1. File a statement with the disputed confidential abuse information and provide a means by which anyone reviewing the disputed confidential abuse information will be made aware of the protected person's statement and have access to it; and
  2. In any subsequent disclosure by the insurer or insurance support organization of the confidential abuse information that is the subject of disagreement, clearly identify the matter in dispute and provide the protected person's statement along with the confidential abuse information being disclosed; and
  3. Furnish the statement to the persons and in the manner specified in 13 NMAC 7.5.15.2.
- As was the case with Access to Confidential Abuse Information, the rights granted to protected persons in this section shall extend to all persons to the extent confidential abuse information about them is collected and maintained by an insurer or insurance support organization in connection with an insurance action. The rights granted to all persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

6.C That with regards to maintaining the confidentiality of location information:

- *Insurer Program Required.* Each insurer shall develop by the effective date of this rule a location information confidentiality program to be followed by all person who have access to the location information of protected persons. The program must include:
  1. A reasonable procedure by which a protected person can request participation in the insurer's location information confidentiality program;
  2. A system of internal control procedures for maintaining the confidentiality of the location information of a protected person, including provisions for regular internal review; and
  3. Procedures to be followed when any action is taken with respect to an application, policy, claim, or other material involving a protected person, including procedures for the designation or a mailing address to be used by the insurer.
- *Notice to Protected Person of a Disclosure of Location Information.* If the insurer is required, pursuant to an order of the Superintendent or a court of competent jurisdiction or as otherwise required by law, to disclose the location information of a protected person, the insurer shall:

1. Give the protected person notice of receipt of the order within ten days of receipt of the order;
2. Advise the person issuing the order that the protected person's location information is confidential and protected by the Domestic Abuse Insurance Protection Act, NMSA 1978 chapter 59A, Article 16B, and by the Confidential Abuse Information rule, 13 NMAC 7.5;
3. Continue to otherwise maintain the confidentiality of the location information.

- If the insurer elects to file suit against the person who committed domestic abuse against a protected person, the insurer shall:
  1. Give the protected person notice of intent to file suit at least 30 days prior to the date suit is filed;
  2. Advise the court in which suit is filed that the protected person's location information is confidential and protected by the Domestic Abuse Insurance Protection Act, NMSA 1978 chapter 59A, Article 16B, and by the Confidential Abuse Information rule, 13 NMAC 7.5;
  3. Continue to otherwise maintain the confidentiality of the location information.
- *Prohibition Against Disclosure-Marketing.* No insurer or insurance support organization may sell or otherwise disclose the location information of a protected person, except as permitted by 59A-16B-4A(3) of the Domestic Abuse Insurance Protection Act, without having first obtained the written consent of the protected person.
- Written consent is not required if the use or disclosure of the location information of the protected person is internal or to an affiliate of the insurer and the only use of the location information will be in connection with the marketing of insurance products, provided the affiliate agrees not to disclose the location information of the protected person for any other purpose or to unaffiliated persons. With respect to the marketing of insurance products, the protected person must be given an opportunity to indicate that he or she does not want his or her location information used for such marketing purposes and has given no indication that he or she does not want his or her location information used for such purposes.
- This prohibition shall not apply to location information disclosed to or used by insurance support organizations, including, but not limited to, index, fraud, and medical information bureaus, which assist insurers or insurance support organizations with underwriting, claims settlement, detection or prevention of fraud, or detection or prevention of material misrepresentation or material nondisclosure.

7. Our Protected Person Program consists of the following:
   - Notification process for all New Mexico residents with open claims filed after 1/1/99.
   - Process to limit access to claim information for claimants in the protection program.
   - Provide the claimant with the option to obtain, review, and if desired, the ability to change or delete related information in the claim file.
   - Process for disclosure to the claimant when records or addresses are disclosed.
   - Process for storing, concealing, and disposing of these claims or of the confidential information.
   - Internal procedures to address how we collect, maintain, use, disclose or transfer confidential abuse information

If you do not submit a written request or the enclosed form with "yes" selected, we will assume that you do not wish to be afforded the status of Protected Person and will continue to process your claim accordingly. If at any time you decide to change your Protected Person status, please notify us of your request in writing.

Right of access to, and right to request changes in, abuse information

Important notice to all New Mexico Customer Care Specialists
The Act provides the following rights to all New Mexico claimants, regardless of whether or not they have elected to enter Unum's Protected Person Program:

- the right to access of confidential abuse information we may have in our file
- the right to request that we "correct, amend, or delete" confidential abuse information in our file
- the right to submit a statement of disagreement, if we cannot agree to the abuse information changes requested by the claimant

If the claimant is requesting access to or a change in our confidential abuse information:

- the request must be **in writing**
- the requested information should be "reasonably described" by the claimant, and
- should be "reasonably locatable and retrievable" by the Customer Care Center
- we must respond in **thirty days** to each request

Should you receive a New Mexico claimant inquiry concerning our confidential abuse claim information, please contact your Program Administrator immediately.

More information on these topics can be found in the Protected Person Claims Processing Guidelines, found in Part II.

Calls, mail, and inquiries on New Mexico Protected Person claims

Overview
The NMDAIPA requires the Customer Care Center to protect the records and location of Protected Persons. This memo outlines how to handle mail and other inquiries that are directed at personnel *other* than the Customer Care Specialist handling the Protected Person claim.

How do I know if a claimant is a Protected Person?
The Program Administrator will immediately e-mail the Customer Care Center organization when an individual has entered the Protected Person program.

The e-mail will include:
- the name of the Protected Person
- the name, location, and phone number of the current Customer Care Specialist

The Program Administrators are also responsible for creating and updating one master list of Protected Persons. This master list will be distributed monthly. This list will include both open and closed Protected Person claims. Any revised list will include a revision date.

On a closed Protected Person claim, the claim contact will be listed as the Program Administrator.

Each Customer Care Center employee should keep the e-mails and latest master list posted in their office for ready reference.

How do I handle mail or calls on a Protected Person?
If you receive a call:
- obtain the name and number of the caller, and
- inform the caller the name of the contact person, and either
- transfer the call to the contact person, or
- immediately refer the message to the contact person

No information other than the above should be given to the caller.

If you receive mail on a Protected Person:
- notify the contact person, and
- immediately forward the mail

Program Administrators

Portland	Ruth Palmer
Chattanooga	Dan Clark
Glendale	Josette Magana
Worcester	Ed Dziewietin
Springfield	Bob Dubiel
Tarrytown	Wanda McCutcheon
Chicago	Marsi Soncrant

Protected Person Claim Processing Guidelines

Introduction
This document provides detailed processing guidelines on Protected Person claims.

Next steps after the claim has been identified as a Protected Person claim
After discussion with the Program Administrator, the assigned Customer Care Specialist will send a special authorization with a cover letter. The authorization and sample letter wording are enclosed for your reference.

Authorizations
The NMDAIPA requires that we provide the Protected Person claimant with a special authorization. The following provision is required in this authorization:

"I understand that I may request in writing that this authorization be revoked, effective ten days after receipt of my request by the Insurer. However, I also understand that in revoking this authorization, my claim could be denied or otherwise adversely affected."

The Protected Person authorization (form number 1015-00), can be ordered directly from Document Management.

Handling and storing of Protected Person claims
Protected Person claims that are not being reviewed or actively worked on should be stored in a cabinet or shelf (not left on a desk).

It is the responsibility of the Customer Care Specialist to maintain the privacy of this claim, and to inform others who may review or work on this claim (i.e. medical, CPA, administrative staff) of the need to maintain privacy of the Protected Person claim.

If a Protected Person closed claim needs to be retrieved for some action (re-opening, appeal, inquiry, etc.) we must maintain the same level of privacy as with an open claim. Closed claims should be stored away when not in use.

Sharing of information with outside sources
Protected Person Customer Care Specialists need to be aware that we must notify outside sources who:

- obtain confidential information for us, and/or
- receive confidential claim information from us of the need to be aware of and abide by the NMDAIPA.

Such sources include at least the following:

1. PMSI
2. Surveillance or other investigative vendors used by the Customer Care Center
3. Medical sources performing Independent Assessments, Functional Capacity Evaluations, or other testing
4. Outside medical sources conducting file reviews, such as those found on the Portland Customer Care Center Independent Assessment Network "Super Specialty Panel"
5. Outside vocational rehabilitation, vocational analysis, medical case management vendors
6. Social Security Claimant Advocacy Program attorneys
7. Other outside vendors who may obtain medical, Social Security, or earnings information
8. Other insurance companies, beyond the UnumProvident Corporation Customer Care Center organization
9. Any other large volume record provider similar to PMSI

Regarding PMSI, Unum will include wording in the company-wide Unum/PMSI services contract that references the NMDAIPA.

If a contract exists with another high-volume records procurement source similar to PMSI, or if a contract arrangement is later contemplated, your Legal contact should be immediately consulted.

A sample letter has been enclosed to use with all vendors, excepting PMSI.that references the NMDAIPA and the vendor's obligations under the NMDAIPA. The Protected Person Customer Care Specialist should enclose this letter, with any records sent and/or any referral made to these vendors.

In determining whether you need to send this "outside source" letter, a simple rule to follow would be that: *other than PMSI, if the source is not part of UnumProvident Corporation, you need to use the letter.*

Sharing of information with GENEX
GENEX has been notified of the NMDAIPA. When referring a Protected Person claim to GENEX, it is the Customer Care Specialist's responsibility to inform GENEX of the protected status of the claim.

The same sample letter used to send to outside sources can be used with GENEX referrals. Suggested wording for GENEX referrals can be found in that sample letter.

Disclosure of Protected Person claimant location or other information to outside sources
The NMDAIPA contains specific requirements regarding the release of claimant location information. If you are about to disclose claim information to an outside source other than PMSI, you will need to review your claim to determine whether the vendor needs the claimant's address and/or phone number or other confidential abuse information to perform the services requested. *If the outside source does not need this information, it should not be sent or disclosed.*

Information/location disclosures and court orders, other litigation
The Act and regulations contain specific guidelines on how to handle Protected Person disclosures where there are court orders or other litigation, including insurer against the claimant. If any of these types of circumstances develop in a Protected Person claim, consult with Legal immediately.

Record-keeping of disclosures
The NMDAIPA requires us to keep records on all Protected Person claim disclosures of information. The specific data to be recorded can be found in the regulations, in 13.7.5.16.

Protected Person Customer Care Specialists are encouraged to review disclosure and record-keeping procedures with the Program Administrator, before making any disclosure.

Right of access to, and right to request changes in, claim information

Note: As these types of records requests may involve complex and/or sensitive issues, the Protected Person Customer Care Specialist should consult with the Program Administrator, the Legal contact, and/or medical staff.

Under the NMDAIPA, Protected Person claimants, like other claimants, have a right to see or obtain some portions of our claim information. The request must be in writing, and we must respond within thirty days.

In addition, Protected Person claimants have a right, once they receive the records, to request in writing that we "correct, amend, or delete" abuse information in our claims. We again have thirty days to respond. If we cannot completely comply with the request, we will need to inform the

claimant in writing, and advise that he/she may submit a statement of the reasons why s/he does not agree. If the claimant does submit such a statement, that statement must be placed in the claim file.

In the event that Unum agrees to make the changes in the records specifically designated by the claimant, Unum will notify:

- any person specifically designated by the protected person who may have, *within the last 2 years,* received such confidential abuse information
- any vendor that may have received such information *within the last 3 years*
- any vendor who may have furnished such information *at any time* in the claim

If the vendor no longer has any confidential abuse information on the claimant, the claimant will be notified of this. If the vendor still possesses confidential abuse information, that source will be furnished a copy of the corrected, amended, or deleted information.

Correspondence to the claimant in these access/change processes must reference records sent to or received from outside vendors.

Please keep in mind that when we agree to correct, amend, or delete confidential abuse information at the written request of the claimant, we are only responsible for our claim information and that information shared with or by our vendors. We are not required to contact the original author of the medical information and require him/her to make changes.

Sample letters are enclosed.

Sample letter: Protected Person acknowledgement and authorization

Dear:

We have received your written request to be considered a Protected Person under the New Mexico Domestic Abuse Insurance Protection Act.

I have enclosed a medical authorization for you to sign, as a Protected Person. Please sign and date the authorization, and return in the enclosed envelope, You may keep a copy of this authorization for your records.

Thank you for your cooperation in this matter.

Should you have any questions, please call me at

Sincerely,

IF THE CLAIM HAS BEEN RE-ASSIGNED TO A NEW CUSTOMER CARE SPECIALIST PLEASE ADD THE FOLLOWING WORDING TO THE ABOVE:

I am writing to introduce myself as your Customer Care Specialist.

I am committed to providing you prompt, accurate, and courteous service.

Authorization for Release of Information

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility, insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation, other organization, institution, or person that has any records or knowledge of me, my health (including any information relating to the use of drugs and alcohol, and any information relating to mental and physical history, condition, advice or treatment), financial or credit information, earnings or other insurance benefits, to release this information to any of the UnumProvident Corporation subsidiaries or their duly authorized representatives. I also authorize the UnumProvident Corporation subsidiaries to request a report from the Medical Information Bureau (MIB), and the association of life insurance companies which operates the Health Claims Index (HCI) and the Disability Income Record System (DIRS). I understand that the dates of my past and present claims with any of the UnumProvident Corporation subsidiaries, excluding medical or personal information, may be reported to MIB and that an HCI or DIRS report may reflect this information including the identity of other insurance companies to which I have submitted claims. I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering a claim for benefits.

This authorization is valid for the duration of my claim. I know that I or my authorized representative has a right to request a copy of this authorization. A copy of this authorization shall be as valid as the original.

I further authorize the UnumProvident Corporation subsidiaries or other authorized representatives to release all information related to this insurance claim to insurance companies, third party administrators, physicians, rehabilitation professionals, vocational evaluators, employers, my insurance agent, and any institution or person on a need to know basis for the purpose of verifying, evaluating, negotiating, or other pertinent uses with respect to my claim for benefits or service.

I understand that I may request in writing that this authorization be revoked, effective ten days after receipt of my request by the Insurer. However, I also understand that in revoking this authorization, my claim could be denied or otherwise adversely affected.

I further authorize the UnumProvident Corporation subsidiaries or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

I am the individual to whom this release/request applies or that person's legal Guardian, Power of Attorney, or Conservator. I know that if I make any representation which I know is false to obtain information from federal records, I could be punished by fine or imprisonment or both.

_____ _____

(Claimant Signature) (Date Signed)

_____ _____

(Print Name Here) (SSN)

I signed on behalf of the claimant, as _____(indicate relationship). **If Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.**

Sample letter: disclosing abuse information to Protected Person claimants

Dear:

This letter concerns your claim with_____.(name of insurance company)

We have received your written request for access to our records.

Enclosed please find the records from _____(name of source) dated _____.

------OPTIONAL WORDING--------

IF NO RECORDS WERE OBTAINED VIA PMSI OR AN OUTSIDE SOURCE AND NO RECORDS WERE DISCLOSED TO AN OUTSIDE SOURCE:

The records referenced above were obtained directly from the source(s), and were not disclosed to anyone outside of our company.

IF PMSI OR OTHER PARTY OBTAINED RECORDS FOR THE CLAIM:

Our company used the services of _____(name of vendor) on_____(date) to obtain these records:

AND

We have contacted _____ (name of vendor) and they have indicated that they have destroyed (or did not keep a copy) of your records.

OR

We have contacted_____(name of vendor) and they have indicated they still have these records.

IF RECORDS WERE DISCLOSED TO AN OUTSIDE PARTY:

These records were disclosed to _____(name of vendor) on _____(date) because _____.

AND

We have contacted _____(name of vendor) and they have indicated that they have destroyed these records.

OR

We have contacted _____(name of vendor) and they have indicated that they still have these records.

OPTIONAL PARAGRAPH REGARDING COST OF COPYING:

Our cost for providing you this information is_____. Please make the check payable to _____. We have enclosed a return envelope for your convenience.

------REQUIRED PARAGRAPH------

Should you want to make a change, correction, or deletion to any of the records sent to you, please provide us this request in writing. In your request, please be specific as to what you want changed, corrected, or deleted. We will re-contact you about your request within 30 days of receiving your request. OPTIONAL SENTENCE---We will also notify you if we re-contact _____(name of vendor) about the records they have.

Should you have any questions, please call me at_____.

Sincerely,

Sample letter: we have agreed to correct, change, or delete abuse claim information

Dear:

This letter concerns your claim with_____(name of insurance company).

We have reviewed your request that we _____(type of action) the_____(name of information)

——OPTIONAL WORDING——

Enclosed please find a copy of that record, as it now appears in your file.

OR, IF WHOLE RECORD/REPORT DELETED:

We have removed _____(name of report) from our file.

IF INFORMATION WAS DISCLOSED TO/OBTAINED BY OUTSIDE SOURCES AND THEY STILL HAVE THE INFORMATION:

We have re-contacted _____(name of vendor) about your request, and have sent them the corrected copy of _____(name of information)

OR, IF WHOLE RECORD/REPORT DELETED:

We have re-contacted_____(name of vendor) about your request, and they have destroyed _____(name of information).

Should you have any questions, please contact me at_____.

Sincerely,

Sample letter: when declining a claimant's request to correct, change, or delete abuse claim information

Dear:

This letter concerns your claim with_____(name of insurance company).

We have reviewed your request that we _____(type of action) _____(specific record/information), and have determined that we cannot comply with your request.

-----OPTIONAL WORDING-----

ENTER PERSONALIZED PARAGRAPH REGARDING (1) WHAT IF ANYTHING WAS CHANGED AND (2) OUR REASONS FOR NOT COMPLYING WITH THE CLAIMANT'S REQUEST

AND

You may send me a written statement, if you do not agree with our decision. Your statement should include what specifically you think is the correct, relevant, or fair information, and why specifically you disagree with our decision. Your statement will be put in your claimfile.

Should you have any questions, please contact me at

Sincerely,

Sample letter: sharing abuse information with outside sources and with GENEX

Dear:

Thank you for agreeing to provide claim services on the claim of_____ (name of claimant) for _____(name of insuring subsidiary).

——OPTIONAL WORDING——

IF THIS LETTER IS GOING TO AN OUTSIDE SOURCE:

Please be aware that the information that we sent to you or that you may obtain may include information covered by the New Mexico Domestic Abuse Insurance Protection Act and related Regulations, and that in performing services with regard to this claim you are agreeing to be bound by the provisions of this Act and the related Regulations and to be subject to their enforcement in the state of New Mexico.

Note: do <u>not</u> change the language found in the above paragraph

IF THIS LETTER IS GOING TO GENEX:

Please note that this claim is covered under the New Mexico Abuse Domestic Abuse Insurance Protection Act. Please take all steps necessary to insure the privacy of this claimant and claim information.

Should you have any questions about this request or the Act or Regulations, please contact me at_____.

Sincerely,

New York Regulation 62

New York Regulation 62 prohibits integrating with disability pension benefits on policies issued in New York unless the insured elects and receives those benefits or the benefit received does not reduce the amounts of his accrued annuity or pension benefits thus funded, regardless of policy language.

Pre-Ex Investigations in 1st Circuit

Introduction

The U.S. Court of Appeals for the 1st Circuit upheld Hughes v. Boston Mutual, a ruling which affects the way we may administer our pre-x condition exclusion for claims governed by the 1st Circuit. In this case, the court determined that an insurer, such as UnumProvident, in order to determine pre-x, needs to evaluate whether the physician and/or the claimant had knowledge during the pre-x period, that the treatment the insured was receiving was for the condition which is the cause of the disability.

What Contract Series are Affected?

All ERISA Plans in the 1st Circuit, with the exception of CXC contracts. This is due to the fact that the language in our policies, except CXC, is almost identical to language in the Boston Mutual policy cited in the case.

Which Claims are Affected?

Claims in which the claimant lives or works in: Maine, Puerto Rico, Massachusetts, Rhode Island, New Hampshire.

Procedure

The investigation to determine whether a claim is pre-existing will be performed in the same manner as for all other claims except that prior to making a determination that a claim is pre-existing, we will apply an additional test:

Were the physician and/or claimant aware, or should they have reasonably been aware that the claimant was being evaluated and/or treated for the disabling condition during the pre-existing period?

If yes, handle as any other claim.

If no, the claim must not be denied on the basis of the pre-existing exclusion (unless it is a CXC contract).

Claim Investigation

A standard pre-x investigation should take place, including obtaining all medical records and conducting a thorough telephone interview with the claimant.

If this is not sufficient to determine if any of the physicians, treatment facilities or the claimant were aware that the claimant was being treated or evaluated for the ultimately disabling condition a doctor to doctor call should be considered.

Important Note

It is not necessary for a diagnosis to have been made during the pre-x period. It is necessary for us to determine that the claimant or provider were aware or should have reasonably been aware that the ultimate diagnosis was possible, probably or likely.

Conclusion

The court has ruled that there must have been an awareness on the part of the claimant or his treatment providers that the claimant was receiving treatment of diagnostic services for the condition which ultimately caused disability during the pre-x period.

When it is not clear whether or not the treatment providers reasonably should have been aware of at least the possibility of the ultimate diagnosis, you should obtain input from a medical resource.

States: Alabama

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Alab.St.Ann. 27-12-24; 27-19-9; 27-19-II

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify Claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule
Insurer needs to demonstrate prejudice only if the claimant has a reasonable explanation for the delay. Pharr v. Continental Cas. Co., 419 So.2d 1018 (Ala.1983); Liberty Mutual Ins. Co. v. Bob Roberts 357 So.2d 968 (Ala.1978)

ERISA Claims

Located in the 11th Circuit Federal Court of Appeals.

States: Alaska

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Ak.Adm.Code 26.010 et seq.; Ak.St.Ann. 21.36.125.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: None
- Complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 15 days after receipt of proof of loss
- Send follow-up letters investigation is incomplete: 45 days after initial notification
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir.1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when the policy has a mental and nervous limitaton.

Alaska does not tax sick pay.

Late Notice/Prejudice Rule - Weaver v. Chappel, 684 P.2d 123 (AK. 1984). Insurer must demonstrate that it was prejudiced due to late filing before claim can be denied due to late filing.

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

More Information

For more information, read about claim payment procedures in Chapter 2: Alaska Claim Payment.

States: Arizona

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling laws: AZ.St.Ann 20-456, 461, 1353; AZ ADC 20-6-801 et seq.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 15 days
- Begin investigation of claims: None
- Complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 15 days after receipt of proofs of loss
- Send follow-up letters that investigation is incomplete: 45 days after date of initial notification
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after affirmation of coverage: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F. 3d 948 (9th Cir. 1993)
Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when the policy has a mental and nervous limitation.

Late Notice/Prejudice Rule - Globe Indem. Co. v. Blomfield, 562 P.2d 1372 (Ariz. Ct. App. 1977) Lindus v. Northern Ins. Co. 438 P. 2d 311 (1968).
Insurer must demonstrate that it was prejudiced due to late filing before claim can be denied due to late filing.

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: Arkansas

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Ark. Ins. Rule and Regulation 43, Section 1 et seq.; Ark.St. 23-66-206(9)

Adopted law similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 20 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: None
- Complete investigation of claim: 45 days
- Notify claimant that more time is needed to review claim: 15 days from date of receipt of proofs of loss
- Send follow-up letters that investigation is incomplete: 45 days from date of the initial notification requesting more time
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: 10 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Insurer does not need to demonstrate prejudice. General American Life Ins. Co. v. Yarbrough, 360F.2d 562 (8th Cir.1966); Haskins v. Occidental Life, 349 F. Supp. 1192.

ERISA Claims

Located in the 8th Circuit Federal Court of Appeals.

States: California

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: CA ST-ANN 790.03 et seq.; CA Code Reg Sub 7.5, sec 2695.1 et seq.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation: 15 days
- Complete investigation of claim: 40 days
- Notify claimant that more time is needed to review claim: 30 days after receipt of claim, including a written list of all information reasonably needed to determine liability
- Send follow-up letters that investigation is incomplete: 30 days
- Accept or deny claim after receipt of proofs of loss: 30 days
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: 30 days
- Respond to inquiry from Department of Insurance: 21 days

Miscellaneous

The Department of Insurance shall deem a complaint justified if the consumer can demonstrate, among other things, that the insurer's actions or omissions were in noncompliance with California insurance laws and regulations or other laws and regulations. Sec. 2694.

Interest on delayed payments: If no notice is sent to claimant within 30 days after receipt of claim listing the information reasonably needed to determine liability, or if payment is not made within 30 days after acceptance of liability, any delayed payment must bear interest, beginning on the 31st day, at the rate of 10% per year.

Anyone involved in investigating a claim must have thorough and adequate training of the California Fair Claim Settlement Practices regulations and be able to provide annual certification of such training by September 1st of each year. Sec. 2695.6.

No insurer shall be precluded from including in any release a provision requiring claimant to waive provisions of the California Civil Code Section 1542, provided that prior to execution of the release the legal effect of the release is disclosed and fully explained by insurer to claimant in writing. Sec.2695.4.

Written notification denying a claim shall include language advising claimant that if claimant believes the claim has been wrongly denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall provide the address and telephone number of the unit of the Department which reviews complaints regarding claims process. Sec.2695.7(b)(3). The denial letter on LEADER for California has this wording.

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir.1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when the policy has a mental and nervous limitation.

Insurer must demonstrate that it was prejudiced due to late filing before claim can be denied due to late filing.

FMLA - Refer to Family Medical Leave Act Section as the State of California has a greater FMLA period than the federal mandate.

Offsets/State Disability: See California State Disability.

Offsets/Workers' Compensation: See California Workers' Compensation.

Settlements: California has a state specific release.

PERS & Other Retirement Plans: Depending upon the specific offset provisions in the policy, the monthly benefit payment may be reduced by the amount of PERS or other similar retirement plan benefits that is being received by the claimant. For more information on retirement plans, contact a social security specialist.

Garnishment: Disability benefits paid by UnumProvident to a claimant are subject to an Earnings Assignment Order for Support, including spousal, family or child support. However, disability benefits are exempt from Earnings Withholding Orders issues by the California Franchise Tax Board. Cal. Code Civ. Pro. Sec. 704.130(a)(b) (c) and 706.011.

Late Notice/Prejudice Rule - Shell Oil Co. v. Winterthur Swiss Ins. Co., 15 Cal.Rptr.2d 815 (Cal.App.1993); Select Ins. Co. v. Superior Court, 276 Cal.Rptr. 598 (4th Dist.1990); Healy Tibbetts Const. Co. v. Foremost Ins. Co., 482 F.Supp. 830 (N.D.Cal.1979); Clemmer v. Hartford Ins. Co., 587 P.2d 1098 (Cal.1979).

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: Colorado

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Co.St.Ann. 10-3-1104 (h); 10-16-202

Adopted laws somewhat similar to NAIC Model; for general provisions see NAIC Model Act and Regs.

Specific Time Restrictions

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is complete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer shall not deny a claim due to late filing if the claimant has a justified Excuse. Aetna v. Samson, 471 F. Supp. 1040 (D. Colo.1979); Dairyland Ins. Co. v. Marez, 601 P.2d 353, aff'd 638 P.2d 286 (Colo. 1981).

ERISA Claims

Located in the 10th Circuit Federal Court of Appeals.

States: Connecticut

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: C.G.S.A.38a-483; 38a-816(6)(15)

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:
- Acknowedge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- To complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: 45 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from the Department of Insurance: None

ERISA & Non-ERISA Claims

"Family Medical Leave Act" - Under state law, leave is 16 weeks in 2 year period.

"Workers comp, Connecticut lien": UnumProvident has right to file lien on a controverted workers' compensation claim. See WC Section.

Connecticut does not permit an insurer to rescind because of fraudulent misrepresentations beyond the two year contestable period. However, Connecticut does permit an insurer defrauded by an insured to recover damages. Refer to Legal for more information.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before claim can be denied due to Late filing. Aetna v. Murphy, 538 A.2d 219 (Conn.1988).

ERISA Claims

Located in 2nd Circuit Federal Court of Appeals.

States: Delaware

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: DE.St.Title 18, Section 2304(16); 3310; DE.Ins.Regs.No.26, Section 2.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: 10 days
- To complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: 30 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before claim can be denied due to late filing. Oglesby v. Penn. Mutual, 877 F.Supp.872 (D.Del. 1995)

ERISA Claims

Located in the 3rd Circuit Federal Court of Appeals.

States: District of Columbia

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: None

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: None
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice before a claim can be denied due to late filing. Waters v. American Auto Ins., 363 F.2d 684 (D.D.C.1966); Greycoat v. Liberty Mutual, 657 A.2d 764 (D.C. Cir.1995)

ERISA Claims

Located in the 4th Circuit Federal Court of Appeals.

Denial letters must inform the claimant that he/she is entitled to review pertinent documents upon which the decision was made. Ellis v. Metropolitan Life, 126 F.3d 228 (4th Cir. 1997)

States: Florida

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Fla.St.Ann. 626.9541(1)(I); 627.614; 627.662; 627.4265

Adopted law similar to NAIC Model; for general provisions see Model Act and Regulations.

Specific Time Restrictions:
- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of claim: 120 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 20 days
- Respond to inquiry from Department of Insurance: None

Job v. Occ. Analysis: Non-ERISA, non-CXC salespersons. Refer to Occ Analysis for more information. Berkshire Life Ins. Co. v. Adelberg, 698 So. 2d 828 (Fla.1997).

ERISA & Non-ERISA Claims

Pre-existing Condition: 12/Rolling 12 not currently being written, but some policies in Florida may have this provision. Policies with a Florida situs, legislation, effective 7/1/95, precludes the sale of pre-x exclusions more restrictive than 6/12. All cases in effect as of 7/1/95 and cases sold subsequent to 7/1/95 in Florida can not have a pre-x provision more restrictive than a 6/12.

Florida does not tax sick pay.

PERS & Other Retirement Plans: Depending upon the specific offset provisions in the policy, the monthly benefit payment may be reduced by the amount PERS or other retirement plan benefits that is being received by the claimant. For more information on Florida retirement plans, contact a social security specialist.

Florida Notice of Insurer Violation: Fla.St.Ann. 624.155; Fla.Reg.4-123.002. As a condition precedent to bringing a civil action against an insurer in Florida, the claimant must give the insurer 60 days notice of any alleged violation. The notice shall be submitted on Form D14-363 entitled "Civil Remedy Notice of Insurer Violation" that is obtained from the Florida Insurance Commissioner. If you receive a demand, please forward to the Head of Appeals in QR immediately. Note: While it (UnumProvident's position that actions under this statute are preempted when the claim is governed by ERISA, a timely response should still be submitted to the Commissioner.)

Late Notice/Prejudice Rule: Insurer must demonstrate prejudice before a claim can be denied due to late filing. Bankers Ins. Co. v. Macias, 475 So.2d 1216 (Fla. 1985); Credit Disability Life Investors Ins. Co. v. Johnson, 422 So.2d 32 (Fla.App.1982); Tiedtke v. Fidelity & Casualty Co., 222 So. 2d 206 (Fla. 1969).

ERISA Claims

Located in the 11th Circuit Federal Court of Appeals.

States: Georgia

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Ga.St.Ann. 33-6-30; 33-6-33; 33-6-34; 33-29-3

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days (Group); 10 days (Individual)
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Georgia does not permit an insurer to rescind because of fraudulent misrepresentations beyond the two year contestable period.

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice. Atlanta Int'l Properties, Inc. v. Georgia Underwriting Ass'n. 256 S.E.2d 472 (Ga.App.1979); Caldwell v. State Farm, 385 S.E.2d 97 (Ga. App. 1989).

ERISA Claims

Located in the 11th Circuit Federal Court of Appeals.

States: Hawaii

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: HI ST 431:13-103(a)(10).

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notificaton of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 30 days
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after affirmation of coverage: 30 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir. 1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when the policy has a mental and nervous limitation.

Offsets/State Disability: See Hawaii state disability.

Late Notice/Prejudice Rule: Standard Oil v. Hawaiian & Guar. Co., 654 P.2d 1345 (Haw.1982). Insurer must demonstrate that it was prejudiced due to late filing before claim can be denied due to late filing.

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: Idaho

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: ID ST-ANN 41-1329.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir.1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when the policy has a mental and nervous limitation.

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice before claim can be denied due to late filing. Viani v. Aetna Ins. Co., 501 P.2d 706 (Idaho 1972), overruled on other grounds.

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: Illinois

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Ill.Adm.Code 919.50; Ill. St.Ch. 5/154.6; Ill.St.Ch. 5/357.10.

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: None
- Complete investigation of claim: None
- Accept or deny claim after receipt of proofs of loss: None
- Notify claimant that more time is needed to review claim. Must include name & address of IL Dept. of Insurance: 45 days from date claim is filed with UnumProvident
- Send follow-up letters that investigation is incomplete: None
- Time to pay claimant after acceptance of liability: 30 days
- Time to pay after settlement of claim: None
- Respond to inquiry from the Department of Insurance: None

Miscellaneous:
If a claim is denied (or less than amount claimed), or unresolved for 45 days after received, the following Notice of Availability of the Department of Insurance must accompany the explanation (of denial or delay) to the insured or beneficiary:

Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767. 50 Ill.Admin.Code 919.40, 919.50, 919.70.

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to show prejudice before claim can be denied due to late filing. Fletcher v. Palos Comm. Consolidated School District, 518 N.E.2d 263 (Ill.1987).

ERISA Claims

Located in the 7th Circuit Federal Court of Appeals.

States: Indiana

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: In.St.Ann. 27-4-1-4.5; 27-8-5-3.

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 20 days

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before claim can be denied due to late filing. Miller v. Dilts, 463 N.E.2d 257 (Ind.1984); Lumpkins v. Grange Mutual Co., 553 N.E.2d 871 (Ind.App. 1990).

ERISA Claims

Located in the 7th Circuit Federal Court of Appeals

States: Iowa

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: IA.St.Ann. 507B.4(9); 514.A3.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to Late Filing. Estate of Wade v. Continental Ins. Co., 514 F.2d 304 (8th Cir.1975); Henschel v. Hawkeye-Security Ins. Co., 178 N.W.2d 409 (Ia.1970)

ERISA Claims

Located in 8th Circuit Federal Court of Appeals.

States: Kansas

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Ks.Legis.Ch.193, 40-2404(9); Ks.Regs. 40-1-34.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communicatons from claimant: 10 days
- Complete investigation of claim: 30 days
- Begin investigation of claim: None
- Notify claimant that more time is needed to review claim: 15 days after receipt of proof of loss
- Send follow-up letters that investigation is incomplete: 45 days from the date of the initial notification requesting more time.
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from the Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to Late Filing. Travelers Ins. Co. v. Feld Car & Truck Leasing Corp., 517 F.Supp. 1132 (D.Kan.1981)

ERISA Claims

Located in 10th Circuit Federal Court of Appeals

States: Kentucky

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Ky.Adm.Code 12:092; Ky.St. Ann. 304.12-230.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: 15 days
- Complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 30 days after receipt of proof of loss
- Send follow-up letters that investigation is incomplete: 45 days from date of initial notification
- Accept or deny claim after receipt of proofs of loss: 30 days
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: None
- Respond to inquiry from the Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer must demonstrate prejudice before a claim can be denied due to late filing. Jones v. Bituminous Cas. Corp., 821 S.W.2d 798 (Ky.1991).

ERISA Claims

Located in the 6th Circuit Federal Court of Appeals.

States: Louisiana

Non-ERISA Claims

Unfair Claims Settlement Practices and Other Claims Handling Laws: LA.St.Ann.22:1214(14); 22:1220; 22:657; 22:213.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: Pay within 30 days after receipt of proof of loss
- Pay claimant after acceptance of liability: 60 days
- Pay after settlement of claim: 30 days
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Workers' Compensation Offset: See WC section.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. DeVille v. Life Ins. Co. of Virginia, 560 So.2d 690 (La.1990)

ERISA Claims

Located in the 5th Circuit Federal Court of Appeals.

More Information

For more information, see also Salary Continuation for Public School Teachers in Louisiana.

States: Maine

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: 24 M.R.S.A. 2152; 2164-D; 2436; 2436-A; 2825.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictons:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 30 days after receiving proof of loss
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 14 days

ERISA & Non-ERISA Claims

See Workers Comp section re: Maine
Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Ouellette v. Maine Bonding & Casualty Co., 495 A.2d 1232 (Me.1985).

ERISA Claims

Located in the 1st Circuit Federal Court of Appeals.

Pre-existing condition: Insurer must evaluate whether the physician and/or insured were aware or should have been aware, during the pre-x period, that the treatment the insured was receiving was for the condition which is the cause of the disability. Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264 (1st Cir.1994).

States: Maryland

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: MD.Adm.Code 09.30.76.01 et seq; MD.St.Ann. Art. 48A, Section 230A.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 30 days after receipt of claim with all necessary documentation
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before claims can be denied due to late filing. Harleysville Ins. Co. v. Rosenbaum, 351 A.2d 197 (MD.App.1976); General Acc. Ins. Co. v. Scott, 669 A.2d 773 (Md. App. 1996).

ERISA Claims

Located in the 4th Circuit Federal Court of Appeals.

Denial letters must inform the claimant that he/she is entitled to review pertinent documents upon which the decision was made. Ellis v. Metropolitan Life, 126 F.3d 228 (4th Cir.1997).

States: Massachusetts

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims handling Laws: MA.St.Ann 176D, Section 3(9); MA.St.Ann. 175, Section 108.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from the Department of insurance: None

ERISA & Non-ERISA Claims

Massachusetts Notice of Insurer Violation MA.St.Ann 176D, Section 3(9); MA.St.Ann. 175, Section 108. The claimant, at least 30 days prior to filing a legal action, must make a written demand for relief from UnumProvident. The demand must identify the claimant, advise UnumProvident of the injury suffered, and reasonably describe the unfair or deceptive act or practice committed by UnumProvident. If you receive a demand, please forward to the Head of Appeals in QR immediately. (Note: While it UnumProvident's position that actions under this statute are preempted when the claim is governed by ERISA, a timely response should still be submitted to the Commissioner.)

Late Notice/Prejudice Rule: Insurer must show that it was prejudiced before a claim can be denied due to late filing. Mass. Acts ch. 437, amending Mass. Gen. L. Ch. 175, Section 112 (Liability); New England Extrusion, Inc. v. American Alliance Ins. Co., 874 F.Supp. 467 (D.Mass.); Johnson Controls, Inc. v. Bowes, 409 N.E.2d 185 (1980).

ERISA Claims

Located in the 1st Circuit Federal Court of Appeals.

Pre-existing condition: Insurer must evaluate whether the physician and/or insured were aware or should have been aware, during the pre-x period, that the treatment the insured was receiving was for the condition which is the cause of the disability. Hughes v. Boston Mut. Life Ins. Co. 26 F.3d 264 (1st Cir.1994).

Massachusetts Extension of Coverage Law

In the state of Massachusetts an employee's coverage is extended for a period of 31 days after the employee's date of termination. Therefore, when conducting a claim review of a Massachusetts employee who has terminated his/her employment, it is extremely important to note the employee's termination date, the employee's first date of medical treatment, and the employee's date of disability. If the date of disability is within 31 days of the employee's termination date (and the claim is otherwise payable), benefits should be extended.

States: Michigan

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Mich.St.Ann. 500.2006; 500.2026; 500.3413.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 60 days
- Pay after settlement of claim: None
- Respond to inquiry from the Department of Insurance: None

ERISA & Non- ERISA Claims

Workers Compensation - Mich.St.Ann. 418.356. See WC Section-MI .

Late Notice/Prejudice Rule: Insurer must demonstrate prejudice before a claim can be denied due to Late Filing. Brackx v. Minnesota Mutual Life Ins., 954 F.Supp. 1189 (E.D.Mich.1997); Monti v. League Life Ins., 391 N.W.2d 490 (Mich.1986).

ERISA Claims

Located in the 6th Circuit Federal Court of Appeals.

States: Minnesota

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Minn.St.Ann. 72A.20, Subdivision 12; 72A.201, Subdivision 1 et seq.; 72A.25.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: None
- Complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 30 days from date of receipt of notification of claim
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: 60 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 5 days
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non- ERISA Claims

Workers' Compensation Lien - 1415.1100; 1415.1200. See WC-MN.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Ryan v. ITT Life Ins. Corp. 450 N.W.2d 126 (Minn. 1990); Reliance Ins. Co. v. St. Paul Ins. Co., 239 N.W.2d 922 (Minn.1976).

ERISA Claims

Located in the 8th Circuit Federal Court of Appeals.

States: Mississippi

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Miss.St.Ann. 83-9-5.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 45 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice. Boliver Cty. v. Forum Ins. Co., 779 F.2d 1081 (5th Cir. 1986); Reliance v. County Place, Inc. 692 F.Supp. 694 (S.D.Miss.1988).

ERISA Claims

Located in the 5th Circuit Federal Court of Appeals.

States: Missouri

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Code of State Reg. 100-1.010 to 100-1.050; MO St.Ann.375.1005; 375.1007.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notifiction of claim: 10 days
- Provide necessary claimforms: 10 days
- Respond to communications from claimant: 10 days
- Begin Investigation of claim: None
- Complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 15 days after the submission of all materials necessary to establish a claim
- Send follow-up letters that inestigation is incomplete: 45 days from date of initial notification requesting more time
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Reid v. Conn. Gen. Life Ins. Co., 17 F.3d 1092 (8th Cir.1994); Tuterri's, Inc. v. Hartford Steam Boiler Inspection & Ins. Co., 894 S.W.2d 266 (Mo. App.1995).

ERISA Claims

Located in the 8th Circuit Federal Court of Appeals.

States: Montana

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: MT ST-ANN 22-209, 33-18-201, 232, 242; MT ADC 6.6.1701.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir. 1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when the policy has a mental and nervous limitation.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. J.G. Link & Co. v. Continental Cas. Co., 470 F.2d 1133 (9th Cir.1971).

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: Nebraska

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims handling Laws: Neb.Adm.Code Title 210, Chapter 61, Section 001 et seq.; Neb.St.Ann. 44-1539; 44-1540.

Adopted laws similar to NAIC Model: for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: 15 days from receipt of proofs of loss
- Complete investigation of claim: None
- Notify Claimant that more time is needed to review claim: 15 days from receipt of proofs of loss
- Send follow-up letters that investigation is incomplete: 30 days from initial notification requesting more time
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 15 days
- Pay after settlement of claim: 15 days
- Respond to inquiry from Department of Insurance: 15 days

Miscellaneous: Neb.Adm.Code Title 210, Chapter 61, Section 008.08. If, after an insurer rejects a claim (or portion of claim), the claimant objects to the rejection and the rejection is maintained, the insurer must notify the claimant in writing that he or she may have the matter reviewed by the Nebraska Department of Insurance, including the Department's address and phone number.

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. MFA Mutual Ins. Co. v. Sailors, 141 N.W.2d 846 Neb.1966).

ERISA Claims

Located in the 8th Circuit Federal Court of Appeals.

States: Nevada

Non-ERISA Claims

Unfair Claims Settlement Practices and Other Claims Handling Laws: NV-St ANN 686A.310; NV ADC 686.310 et seq.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 20 days
- Provide necessary claim forms: 20 days
- Respond to communications from claimant: 20 days
- Begin investigation: 20 days
- Complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 20 days after receipt of claim with a request for additional information that is needed.
- Send follow-up letters that investigation is incomplete: 45 days after the date of the initial notification
- Accept or deny claim after receipt of proofs of loss: 30 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 10 days

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir.1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when the policy has a mental and nervous limitation.

No state tax on sick pay.

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice. State Farm v. Cassinelli, 216 P.2d 606 (Nev.1950).

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: New Hampshire

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims handling Laws: NH.St.Ann. 417:4XV; NH.Adm. Reg.1001.01 et seq.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: 5 days
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 10 days after receipt of reasonable notice of loss
- Send follow-up letters that investigation is incomplete: 30 days from date of initial notification that more time is needed
- Accept or deny claim after receipt of proofs of loss: 10 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 5 days
- Respond to inquiry from the Department of Insurance: 10 days

Miscellaneous
Any letter written setting forth the need for further time after the first 30-day period must contain the following statement:

Should you wish to take this matter up with the New Hampshire Insurance Department, it maintains a service division to investigate complaints at 169 Manchester Street, Concord, NH, 03301. The New Hampshire insurance department can be reached, toll-free, by dialing 1-800-852-3416. N.H. Code Admin.R.Ins., Section 1001.07.

Any notice rejecting a claim in whole or in part shall contain the following statement:

We will, of course, be available to you to discuss the position we have taken. Should you, however, wish to take this matter up with the New Hampshire Insurance Department, it maintains a service division to investigate complaints at 169 Manchester Street, Concord, NH, 03301. The New Hampshire insurance department can be reached, toll-free, by dialing 1-800-852-3416. N.H. Code Admin.R. Ins., Section 1001.07.

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Pawtucket Mut.Ins.Co. v. Lebrecht, 190A. 2d 420 (N.H.1963); Commercial Union Assur. Cos. v. Monadnock Regional Sch.Dist., 428 A.2d 894 (N.H. 1981).

ERISA Claims

Located in the 1st Circuit Federal Court of Appeals.

Pre-existing condition: An insurer must evaluate whether the physician and/or insured were aware or should have been aware, during the pre-x period, that the treatment the insured was receiving was for the condition which is the cause of the disability. See procedure for further guidance. Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264 (1st Cir.1994).

States: New Jersey

Non-ERISA

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: N.J.Adm.Code 11:2-17.1 et seq.; N.J.St.Ann.17:29B-4.

Adopted laws similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: 10 days
- To complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 60 days
- Send follow-up letters that investigation is incomplete: 45 days from the date of the initial notification requesting more time
- Accept or deny claim after receipt of proofs of loss: 60 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 10 days
- Respond to inquiry from Department of Insurance: 15 days

Miscellaneous: All correspondence to a claimant required of UnumProvident shall be written in easy to read and understandable terms. N.J.Adm.Code 11:2-17.4(b).

UnumProvident cannot coerce claimant to settle a disbility claim on a lump sum basis. N.J.Adm. Code 11:2-17.9(c).

UnumProvident must distribute copies of the Unfair Claims Settlement Practices laws to every person directly responsible for the handling and settlement of claims, and such persons shall be thoroughly conversant and comply with this law. N.J.Adm.Code 11:2-17.4(a).

ERISA & Non-ERISA Claims

New Jersey does not tax sick pay.

See NJ State Disability.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Trico Mortgage Co. v. Penn. Title Ins. Co., 281 N.J.Super.341, 657 A.2d 890 (App.Div.1995); Cooper v. Gov't Employees Ins. Co., 237 A.2d 870 (N.J. 1968).

ERISA Claims

Located in the 3rd Circuit Federal Court of Appeals.

States: New Mexico

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: NM.St.Ann. 59A-16-20; 59A-16-21; 59A-22-9.

Adopted law similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictons:

- Acknowledge receipt of notificaton of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 45 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Foundation Reserve Ins. Co. v. Esquibel, 607 P.2d 1150 (N.M.1980).

ERISA Claims

Located in the 10th Circuit Federal Court of Appeals.

Other

See also New Mexico Domestic Abuse Insurance Protection Act.

States: New York

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Codes, Rules and Regulations of the State of New York, Title 11, Chapter IX, Section 216.0 et seq.; NY.St.Ann.Chapter 28, Article 26, Section 2601.

Adopted law similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: 15 days
- Complete investigaton of claim: None
- Notify claimant that more time is needed to review claim: 15 days after receipt of proofs of loss
- Send follow-up letters that investigaton is incomplete: 90 days after initial notification requesting more time
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 5 days
- Respond to inquiry from the Department of Insurance: 10 days

Miscellaneous: UnumProvident must distribute copies of the regulations to persons directly responsible for the supervision, handling and settlement of claims, and all such persons must be thoroughly conversant with, and comply with, the regulations. Section 216.0(e)(6).

ERISA & Non-ERISA Claims

See New York Regulation 62. Offers information on integration/offsets and retirement/disability pension benefits.

PERS & Other Retirement Plans: Depending upon the specific offset provisions in the policy, the monthly benefit payment may be reduced by the amount of PERS or other similar retirement plan benefits that is being received by the claimant. For more information on NY retirement plans, contact a social security specialist.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice only if the claimant has a reasonable explanation for the delay. Todd v.Bankers,Life & Casualty Co., 523 N.Y.S. 2d 206 (1987)(Disability).

New York will no longer allow the self-reported. Limitation to be sold on New York situs cases.

NY State DBL

ERISA Claims

Located in the 2nd Circuit Federal Court of Appeals.

States: North Carolina

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws:.NC.St.Ann. 58-63-15(11); 58-51-15(6); 11 NCAC 4.0319.

Adopted law similar to the NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:
- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from Claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Provide claimant with a status of the claim: 45 days after reciept of initial claim
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Great American Ins. Co. v. C.G. Tate Constrt. Co., 340 S.E.2d 743 (N.C.1986); Great American Ins. Co. v. C.G. Tate Constrt. Co., 279 S.E.2d 769 (N.C. 1981).

ERISA Claims

Located in the 4th Circuit Federal Court of Appeals.

Denial letters must inform the claimant that he/she is entitled to review pertinent documents upon which the decision was made. Ellis v. Metropolitan Life, 126 F.3d 228 (4th Cir. 1997).

States: North Dakota

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: N.D.St.Ann. 26.1-04-03; 26.1-36-04.

Adopted law similar to NAAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:
- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Finstad v. Steiger Tractor, Inc., 301 N.W.2d 392 (N.D. 1981).

ERISA Claims

Located in the 8th Circuit Federal Court of Appeals.

States: Ohio

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Oh.Adm.Code 3901-1-07.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: 15 days from receipt of claim
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 15 days after receipt of proof of loss
- Send follow-up letters that investigation is incomplete: 90 days after initial notification to claimant that more time is needed to investigate claim
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 5 days
- Respond to inquiry from the Department of Insurance: 15 days

ERISA & Non-ERISA Claims

PERS & Other Retirement Plans: Depending upon the specific offset provisions in the policy, the monthly benefit payment may be reduced by the amount of PERS or other similar retirement plan benefits that is being received by the claimant.

For more information on PERS and STRS in Ohio, contact a Social Security Specialist.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a calim can be denied due to late filing. American Employers Ins. Co. v. Metro Regional Transit Authority, 12 F.3d 591 (6th Cir.1994); Zurich Ins. Co. v. Valley Steel Erectors, Inc., 233 N.E.2d 597 (Ohio Ct. App. 1968).

ERISA Claims

Located in the 6th Circuit Federal Court of Appeals.

States: Oklahoma

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Ok.St.Ann. 1250.5; 1219; 3629; 1254.

1. Adopted laws somewhat similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.
2. Specific Time Restrictions:
   Acknowledge receipt of notification of claim: 20 days
   Provide necessary claim forms: 15 days
   Respond to communications from claimant: 20 days
   Begin investigation of claim: None
   Complete investigation of claim: None
   Notify claimant that more time is needed to review claim: 30 days after receipt of proof of loss
   Send follow-up letters that investigation is incomplete: None
   Accept or deny claim after receipt of proof of loss: 60 days
   Pay claimant after acceptance of liability: 30 days
   Pay after settlement of claim: None
   Respond to inquiry from Department of Insurance: 15 days
3. Miscellaneous: Ok.St.Ann. 1219 Failure to provide the claimant with notification that there will be a delay in determining the merits of the claim constitutes prima facie evidence that the claim will be paid in accordance with the terms of the policy. If a claim is not paid within 60 days after receipt of proof of loss, an insurer must pay interest, which will begin to accrue on the 61st day after receipt of proof of loss until the claim is paid.

   Requesting a refund of all or a portion of a payment of a claim made to a claimant more than 24 months after the payment is made. This does not apply if:

   The payment was made because of fraud committed by the claimant; or
   The claimant has otherwise agreed to make a refund to the insurer for overpayment of a claim.

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Dang v. Unum, 1999 WL 258236 (10th Cir. 1999); Continental Casualty v. Beaty, 455 P.2d 684 (Ok. 1969)

ERISA Claims

Located in the 10th Circuit Federal Court of Appeals.

States: Oregon

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: ORS 740.230; OR Admin. R.836-80-205 et seq.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions (calendar days):

- Acknowledge receipt of notification of claim: 30 days after receipt of notification
- Provide necessary claim forms: 20 days
- Respond to communications from claimant: 30 days after receipt of communication
- Begin investigation of claim: None
- Complete investigation of claim: 45 days after receipt of notification unless the investigation can't be reasonably completed within that time
- Notify claimant that more time is needed to review claim: 30 days after receipt of the proofs of loss
- Send follow-up letters that investigation is incomplete: 45 days from the initial notification
- Accept or deny claim after receipt of proofs of loss: 30 days
- Pay claimant after affirmation of coverage: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 21 days after receipt of inquiry

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir.1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when a policy has a mental and nervous limitation.

Offset for Other Income Benefits/Personal Injury Protection Benefits - O.R.S. 742.520; 742.524. Every motor vehicle liability policy shall provide for personal injury protection benefits. Under this statutory scheme, if the injured person's disability continues for at least 14 days, he or she is entitled to 70% of the loss of income from work during the period of his or her disability until the date that he or she is able to return to their usual occupation.

Late Notice/Prejudice Rule: Lusch v. Aetna, 538 P.2d 902 (Or.1975). Insurer must demonstrate that it was prejudiced due to late filing before claim can be denied due to late filing.

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: Pennsylvania

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Pa.Adm.Code 146.1 et seq.; . . Pa.St.Ann. 1171.5(10).

Adopted law similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: None
- To complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 15 days after receipt of proofs of loss
- Send follow-up letters that investigation is incomplete: 30 days from the date of the initial notification requesting more time, and then 45 days thereafter.
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Pennsylvania does not tax sick pay.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Perry v. Middle Atlantic Lumberman's Mutual, 542 A.2d 81 (Pa.1988); Brakeman v. Potomac Ins. Co., 371 A.2d 193 (Pa.1977); Weiner v. Metropolitan Life Ins. Co., 416 F.Supp.551 (E.D.Pa. 1976).

ERISA Claims

Located in the 3rd Circuit Federal Court of Appeals.

States: Puerto Rico

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Puerto Rico Ins. Reg. Rule XLVII, Section 1 et seq.

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: 15 days
- Complete investigation of claim: 45 days
- Notify claimant that more time is needed to review claim: 15 days after receiving proof of loss
- Send follow-up letters that investigation is incomplete: 90 days after date of initial notification
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 10 days
- Respond to inquiry from the Department of Insurance: 15 days

ERISA & Non-ERISA Claims

See Puerto Rico state disability.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Allstate Ins. Co. v. Occidental Int'l, Inc., 967 F. Supp. 642 (D.P.R.1997); affirmed 1998 WL 124509, 140 F.3d 1 (1st Cir.1998).

ERISA Claims

Located in the 1st Circuit Federal Court of Appeals.

Pre-existing condition: Insurer must evaluate whether the physician and/or insured were aware or should have been aware, during the pre-x period, that the treatment the insured was receiving was for the condition which is the cause of the disability. See procedure for further guidance. Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264 (1st Cir.1994).

States: Rhode Island

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: RI.St.Ann.27-9.1-3; 27-9.1-4.

Adopted law containing some provisions which are similar to the NAIC Model; for general provisions see NAIC Unfair Claims Settlement Practices Act and Regulations.

Specific Time Restrictions:
- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: 30 days
- Pay claimant after acceptance of liability: None
- Pay claimant after settlement of claim: None
- Pay after settlement of claim: None
- Respond to inquiry from the Department of Insurance: None

ERISA & Non-ERISA Claims

See Rhode Island state disability.

See FMLA. (Leave is 13 weeks in 2 year period).

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Cooley v John M. Anderson Co., 443 A.2d 435 (R.I.1982)(Auto).

ERISA Claims

Located in the 1st Circuit Federal Court of Appeals.

Pre-existing condition - In all ERISA plans in the 1st Circuit, an insurer must evaluate whether the physician and/or insured were aware or should have been aware, during the pre-x period, that the treatment the insured was receiving was for the condition which is the cause of the disability. See procedure for further guidance. Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264 (1st Cir.1994).

States: South Carolina

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: SC.St.Ann. 38-59-10 et seq.

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 20 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice. The First Savings Bank v. American Casualty Company of Reading, 985 F.2d 553, 1993 WL 27403 (4th Cir.1993) (Unpublished Disposition); Prior v. S.C.Medical Malpractice Liability Insurance Joint Underwriting Assoc., 407 S.E.2d 655 (S.C.App.1991).

ERISA Claims

Located in the 4th Circuit Federal Court of Appeals.

Denial letters must inform the claimant that he/she is entitled to review pertinent documents upon which the decision was made. Ellis v. Metropolitan Life, 126 F.3d 228 (4th Cir.1997).

States: South Dakota

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: SD.St.Ann.58-33-66; 58-33-68; 58-12-1; 58-17-23.

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 30 days
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 20 days

ERISA & Non-ERISA Claims

South Dakota does not tax sick pay.

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice. Gordinier v. Continental Ass. Co., 7 N.W.2d 298 (1942); Wolff v. Royal Ins. Co. of America, 472 N.W.2d 233 (S.D.1991).

ERISA Claims

Located in the 8th Circuit Federal Court of Appeals.

States: Tennessee

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Tenn.St.Ann. 56-8-104(8); 56-26-108(6).

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry of the Department of Insurance: None

ERISA & Non-ERISA Claims

Tennessee does not tax sick pay.

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Alcazar v. Hayes, 982 S.W.2d 845 (Tenn.1998)

ERISA Claims

Located in the 6th Circuit Federal Court of Appeals.

States: Texas

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: TX.Ins.Art.21.55; · · TX.Ins.Art.21.21(10); TX.Adm.Code 21.203; 21.204.

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from the claimant: 15 days
- Begin investigation of claim: 15 days
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 15 days from receipt of final proof of loss
- Send follow-up letters that investigation is incomplete: 45 days from date that claimant is notified that more time is needed. Insurer must accept or deny claim within this 45 day period.
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: 5 days
- Pay after settlement of claim: 5 days
- Respond to inquiry from Department of Insurance: 10 days

ERISA & Non-ERISA Claims

Texas does not tax sick pay.

PERS & Other Retirement Plans Depending upon the specific offset provision in the policy, the monthly benefit payment may be reduced by the amount of PERS or other similar retirement plan benefits that is being received by the claimant. For more information on retirement plans, contact a social security specialist.

Notice of Insurer Violation: Section 17.50 of the Deceptive Trade Practices Act; Article 21.21 of the Texas Ins. Code.

Under these provisions, a plaintiff/claimant must give written notice to the defendant/insurer at least 60 days prior to filing suit in order to seek certain damages. If you receive such a demand, please forward it to the Head of Appeals in QR immediately. (Note: While it is UnumProvident's position that actions under this statute are preempted when the claim is governed by ERISA, a timely response should still be submitted to the Commissioner.)

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Harwell v. State Farm, 896 S.W.2d 170 (TX.1995); Wheeler v. Allstate Ins. Co., 592 S.W.2d 2 (Tex.Civ.App.1979).

ERISA Claims.

Located in the 5th Circuit Federal Court of Appeals.

States: Utah

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: UT.Adm.Code R590-89-1; UT.St.Ann. 31A-26-303.

Adopted law similar to Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: None
- Complete investigation of claim: 45 days
- Notify claimant that more time is needed to review claim: 30 days after receipt of proof of loss
- Send follow-up letters that investigation is incomplete: 30 days after the initial notification requesting more time.
- Accept or deny claim after receipt of proofs of loss: 30 days
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. FDIC v. Oldenburg, 34 F.3d 1529 (10th Cir.1994); UT.St.Ann 31A-21-312(2).

ERISA Claims

Located in the 10th Circuit Federal Court of Appeals.

States: Vermont

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: VT.Regs. 79-2, Section 1 et seq.; VT.St.Ann.3665; VT.St.Ann. 4724(9).

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: None
- To complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 15 days after receipt of proofs of loss
- Send follow-up letters that investigation is incomplete: 30 days after date of initial notification requested more time
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: 10 days
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Cooperative Fire Ins. v. White Caps, Inc. 694 A.2d 34 (Vt.1997).

ERISA Claims

Located in the 2nd Circuit Federal Court of Appeals.

Other

See also Vermont Domestic Partner Legislation in the General section of this Manual.

States: Virginia

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Va.Adm.Code 5-400-10 et seq.; Va.St.Ann. 38.2-510.

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 15 days after receipt of proof of loss
- Send follow-up letters that investigation is incomplete: 45 days after the date of the initial notification requesting more time.
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. State Farm v. Scott, 372 S.E.2d 383 (Va.1988).

ERISA Claims

Located in the 4th Circuit Federal Court of Appeals.

Denial letters must inform the claimant that he/she is entitled to review pertinent documents upon which the decision was made. Ellis v. Metropolitan Life, 126 F.3d 228 (4th Cir.1997).

States: Virgin Islands

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: V.I.C., Title 22, Chapter 35, Section 860.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- To complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Leuckel v. Federal Ins. Co., 303 F.Supp. 407 (D.Virgin Islands 1969); LaPlace v. Sun Insurance Office, LTD, 298 F.Supp.764 (D.Virgin Islands 1969).

ERISA Claims

Located in the 3rd Circuit Federal Court of Appeals.

States: Washington

Non-ERISA Claims

Unfair Claims Settlement Practices and Other Claims Handling Laws: WA ST 48.030.010; WA ADC 284-30-300 et seq.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 individual; 15 group
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 10 individual; 15 group
- Begin investigation of claim: None
- Complete investigation of claim: 30 days
- Notify claimant that more time is needed to review claim: 15 days after receiving proofs of loss
- Send follow-up letters that investigation is incomplete: 45 days after initial notification, and 30 days thereafter
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 15 days
- Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

MN v. Physical - Patterson v. Hughes, 11 F.3d 948 (9th Cir. 1993). Insurer must evaluate the impact any physical symptom or condition has on a claim for disability when a policy has a mental and nervous limitation.

Washington does not tax sick pay.

Offset for Other Income Benefits/Personal Injury Protection Coverage - RCWA 48.22.085; 48.22.095; 48.22.005. Automobile liability insurer must offer minimum personal injury protection coverage which includes income continuation benefits. These benefits can amount to 85% of the insured's loss of income from work. The insured can reject, in writing, personal injury protection coverage.

Late Notice/Prejudice Rule - Spangler v. INA, 562 P.2d 635 (Wash. 1977); Castle & Cooke, Inc. v. Great American Ins. Co., 711 P.2d 1108 (Wash. Ct.App.1986). Insurer must demonstrate that it was prejudiced due to late filing before claim can be denied due to late filing.

ERISA Claims

Located in the 9th Circuit Federal Court of Appeals.

States: West Virginia

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: WV.Code of State Rules 114-14-2 et seq.; WV.St.Ann. 33-11-4(9).

Adopted law similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 15 days
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: 15 days
- Begin investigation of claim: 15 days
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: 15 days after receipt of proof of loss
- Send follow-up letters that investigation is incompete: 30 days after the date of the initial notification requesting more time
- Accept or deny claim after receipt of proofs of loss: 15 days
- Pay claimant after acceptance of liability: None
- Pay after settlement of claim: 15 days
- Respond to inquiry from the Department of Insurance: 15 days

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Kendall v. Travelers, 45 F.Supp. 956 (N.D.W.V. 1942); State Farm v. Milam, 438 F.Supp. 227 (S.D.W.V. 1977).

ERISA Claims

Located in the 4th Circuit Federal Court of Appeals.

Denial letters must inform the claimant that he/she is entitled to review pertinent documents upon which the decision was made. Ellis v. Metropolitan Life, 126 F.3d 228 (4th Cir.1997).

States: Wisconsin

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Wisc.Adm.Code 6.11; Wisc. St.Ann. 628.46.

Adopted laws similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: 10 days
- Provide necessary claim forms: 10 days
- Respond to communications from claimant: 10 days
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 30 days
- Pay after settlement of claim: 30 days
- Respond to inquiry from the Department of Insurance: None

ERISA & Non-ERISA Claims

Late Notice/Prejudice Rule: Insurers need to demonstrate prejudice before a claim can be denied due to late filing. Wis.St.Ann. 632.26(2); Maryland Casualty v. Wausau Chemical Corp., 809 F.Supp. 680 (W.D.Wis. 1992); Gerrard Realty Corp. v. American States Ins. Co., 277 N.W.2d 863 (Wis. 1979)

ERISA Claims

Located in the 7th Circuit Federal Court of Appeals.

States: Wyoming

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Wy.St.Ann. 26-13-124; 26-18-110; 26-19-107.

Adopted law somewhat similar to NAIC Model; for general provisions see NAIC Unfair Claim Settlement Practices Model Act and Regulations.

Specific Time Restrictions:

- Acknowledge receipt of notification of claim: None
- Provide necessary claim forms: 15 days
- Respond to communications from claimant: None
- Begin investigation of claim: None
- Complete investigation of claim: None
- Notify claimant that more time is needed to review claim: None
- Send follow-up letters that investigation is incomplete: None
- Accept or deny claim after receipt of proofs of loss: None
- Pay claimant after acceptance of liability: 45 days
- Pay after settlement of claim: None
- Respond to inquiry from Department of Insurance: None

ERISA & Non-ERISA Claims

Wyoming does not tax sick pay.

Late Notice/Prejudice Rule: Insurer need not demonstrate prejudice. Phelan v. New Amsterdam Casualty Co., 5 F.Supp. 810 (D.Wy.1984).

ERISA Claims

Located in the 10th Circuit Federal Court of Appeals.

California State Disability

Private Plan Requirements

Statutes in the Unemployment Tax Code set forth the requirements for private disability plans. These plans must be approved by the Unemployment Development Department, in addition to having the forms approved by the Insurance Department.

The private plan must be offered to all present and future employees and not be restricted to segments of employees which are expected to have the lowest claims cost.

A majority of employees must agree in writing and an individual worker may reject the private plan for coverage under the state plan.

Private plans must exceed state requirements in at least one respect.

There is no employer contribution for the state plan, but for private plans employers must contribute .12% of taxable wages to the fund plus a share of the state's administrative cost for private plans.

Date of Enactment, Title, Agency

1946. Unemployment Compensation Disability Benefits. Disability Insurance Branch, Employment Development Department (EDD), 750 N Street, P.O. Box 826880, Sacramento 94280-0001. (916) 654-8198.

Types of Plans Allowed

State plan or approved voluntary (private) plan. All voluntary plans must be approved by the director of EDD and are subject to oversight. Voluntary plan must equal or exceed minimum requirements of statute in at least one respect, and majority of employees must consent in writing. Most employers rely on the state plan. Approved voluntary plan may be insured or self-insured.

Employee Contribution

1% of first $31,767 in 1995; 0.8% of first $31,767 in 1996 and 1997; beginnining 1/1/98, 0.5% of first $31,767. Rates are set annually based on claims experience and the need to ensure fiscal adequacy of the disability fund.

Employer Contribution

None mandated. Employer may contribute toward cost of state or voluntary (private) plan, or pay its entire cost, at employer's option. State plan employer contributions are considered constructive income paid to the employee and are taxable.

Employers Covered

All employers are required to contribute to state unemployment insurance fund; that is, employers who pay more than $100 in wages in any calendar quarter in the current or preceding calendar year and employ one or more employees (except public entities, public school districts, and self-employed individuals who may elect disability insurance coverage). Employers of domestic workers must ensure disability insurance coverage exists if they pay at least $750 in any quarter.

Workers Excluded

In California, many services for nonprofit organizations have been covered for disability insurance since 1972. In 1978, coverage was extended to many domestic workers and employees of nonprofit pre-schools and primary, secondary, and vocational schools. There is a $750 threshold for disability insurance coverage paid to all domestic workers employed by an entity in any calendar quarter of the current or preceding calendar year.

Eligibility, Minimum Earnings

$300 in wages during base period (first four quarters of last five completed quarters in covered employment). Cash tips of $20 or more received from customers by employees in any calendar month during the course of their employment are wages for disability insurance purposes only.

Weekly Benefit Range

$50 minimum; Maximum is calculated as the lesser of base year earnings or 52 times weekly maximum benefit. Scheduled benefits are indexed to quarterly wages.

1/1/78	$146
1/1/80	$154
1/1/82	$175
1/1/84	$224
1/1/90	$266
1/1/91	$336
1/1/94	$336
1/1/95	$336

Duration of Benefits

Benefits may continue for a maximum of 52 weeks per disability, or until base period wage limits are exhausted.

Waiting Period

Seven days nonpayable waiting period.

Partial Weeks

Benefits are paid for each day over seven, usually on the basis of one-seventh of a week.

Disqualifying Other Income

Unemployment insurance or voluntary disability insurance benefits. For temporary disability, UCD pays the difference if Workers' Compensation is less than UCD benefit. For injuries incurred on or after January 1, 1994, when an employee receives or is entitled to receive permanent disability benefits at less than the state disability (SD) benefit weekly rate, the employee is eligible to receive the difference in SD benefits. SD lien recovery is allowed for duplicative periods of SD and permanent disability that result from the same injury or illness. Disability benefits for any seven day week or partial week, when combined with regular wage received from an employer, may not exceed basic weekly wage, exclusive of overtime, paid prior to the commencement of the disability period.

Other Benefits

Benefits are payable while resident in an alcoholic recovery home for a period of 30 days, or while resident in a drug-free residential facility for a maximum of 45 days, if participating in an approved recovery program on referral or recommendation of a physician. Both types of benefits may be paid for an additional period if recommended by the referring physician.

The additional allowable period is 60 days for residents of an alcoholic recovery home and 45 days for a drug-free facility. The total period for which benefits may be paid cannot exceed 90 days. The limitation on the benefits does not apply to disabilities caused by acute or chronic alcoholism, or drug abuse, being medically treated.

The definition of "disability" or "disabled" includes inability to work because of a written order from a state or local health officer to an individual infected with, or suspected of being infected with, a communicable disease.

Successive Periods of Disability

Two consecutive periods of disability due to the same or related cause or condition shall be considered one period of disability if they are separated by a period of not more than 14 days. If separated by more than 14 days, they will be considered as separate periods of disability.

Extension of Benefits

None.

Hawaii State Disability

Date of Enactment, Title, Agency

1969. Temporary Disability Insurance Law. Disability Compensation Division, Department of Labor and Industrial Relations, 830 Punchbowl P.O. Box 3769, Honolulu 96812. (808) 586-9151

Types of Plans Allowed

Private plans, insured or self-insured, or acceptable collectively bargained sick leave plan. No state plan exists. Plan must provide statutory benefits or benefits judged by Disability Compensation Division to be at least the equivalent of statutory benefits. Insured and self-insured are required to have claims offices situated in Hawaii to process claims and pay benefits.

Employee Contribution

Up to 0.5% of wages or 50% of costs, not to exceed $2.97 weekly in 1995; $3.00 weekly in 1996, $3.03 in 1997, $3.07 in 1998; $3.14 in 1999.

Employer Contribution

Employer may pay entire cost, or may withhold employee contributions for one-half the cost, but not to exceed 0.5% of employee's weekly taxable wage and subject to a maximum employee contribution of $3.00 per week in 1996; $3.03 in 1997; $3.07 in 1998; $3.14 in 1999.

Employers Covered

All employers of one or more employees except federal government. Domestic workers are covered if they earn at least $225 per calendar quarter.

Workers Excluded

Hawaii exempt some persons working on a straight commission basis.

Eligibility; Minimum Earnings

Effective December 31, 1999: $400 in wages during the 52 weeks immediately preceding the first day of disability, with 14 weeks in covered employment (not necessarily consecutive or with only one employer), 20 hours or more of paid work in each week.

Weekly Benefit Range

If employee's average weekly wage is less than $26, benefit is equal to the average weekly wage but not more than $14. If average weekly wage is $26 or more, benefit is 58% of average weekly wage, subject to a maximum recalculated annually.

1/1/91	$274
1/1/92	$291
7/1/92	$307
1/1/93	$323
1/1/94	$338
1/1/95	$345.00
1/1/96	$348.00

1/1/97	$352.00
1/1/98	$357.00
1/1/99	$365.00

Duration of Benefits

Benefits may last for 26 weeks per benefit year.

Waiting Period

Seven days.

Partial Weeks

Benefits for partial weeks are based on the number of days the employee worked. If the employee worked five days a week and was disabled for one day beyond the seven-day waiting period, the benefit would be one-fifth of the weekly benefit rate.

Disqualifying Other Income

Workers' Compensation, unemployment insurance benefits, and any other payments or awards (except employee's own income replacement plan, if any).

New Jersey State Disability

Date of Enactment, Title, Agency

1948. Temporary Disability Benefits Law. Department of Labor, Division of Temporary Disability Insurance, P.O. Box 387, Trenton 08625-0387. (609) 292-2700.

Types of Plans Allowed

State plan or private plan, insured or self-insured. Private plan must be as liberal as state plan in eligibility requirements, benefit amounts, and duration. If employee contributions are required, majority of employees must consent to plan in writing and contribution levels may not exceed those of state plan. Private plan may exclude certain classes of employees, but not on basis of sex, age, race, or wages paid, and not in a manner resulting in adverse selection to state plan.

Workers not covered by private plan are automatically covered under the state plan.

Employee Contribution

0.5% of first $17,500 in 1996; $18,000 in 1996; $18,600 in 1997; $19,300 in 1998. Maximum individual disability insurance deduction in 1998 is $96.50.

Employer Contribution

New employees have the same start-up role as the employee contribution: 0.5% of the taxable wage base on the first $19,300 of each employee's earnings during 1998. However, based on employer's benefit experience and condition of State Disability Benefits Fund, the future rate could vary.

Employers Covered

All employers of one or more employees with minimum annual payroll of $1,000; program is optional for governmental entities.

Workers Excluded

New Jersey exclude from coverage those whose religious beliefs lead them to rely on prayer for healing; exempt some persons working on a straight commission basis; unemployed persons are covered only if eligible for unemployment insurance.

Eligibility, Minimum Earnings

$128 in 1996, $133 in 1997, $138 in 1998, and $144 in 1999 in each 20 weeks of covered employment; or earnings of $7.700 in 1996, $8,000 in 1997, $8,300 in 1998, and $8700 or more in 1999 in 52 weeks preceding the disability.

Weekly Benefit Range

Two-thirds of average weekly wage. Average weekly wage is based on earnings in the eight calendar weeks preceding disability. (Maximum recalculated annually.)

1/1/81	$133
1/1/82	$145
1/1/83	$158

1/1/84	$170
10/1/84	$180
1/1/85	$189
1/1/86	$200
1/1/87	$213
1/1/88	$226
1/1/89	$241
1/1/90	$261
1/1/91	$272
1/1/92	$288
1/1/93	$304
1/1/94	$325
1/1/95	$331
1/1/96	$339
1/1/97	$350
1/1/98	$364
1/1/99	$381

Duration of Benefits

Benefits end when the lesser of one-third of base pay during the year preceding the disability or 26 weeks is reached during period of disability.

Waiting Period

Seven days, but payment may be issued for that period retroactively if the individual is otherwise eligible during that period and is eligible for benefits in each of the three consecutive weeks immediately following the waiting week.

Partial Weeks

Benefits are paid for each day over seven, usually on the basis of one-seventh of a week.

Disqualifying Other Income

Unemployment compensation or any other state or federal disability benefits; income for work performed during period of disability is a disqualification for benefits on a day for day basis; TDI benefits may be reduced so that the sum of the benefits and any employer-paid benefits (sick leave, vacation pay, etc.) do not exceed the claimant's regular pay; pension benefits to which the last employer contributed will reduce the benefit amount on a dollar-for-dollar basis.

New York State Disability

DBL is considered part of Workers' Compensation Insurance and is administered by the state's Workers' Compensation Board.

Date of Enactment, Title, Agency

1949. Disability Benefits Law. Disability Benefits Bureau, Workers' Compensation Board, 180 Livingston Street, Brooklyn, 11248-0005. (718) 802-6964.

Types of Plans Allowed

State insurance fund or private plan, insured or self-insured. Private plan must provide benefits determined to be at least as favorable as the statutory requirement. (Automatic approval given to "standard" plans offered by a number of carriers. Most employers self-insure or use an insurance carrier.)

Up to June 30, 1989, state law allowed for a minimum cash benefit of 60%; the remaining 40% of benefit could be in the form of hospital, medical, or other added benefits (e.g., elimination of waiting period, extended benefit duration). Effective July 1, 1989, the plan must pay at least the statutory requirement. Special Fund for Disability Benefits pays statutory benefits to persons who are unemployed for more than four weeks and who were claiming or receiving unemployment benefits immediately prior to disability.

Employee Contribution

0.5% of wages; 60 cents weekly maximum; employers pay balance.

Employer Contribution

Balance of cost for "standard" plans; share of state's administrative costs.

Employers Covered

All employers who have employed one or more employees for at least 30 days in a calendar year. An employer becomes a "covered" employer four weeks after the 30th day of such employment; employer liability continued for four weeks after an employee's termination of employment. Domestic employees working at least 40 hours per week in a private home for one employer are covered.

Workers Excluded

Although most jurisdictions exclude students from coverage, New York excludes only daytime students in elementary or secondary schools who work during the regular school year or their regular vacation period. Unemployed persons are covered only if eligible for unemployment insurance.

Eligibility, Minimum Earnings

Four weeks in full-time covered employment or 25 days in part-time covered employment. Unemployed must meet requirements for unemployment insurance.

Weekly Benefit Range

50% of weekly wage for disabilities that commence on or after July 1, 1989; the maximum statutory benefit rate is $170. The minimum benefit is $20.

Duration of Benefits

Benefits continue for as long as 26 weeks in any 52 week period.

Waiting Period

Seven days maximum for illness or injury. Unemployed persons who become disabled between 4 and 26 weeks after termination of employment, and who are receiving unemployment compensation, receive disability benefits commencing with the first day of disability that disqualifies them for unemployment compensation.

Partial Weeks

Benefits for partial weeks are based on the number of days the employee worked. If the employee worked five days a week and was disabled for one day beyond the seven-day waiting period, the benefit would be one-fifth of the weekly benefit rate.

Disqualifying Other Income

Workers' Compensation, unemployment compensation, or any sick pay. In addition, an employee is not entitled to benefits for any day he receives his regular renumeration.

Puerto Rico State Disability

Date of Enactment, Title, Agency

1968. Disability Benefit Act. Department of Labor and Human Resources, Bureau of Employment Security, Prudencio Rivera Martinez Building, 505 Munoz Rivera Avenue, Hato Rey 00918. (787) 754-2142.

Types of Plans Allowed

State plan or private plan, insured or self-insured. Management and majority of employees must agree on plan. Private plan must be as liberal as state plan in eligibility requirements, benefit amounts, and duration. Contribution levels may not exceed those of state plan. Mix of employees must be "reasonable."

Employee Contributions

Up to 0.6% (of 1%) of first $9,000 in wages.

Employer Contributions

Same as employee contribution: 0.6% of first $9,000 of each employee's annual earnings. Employer is responsible for premium payments to the Department of Labor or a private plan.

Employers Covered

Any employer who, during 30 days of the current or preceding calendar year, has had one or more employees.

Eligibility, Minimum Earnings

$180 in wages during base year (in any one of the first four of last five consecutive calendar quarters immediately preceding date on which application for benefits is filed).

Weekly Benefit Range

65% of weekly earnings. Minimum $12 per week on base annual income of $150. Maximums: $113 for non-agricultural workers; $55 for agricultural workers. Additional benefits are given in cases of death or dismemberment.

Duration of Benefits

Benefits may continue for as long as 26 weeks. Vacation pay and sick leave payments are excluded from the maximum.

Waiting Period

7 day waiting period, with benefits starting on first day of hospitalization. No waiting period for certain unemployed persons nor for maternity claims.

Partial Weeks

Benefits are paid for each day over seven, usually on the basis of one-seventh of a week.

Disqualifying other Income

Pension or retirement income if received after the beginning of the disability period and the person has not work 15 or more weeks; and employer-related income during the disability period.

Other Benefits

Death benefit of $4,000 is payable for persons who "die suddenly" from cause of disability for which benefits are being paid, or within 52 weeks from commencement of covered disability. Act also provides certain dismemberment benefits, ranging from $2,000 to $4,000.

Rhode Island State Disability

Date of Enactment, Title, Agency

1942. Temporary Disability Insurance Act. Temporary Disability Insurance Division, Department of Employment & Training, 101 Friendship St., Providence 02903. (401) 222-3625.

Types of Plans Allowed

No private plans allowed unless supplementary to state plan.

Employee Contribution

1.1% of first $38,000 of earned income in 1996; 1.2% of first $38,000 in 1997; 1.2% of the first $38,000 in 1998; 1.2% of the first $38,600 in 1999.

Employer Contribution

None mandated.

Employers Covered

All private employers, including employers of domestic workers who earn more than $1,000 per calendar quarter. Program is optional for local governments; federal and state governments are exempt. Sole proprietors also are exempt.

Workers Excluded

Rhode Island excludes from coverage those whose religious beliefs lead them to rely on prayer for healing. Students are covered with the exception of minors of 14 and 15 years of age.

Eligibility, Minimum Earnings

$6,780 in base period (base period is the first four of the last five calendar quarters immediately preceding the claim); or at least $1,130 in one of the base quarters, and total base period wages of at least 1-1/2 times the highest quarter earnings, and total base period wages of at least $2,260.

Weekly Benefit Range

Maximum at 85% of state-wide weekly wage recalculated annually until 4.62% of wages in base period quarter with highest wages. Additional 7% of individual's benefit rate for each dependent child under age 18 for up to five children.

7/1/92	$374	7/1/96	$428	7/1/00	$504
7/1/93	$394	7/6/97	$441		
7/1/94	$403	7/1/98	$463		
7/1/95	$413	7/1/99	$487		

Duration of Benefits

Benefits continue for 30-week maximum.

Waiting Period

Seven days, but payment can be made for that period after 28 days of unemployment due to disability. Waives the waiting period if the individual goes from unemployment insurance directly to TDI.

Partial Weeks

A "lag payment" of one-fifth of the weekly benefit rate is paid for each day of a partial calendar week at the beginning or termination of a disability.

Disqualifying Other Income

Workers' Compensation. No reduction in benefits for any wage continuation from employer.

Unfair Claims Regulations: California

10 CA ADC s 2695.1
10 CCR s 2695.1
Cal. Admin. Code tit. 10, s 2695.1

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s 2695.1. Preamble.

(a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices which, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Commissioner has promulgated these regulations in order to accomplish the following objectives:
(1) To delineate certain minimum standards for the settlement of claims which when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);
(2) To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;
(3) To discourage and monitor the presentation to insurers of false or fraudulent claims; and,
(4) To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices; other methods, act(s), or practices not specifically delineated in this set of regulations may also be a violation of California Insurance Code Section 790.03(h) pursuant to the provisions of California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of claims brought under all classes of insurance except as specifically provided below:
(1) Workers' compensation insurance;
(2) Liability insurance for the professional malpractice of health care providers as defined in California Code of Civil Procedure Section 364(f)(1);
(3) Self insured or self funded plans which are bona fide Employee Retirement Income Security Act ("ERISA") plans which are not also multiple employer welfare arrangements, to the extent that these ERISA plans are not covered by insurance;
(4) Any other self funded or self insured plan, to the extent it is not covered by insurance, which is lawfully conducting business in this state.

(c) These regulations recognize the unique relationship which exists under a surety bond between the insurer, the obligee or beneficiary, and the principal. In contrast to other classes of insurance, surety insurance involves a promise to answer for the debt, default or miscarriage of a principal who has the primary duty to pay the debt or discharge the obligation and who is bound to indemnify the insurer. Therefore, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.
(d) These regulations shall not apply to the handling or settlement of claims brought under Workers' Compensation insurance policies.
(e) All licensees, as defined in this regulations, shall have thorough knowledge of the regulations contained in this subchapter.

Note: Authority cited: Sections 790.10, 1871.1, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

History

1. New subchapter 7.5 (sections 2695.1-2695.17) filed 12-15-92; operative 1-14- 93 (Register 92, No. 52).
2. Editorial correction of printing error in History 1. (Register 93, No. 4).
3. Amendment of subchapter heading and subsection (b), new subsections (b)(1)- (b)(4), repealer and new subsection (c), amendment of subsection (d), repealer of subsection (e) and subsection relettering filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

10 CA ADC s 2695.2
10 CCR s 2695.2
Cal. Admin. Code tit. 10, s 2695.2

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s 2695.2. Definitions.

As used in these regulations:

(a) "Beneficiary" means:
(1) for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured; or,
(2) for the purpose of surety claims, a person who is within the class of persons intended to be benefitted by the bond;

(b) "Calendar days" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "Claimant" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.

(d) "Claims agent" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:
1) an attorney retained by an insurer to defend a claim brought against an insured; or,
2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim.

(e) "Extraordinary circumstances" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "First party claimant" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "Gross settlement amount" means the amount of the draft tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "Insurance agent" means:

(1) the term "insurance agent" as used in section 31 of the California Insurance Code; or,
(2) the term "life agent" as used in section 32 of the California Insurance Code; or,
(3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,
(4) an underwritten title company.

(i) "Insurer" means a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non- profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article 4.7 of the Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term insurer, for purposes of these regulations includes non- admitted insurers, the California FAIR Plan, and those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, and shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers;

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond". For the purposes of these regulations the term insurance policy or policy includes any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk or the California FAIR plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of damages afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(l) "Knowingly committed" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) "Licensee" means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in the State of California or with California residents. The term "licensee" for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company is not authorized to handle policy claims on behalf of the title insurer.

(n) "Notice of claim" means any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen. For purposes of these regulations the term "notice of claim" shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.

(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "Proof of claim" means any documentation in the claimant's possession submitted to the insurer which provides any evidence of the claim and that supports the magnitude or the amount of the claimed loss.

(t) "Remedial measures" means those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:
(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;
(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;
(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "Replacement crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) "Surety bond" or "bond" means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "Third party claimant" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage.

Note: Authority cited: Sections 132(d), 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 31, 32, 101, 106, 675.5(b), (c) and (d), 676.6, 790.03(h) and 10082, Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

10 CA ADC s 2695.3
10 CCR s 2695.3
Cal. Admin. Code tit. 10, s 2695.3

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s 2695.3. File and Record Documentation.

(a) Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined;

(b) To assist in such examination all insurers shall:
(1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment; this data must be available for all open and closed files for the current year and the four preceding years;

(2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and
(3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.
(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

Note: Authority cited: Sections 710.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment of subsections (b)(1) and (b)(2) filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

<<(Chapter Originally Printed 5-15-46)>>
10 CA ADC s 2695.3
END OF DOCUMENT

10 CA ADC s 2695.4
10 CCR s 2695.4
Cal. Admin. Code tit. 10, s 2695.4

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s 2695.4. Representation of Policy Provisions and Benefits.

a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

(b) No insurer shall conceal benefits, coverages or other provisions of the bond which may apply to the claim presented under a surety bond.

(c) No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file (1) of demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

(e) No insurer shall:
(1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release the legal effect of the release is disclosed and fully explained by the insurer to the

claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;
(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542, provided that prior to execution of the release the legal effect of the release is disclosed and fully explained by insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim that contain or are accompanied by language releasing the insurer, the insured, or the principal on a surety bond from total liability unless the policy or bond limit has been paid, or there has been a compromise settlement agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or bond.

Note: Authority cited: Sections 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(1),(3) and (4), Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment of section heading and subsection (a), repealer and new subsection (b), repealer of subsection (f) and subsection relettering filed 1- 10-97; operative 5-10-97 (Register 97, No. 2).

<<(Chapter Originally Printed 5-15-46)>>
10 CA ADC s 2695.4
END OF DOCUMENT

10 CA ADC s 2695.5
10 CCR s 2695.5
Cal. Admin. Code tit. 10, s 2695.5

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s 2695.5. Duties upon Receipt of Communications.

(a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

(b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be

revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer. Failure of the licensee or claims agent to immediately transmit notice of claim to the insurer shall constitute a separate and distinct violation of California Insurance Code Section 790.03(h)(3) and this subsection, where the insurer has provided the appointed licensee or claims agent with written instructions as to the proper handling of a notice of claim. Transmission of the notice of claim by the licensee or claims agent to the insurer in conformity with the written instructions received from the insurer shall satisfy the licensee's or claims agent's duty under this section to promptly transmit the notice to the insurer.

(e) Upon receiving notice of claim, every insurer, except as specified in subsection 2695.5(e)(4) below, shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:
(1) acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.
(2) provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;
(3) begin any necessary investigation of the claim.
(4) Subsection 2695.5(e) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code or life insurance subject to Section 10172.5 of the Insurance Code.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

Note: Authority cited: Sections 790.10, 12340-12417, inclusive, 12921, 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(2) and (3), Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

<<(Chapter Originally Printed 5-15-46)>>
10 CA ADC s 2695.5
END OF DOCUMENT

10 CA ADC s 2695.6
10 CCR s 2695.6
Cal. Admin. Code tit. 10, s 2695.6

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s 2695.6. Training and Certification.

(a) Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims, and shall do so within ninety (90) days after the effective date of these regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding the regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys. A licensee shall demonstrate compliance with this subsection by the following methods:
(1) where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands the regulations and any and all amendments thereto;
(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:
(A) that the licensee's claims adjusting manual contains a copy of these regulations and all amendments thereto; and,
(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;
(3) where the licensee retains independent adjusters, the licensee must provide training to the independent adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the independent adjuster may annually certify in writing, under penalty of perjury, on an annual basis, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;
(4) a copy of the certification required by subsections 2695.6(b)(1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.
(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.

Note: Authority cited: Sections 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h)(3), Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

<<(Chapter Originally Printed 5-15-46)>>
10 CA ADC s 2695.6
END OF DOCUMENT

10 CA ADC s 2695.7
10 CCR s 2695.7
Cal. Admin. Code tit. 10, s 2695.7

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s 2695.7. Standards for Prompt, Fair and Equitable Settlements.

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part.
(1) Where an insurer denies or rejects a first party claim in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific policy provision, condition or exclusion, the written denial shall include reference

thereto and provide an explanation of the application of the provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim in whole or in part, or disputes liability or damages shall do so in writing.
(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.
(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.
(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code, life insurance subject to Section 10172.5 of the Insurance Code, or mortgage guaranty insurance subject to Section 12640.09(a) of the Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the Insurance Code.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, then, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.
(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) No insurer shall persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a timely claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low;
(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;
(2) the extent to which the insurer considered evidence made known to it or reasonably available;
(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;
(5) the procedures used by the insurer in determining the dollar amount of property damage;
(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;
(7) any other credible evidence presented to the Commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment of the amount of the claim which has been determined and is not disputed by the insurer. In claims where multiple coverage is involved, payments which are not in dispute and where the payee is known shall be tendered immediately, but in no event in more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. This subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.
(1) Subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code, of life insurance subject to Section 10172.5 of the Insurance Code, of mortgage guaranty insurance subject to Section 12640.09(a) of the Insurance Code, or of fire insurance subject to Section 2057 of the Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the Insurance Code.
(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Insurance Code Sections 1871.1(a) and 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:
(1) increased to eighty (80) calendar days; or,
(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision to pay medical benefits shall do so only when the insurer has a good faith belief that such an examination is necessary to enable the insurer to determine the reasonableness and/or necessity of any medical treatment.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

Note: Authority cited: Sections 553, 554, 790.10, 11580.2(k), 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2, 11152 and 1861.03(a), Government Code; McLaughlin v. Connecticut General Life Ins. Co. , 565 F.Supp. 434 (N.D.Cal. 1983). Reference: Section 790.03(h)(2), (3), (4), (5), (13) and(15), 1871.1, and 1872.4, Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment of section heading, section and Note filed 1-10-97; operative 5- 10-97 (Register 97, No. 2).

<<(Chapter Originally Printed 5-15-46)>>
10 CA ADC s 2695.7
END OF DOCUMENT

10 CA ADC s 2695.11
10 CCR s 2695.11
Cal. Admin. Code tit. 10, s 2695.11

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
Title 10. Investment
Part 2. Establishment of Agency or Branch Office
Chapter 5. Insurance Commissioner
Subchapter 7.5. Fair Claims Settlement Practices Regulations

s 2695.11. Additional Standards Applicable to Life and Disability Insurance Claims.

(a) No insurer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:
(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting such withholding procedure, or
(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:
(A) The overpayment was erroneous under the provisions of the policy.
(B) The error which resulted in the payment is not a mistake of the law.
(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.
(D) Such notice states clearly the cause of the error and states the amount of the overpayment.
(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

Note: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(1), (2), (3), (5), and (13), Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Repealer of former section 2695.11 and renumbering and amendment of former section 2695.12 to new section 2695.11 filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

<<(Chapter Originally Printed 5-15-46)>>
10 CA ADC s 2695.11
END OF DOCUMENT

10 CA ADC s 2695.12
10 CCR s 2695.12
Cal. Admin. Code tit. 10, s 2695.12

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
Title 10. Investment
Part 2. Establishment of Agency or Branch Office
Subpart 7. Withdrawal and Release of Eligible Assets -Blanket Approval
Chapter 5. Insurance Commissioner
Subchapter 7.5. Fair Claims Settlement Practices Regulations

s 2695.12. Noncompliance and Penalties.

(a) A licensee has knowingly committed an act or acts in noncompliance with this subchapter under the following circumstances including, but not limited to:
(1) where the licensee has promulgated express policies or procedures that are in noncompliance with this subchapter; or
(2) where the act(s) in noncompliance with this subchapter are committed by an employee or claims agent of a licensee and the licensee through its management, either:
(A) gives prior approval of the act(s); or,
(B) subsequently ratifies the propriety of the act(s); or,
(3) where the act(s) are committed by an employee or claims agent of a licensee, and it is established that:
(A) the licensee has failed to adopt, communicate and implement standards for the prompt, fair and reasonable investigation and settlement of claims in accordance with this subchapter or assure that such standards are consistently being met; or,
(B) the licensee's management was aware of facts which did apprise or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures.

(b) In determining noncompliance with this subchapter and appropriate penalties, if any, the Commissioner shall consider admissible evidence on the following:
(1) the existence of extraordinary circumstances;
(2) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the Insurance Code;
(3) the complexity of the claims involved;
(4) gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred;
(5) substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;
(6) secreting of property which has been claimed as lost or destroyed.
(7) the relative number of claims where the noncomplying act(s) are found to exist, as contrasted to the total number of claims handled by the licensee during the relevant time period;
(8) whether the licensee has taken remedial measures with respect to the noncomplying act(s);
(9) the existence or nonexistence of previous violations by the licensee;
(10) the degree of harm occasioned by the noncompliance; and
(11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter.
(12) Frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter.

(c) The Commissioner shall not consider reasonable mistakes or opinions as to valuation of property, losses or damages when determining the licensee's non- compliance with this subchapter or penalties to be assessed.

Note: Authority cited: Sections 790.035, 790.07, 790.08, 790.09, 790.10, 1872.4, 12340-12417, inclusive, 12921, 1065, 704, 780-784, 1011, 11690, 12926 and 12928.6, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h),
790.035(a), 790.04, 790.05, 790.06, 790.08 and 790.10, Insurance Code.

History

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Renumbering and amendment of former section 2695.12 to new section 2695.11, and renumbering and amendment of former section 2695.14 to new section 2695.12, including amendment of section heading and Note, filed 1-10-97; operative 5-10- 97 (Register 97, No. 2).

<<(Chapter Originally Printed 5-15-46)>>
10 CA ADC s 2695.12
END OF DOCUMENT

NAIC Unfair Claims Settlement Practices Model Act

Purpose

The National Association of Insurance Commissioners have drafted model laws for legislative bodies of U.S. states to adopt, if desired. Most states have adopted some or parts of the Model Act. The purpose of this Model Act is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance.

Definitions

When used in this Act:

"Commissioner" means the Commissioner of Insurance of this state; Drafting Note: Insert the title of the chief insurance regulatory official whereever the term "commissioner" appears.

"Insured" means a person, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and third party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance.

"Person" means a natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations.

"Policy" or "certificate" means a contract of insurance, indemnity, medical, health or hospital service, or annuity issued. "Policy" or "certificate" for purposes of this Act, shall not mean contracts of workers compensation, fidelity, suretyship or boiler and machinery insurance.

Unfair Claims Settlement

It is an improper claims practice for a domestic, foreign or alien insurer transacting business in this state to commit an act defined in Section 4 of this Act if:

Practices Prohibited

It is committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder; or

It has been committed with such frequency to Indicate a general business practice to engage in that type of conduct.

Unfair Claims Practices Defined

Any of the following acts by an insurer, if committed, constitutes an unfair claims practice:

Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

Refusing to pay claims without conducting a reasonable investigation;

Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;

Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;

Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;

Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions;

Failing to provide forms necessary to present claims within calendar days of a request with reasonable explanations regarding their use;

Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner.

NAIC Unfair Claims Settlement Practices Model Regulations

Purpose

The National Association of Insurance Commissioners have drafted model regulations for Insurance Departments of the U.S. states to enact, if desired. Most states have adopted some or all of the model regulations. Refer to specific states for actual claim handling deadlines. The purpose of the regulations is to set forth minimum standards for the investigation and disposition of life, accident and health claims arising under policies or certificates issued pursuant to State law.

Definitions

All definitions contained in the Unfair Claims Settlement Practices Act (or Unfair Trade Practices Model Act) are hereby incorporated by reference. As otherwise used in this regulation:

"Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

"Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured;

"Claim file" means any retrievable electronic file, paper file or combination of both;

"Claimant" means an insured, the beneficiary or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy;

"Days" means calendar days;

"Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim.

"Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

"Limited insurance representative" means an individual, partnership or corporation who is authorized by the Commissioner to solicit or negotiate certificates or policies for a particular line of insurance which the Commissioner may by regulation deem essential for the transaction of business in this State and which does not require the professional competency demanded for an insurance agent's or broker's license.

"Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

"Proof of loss" means written proofs, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of all insureds or beneficiaries submitting the claims;

"Reasonable explanation" means information sufficient to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made;

"Written communications" includes all correspondence, regardless of source or type, that is materially related to the handling of the claim.

Claim Practices

Every insurer, upon receiving due notification of a claim shall, within XX days of the notification, provide necessary claim forms, instructions and reasonable assistance so the insured can properly comply with company requirements for filing a claim.

Upon receipt of proof of loss from a claimant, the insurer shall begin any necessary investigation of the claim within XX days.

The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.

The insurer shall affirm or deny liability on claims within a reasonable time and shall offer payment within XX days of affirmation of liability if the amount of the claim is determined and not in dispute. If portion(s) of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within XX days.

With each claim payment, the insurer shall provide to the insured an Explanation of Benefits that shall include the name of the provider or services covered, dates of service, and a reasonable explanation of the computation of benefits.

An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification unless such penalty is specifically and clearly set forth in the policy.

If a claim remains unresolved for XX days from the date proof of loss is received, the insurer shall provide the insured or, when applicable, the insured's beneficiary, with a reasonable written explanation for the delay. In credit, mortgage and assigned accident/health claims, the notice shall be provided to the debtor/insured or medical provider in addition to the insured. If the investigation remains incomplete, the insurer shall, XX days from the date of initial notification and every XX days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

The insurer shall acknowledge and respond within XX days to any written communications relating to a pending claim.

When a claim is denied, written notice of denial shall be sent to the claimant within XX days of the determination. The insurer shall reference the policy provision, condition or exclusion upon which the denial is based.

No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

Insurers offering cash settlements of first party long-term disability income claims, except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability, shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rate assumptions, etc. appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by him/her at the time a settlement is entered into.

No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been

a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy.

No insurer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:

1. The insurer has in its files clear, documented evidence of an overpayment and written authorization from the insured permitting such withholding procedure, or
2. The insurer has in its files clear, documented evidence that:

- The overpayment was clearly erroneous under under the provisions of the policy and if the overpayment is not the subject of a reasonable dispute as to facts.
- The error that resulted in the payment is not a mistake of the law.
- The insurer has notified the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or their parties, the insurer notified the insured within XX days after the date of the evidence of discovery of such error is included in its file. For the purpose of this rule, the date of the error shall be the day on which the draft for benefits is issued.
- Such notice stated clearly the nature of the error and the amount of the overpayment.

3. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he/she may have the matter reviewed by the Department of Insurance.

File & Record Documentation

Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by his/her duly appointed designees. To aid in such examination:

The insurer shall maintain claim data that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This date shall be available for all open and closed files for the current year and the two (2) preceding years.

Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

Each document within the claim file shall be noted as to date received, date processed or date mailed.

For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT) or micrographics and be capable of duplication to hard copy.

NY Unfair Claims Settlement Practices Law

1. NY Circular Letter 1991-11 (September 5, 1991)
2. NY Circular Letter No. 1996-15 (October 16, 1996)
3. McKinney's Insurance Law Ch. 28, Art. 26
4. McKinney's Insurance Law Ch. 28, Art. 26, Refs & Annos
5. Unfair Claims Settlement Practices and Claim Cost Control Measures

NY Circular Letter 1991-11
NY Circular Letter No. 1991-11 (September 5, 1991)

This document supplements1989-5
This document is supplemented by1996-15

NEW YORK INSURANCE BULLETINS AND RELATED MATERIALS
CIRCULAR LETTERS
Circular Letter 1991-11
September 5, 1991

TO: All Insurers and Risk Retention Groups Doing Business in New York State
FROM: Salvatore R. Curiale
Superintendent of Insurance
DATE: September 5, 1991
RE: SCOPE OF REGULATION 64 ON CLAIMS SETTLEMENT PRACTICES

Regulation No. 64 (11 NYCRR 216) establishes minimum standards for claims- handling practices. These standards, if violated without just cause and with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices pursuant to Article 26 of the Insurance Law. When settling claims, insurers are expected to adhere to all pertinent Regulation 64 standards.

It has come to the Department's attention that there may be confusion on the part of some insurers concerning the kinds of insurance to which Regulation 64 applies. Several sections of the Regulation, in defining minimum standards for prompt, fair and equitable settlements, pertain only to motor vehicle property damage liability and physical damage claims, including verification and reporting requirements.

The other sections of Regulation 64 apply to all lines of business except those specifically exempted by s 216.2: workers' compensation, credit, title, inland marine (unless subject to the provisions of s 3425 of the Insurance Law), and ocean marine insurance. In addition:
subdivisions (a) and (b) of s 216.6 do not apply to life insurance;
subdivision (b) of s 216.6 does not apply to accident and health insurance; and
ss 216.4 and 216.5 and subdivision (c) of s 216.6 do not apply to accident and health insurance (where the claimant is not a policyholder, certificate holder under a group insurance policy, or relative or member of the household of such policyholder or certificate holder).

Thus, subject to the above parameters, sections in Regulation 64 that apply to all lines of insurance include:
s 216.0--Preamble
s 216.1--Definitions
s 216.3--Misrepresentation of Policy Provisions
s 216.4--Failure to Acknowledge Pertinent Communications
s 216.5--Standards For Prompt Investigation of Claims
s 216.6--Standards For Prompt, Fair and Equitable Settlements
s 216.9--Written Notice to Claimants of Payment of Claim in Third-party Settlements

s 216.11-Examinations

While a number of market conduct investigations into insurer claim practices have focused upon auto insurance, emphasis in the future will also be placed on determining compliance with minimum claims settlement standards in regard to other applicable lines of business. Appropriate actions, as outlined-in annexed Circular Letter No. 5 (1989), will continue to be taken in all instances where market conduct investigations reveal unfair claims settlement practices.

The executive in charge of claims should send written acknowledgement of this Circular Letter, no later than September 20, 1991, to:

David Holstein
Supervising Insurance Examiner
Market Conduct Unit
Property & Casualty Insurance Bureau
New York State Insurance Department
160 West Broadway
New York, New York 10013-3393.

NY Circular Letter 1991-11

END OF DOCUMENT

END OF DOCUMENT

NY Circular Letter 1996-15
NY Circular Letter No. 1996-15 (October 16, 1996)
This document supplements1991-11

NEW YORK INSURANCE BULLETINS AND RELATED MATERIALS
CIRCULAR LETTERS
Circular Letter.1996-15
October 16, 1996

TO: All Authorized Property Insurers Writing Business in New York State
FROM: Stewart Keir
Assistant Deputy Superintendent and Chief--Property/Casualty Insurance Bureau
DATE: October 16, 1996

RE: INSURANCE COVERAGE FOR LOSSES RESULTING FROM FLOODS

Insurance coverage for losses resulting from floods is for the most part not covered under any property insurance policy whether it be on the home or business. In 1968 the National Flood Insurance Program (NFIP) was created specifically to provide financial security for both home and business owners in flood prone areas.

The NFIP provides affordable, easily obtainable flood insurance for residents and property owners who are located in areas designated by the Federal government as a special flood hazard community which implements and enforces measures to reduce future flood risks. The majority of New York State towns, villages and cities are participants in the NFIP. This program allows insureds to purchase insurance that will protect their property against direct loss by flood, loss resulting from flood-related erosion, and damage caused by mudslide. Coverage can be obtained up to $185,000 for a single family dwelling and up to $200,000 for a non-residential building. Contents coverage can be obtained on a residential structure for up to $60,000 and on a small business up to $300,000.

Property owners can obtain flood insurance directly through the Federal Insurance Administration or through private insurance companies who participate in the "Write Your Own" program allowed under federal regulation. This program was started in 1981 by the Federal Insurance Administrator to reinvolve the private sector insurance companies in the flood program. This program allows the private insurer to directly write a flood policy and be reimbursed by the federal government for claims and expenses which exceed the premiums they receive from policyholders.

Section 2601-NYIL and Regulation 64, in part, prohibits insurers doing business in this State from engaging in unfair claims settlement practices and provides that, if any insurer performs any of the acts or practices proscribed by that section without just cause and with such frequency as to indicate a general business practice, then those acts shall constitute unfair claims settlement practices, subject to Departmental disiplinary actions, as warranted.

The purpose of this Circular Letter is to direct your attention once again to Circular Letter No. 11 (1991) "Scope of Regulation 64 on Claims Settlement Practices" (attached) [FN1] and to advise that flood insurance policies written under the "Write Your Own Program" are subject to the claims paying practices provisions of Section 2601 and Regulation 64.

Kindly acknowledge receipt of this Circular Letter to:
David Holstein
Supervising Insurance Examiner
New York State Insurance Department
160 West Broadway
Property/Casualty Bureau, 13th floor
New York, NY 10013
(212) 602-8745

NY Circular Letter 1996-15

END OF DOCUMENT

NY INS s 2601
McKinney's Insurance Law s 2601
TEXT

McKinney's Consolidated Laws Of New York Annotated Insurance Law

Chapter 28 Of The Consolidated Laws
Article 26--Unfair Claim Settlement Practices; Other Misconduct; Discrimination

Current through L.1999, ch. 659

s 2601. Unfair claim settlement practices; penalties

(a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:

(1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;

(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear, except where there is a reasonable basis supported by specific information available for review by the department that the claimant has caused the loss to occur by arson. After receiving a properly executed proof of loss, the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days;

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; or

(6) failing to promptly disclose coverage pursuant to subparagraph (A) of paragraph two of subsection (f) of section three thousand four hundred twenty of this chapter.

(b) Evidence as to numbers and types of complaints to the department against an insurer and as to the department's complaint experience with other insurers writing similar lines of insurance shall be admissible in evidence in any administrative or judicial proceeding under this section or article twenty-four or seventy-four of this chapter, but no insurer shall be deemed in violation of this section solely by reason of the numbers and types of such complaints.

(c) If it is found, after notice and an opportunity to be heard, that an insurer has violated this section, each instance of noncompliance with subsection (a) hereof may be treated as a separate violation of this section for purposes of ordering a monetary penalty pursuant to subsection (b) of section one hundred nine of this chapter. A violation of this section shall not be a misdemeanor.

CREDIT
CREDIT(S)
1999-2000 Electronic Pocket Part Update
(As amended L.1997, c. 547, s 1, eff. Jan. 8, 1998.)
<General Materials (GM) - References, Annotations, or Tables>

HISTORICAL AND STATUTORY NOTES
HISTORICAL NOTES -- HISTORICAL AND STATUTORY NOTES
1999-2000 Electronic Pocket Part Update
1997 Legislation
L.1997, c. 547 amendment:
Subsec. (a), par. (6). L.1997, c. 547, s 1 added the paragraph.
1985 Main Volume
Derivation. L.1939, c. 882, s 40-d, added L.1970, c. 296, s 1; amended L.1981, c. 711, s4.

LEGISLATIVE HISTORIES
L.1997, c. 547: For Legislative, Executive or Judicial memorandum relating to this law, see the

Table of Contents in McKinney's 1997 Session Laws of New York.

CROSS REFERENCES
Fire insurance; appraisal of loss; procedure for selection of umpire on failure to agree, see Insurance Law s 3408.
Notice of claim
Individual accident and health insurance policies, provisions regarding, see Insurance Law s 3216.
Liability insurance, see Insurance Law s 3420.
Property insurance, see Insurance Law s 3407.
Standard claim forms for fire losses, see Insurance Law s 3413.
Violation of this section defined as an unfair method of competition or an unfair and deceptive act or practice, see Insurance Law s 2402.

NEW YORK CODES, RULES AND REGULATIONS
1985 Main Volume
Claims for personal injury benefits under the Comprehensive Automobile Insurance Act, see 11 NYCRR 65.6, 11 NYCRR 65.15.
Standard fire claim form, see 11 NYCRR 62-3.0 et seq.
Unfair claims settlement practices and claim cost control measures, see 11 NYCRR 216.0 et seq.

WEST'S MCKINNEY'S FORMS
The following forms appear in Selected Consolidated Laws under Insurance Law s 2601:
Notice of motion to dismiss complaint against insurer for unfair claim settlement practices, see SCL, INS s 2601, Form 1.
Affirmation in support of motion to dismiss complaint against insurer for unfair claim settlement practices, see SCL, INS s 2601, Form 2.
Affidavit in support of motion to dismiss complaint against insurer for unfair claim settlement practices, see SCL, INS s 2601, Form 3.

AMERICAN LAW REPORTS
Emotional or mental distress as element of damages for liability insurer's wrongful refusal to settle. 57 ALR4th 801.

LAW REVIEW AND JOURNAL COMMENTARIES
Bad faith litigation: a window period on the horizon. Scahill. 63 N.Y.St.B.J. 31 (Nov. 1991).
Can the puzzle be solved: Are punitive damages awardable in New York for first-party bad faith? Neil A. Goldberg, Thomas F. Segalla and Richard J. Cohen, 44 Syracuse L.Rev. 723 (1993).
Disciplining the recalcitrant insurer: punitive damages for breach of contract. Riley, 57 N.Y.St.B.J. 30 (February 1985).
Punitive damages after "Rocanova." Evan H. Krinick, 211 N.Y.L.J. 1 (June 1, 1994).
Punitive damages and attorney's fees against insurers before Court of Appeals. James P. Tenney, 214 N.Y.L.J. 1 (Oct. 18, 1995).
Punitive damages and Insurance Law s 2601. Evan H. Krinick, 211 N.Y.L.J. 1 (March 17, 1994).

LIBRARY REFERENCES
1985 Main Volume
Texts and Treatises
29 NY Jur, Insurance s 119.5.
2A Couch on Insurance 2d, Penalties for Vexatious Delay or Refusal to Pay Loss ss 21:41, 21:42.

NOTES OF DECISIONS
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1/2. Preemption

Under New York law, unfair claims settlement statute does not preempt common law claim for breach of covenant of good faith and fair dealing, even if alleged breaches consist of conduct cumulatively meeting statutory definition of unfair claim settlement practice. Greenspan v. Allstate Ins. Co., 1996, 937 F.Supp. 288.

Plaintiff's claims that his former employer and its parent company failed to provide him with insurance coverage for home health care as required by his employee benefits plan constituted unfair insurance claim settlement practice in violation of New York law was preempted under ERISA; relief that plaintiff sought was available to him under ERISA. Shackelton v. Connecticut General Life Ins. Co., 1993, 817 F.Supp. 277.

Cross claim for punitive damages against insurer, brought by claimant to insurance policy benefits, to extent it alleged that insurer failed to promptly investigate competing claims and failed to make good faith effort to effectuate prompt settlement of claims, was preempted by statutory provision limiting prosecution of such claims to state insurance department. Matter of Bernstein (2 Dept. 1989) 156 A.D.2d 683, 549 N.Y.S.2d 446.

1. Nature of remedy

Insured's action against insurer predicated on violation of McKinney's Insurance Law s 40-d [now this section] was properly dismissed, since redress under that statute by way of action for damages is not available to individual litigant. J & B Schoenfeld, Fur Merchants, Inc. v. Albany Ins. Co. (1 Dept. 1985) 109 A.D.2d 370, 492 N.Y.S.2d 38.
Insurance Law of 1939 s 40-d [now this section] setting standard by which insurers are to process claims does not create private right of action but rather affords public right of redress by insurance department for violations after a hearing and determination. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

2. Frequency of practice

Even if Insurance Law of 1939 s 40-d [now this section] proscribing unfair business practices of insurers could be read to create private cause of action, allegations of complaint were insufficient to bring case within said section in that, in particular, nothing demonstrated that conduct complained of by plaintiff occurred in more than one isolated instance. Hubbell v. Trans World Life Ins. Co. of New York, 1980, 50 N.Y.2d 899, 430 N.Y.S.2d 589, 408 N.E.2d 918.

Liability insurers were not estopped from relying on their untimely and purportedly defective

notice of disclaimer as a defense in an action brought by their insured's judgment creditor to satisfy the judgment, where no coverage existed and the judgment creditor did not plead or prove a deceptive business practice or unfair claims settlement practice or show any actual prejudice flowing from the disclaimer. Aetna Cas. & Sur. Co. v. ITT Hartford Ins. Co. (1 Dept. 1998) 249 A.D.2d 241, 672 N.Y.S.2d 310.

Insured could not recover for alleged unfair claims practices based on allegation of isolated deceptive business practice aimed at insured alone, rather than on allegation of recurrent deceptive business practice aimed at public at large; insured's allegations did not amount to claim that challenged practice was "general business practice," within meaning of statute authorizing recovery. Myers, Smith & Granady, Inc. v. New York Property Ins. Underwriting Ass'n (1 Dept. 1994) 201 A.D.2d 312, 607 N.Y.S.2d 288, leave to appeal granted in part, dismissed in part 83 N.Y.2d 942, 615 N.Y.S.2d 870, 639 N.E.2d 410, affirmed 85 N.Y.2d 832, 623 N.Y.S.2d 840, 647 N.E.2d 1348.

Causes of action predicated upon violation of insurance statute defining unfair claim settlement practices and request for punitive damages and attorney fees in connection with fire loss claim should have been dismissed, where complaint contained no allegation that insurer engaged in any conduct or transactions affecting general public. Piduch v. Lumbermens Mut. Cas. Co. (4 Dept. 1986) 124 A.D.2d 999, 508 N.Y.S.2d 790.

2A. Bad faith

Under New York law, insured who could not demonstrate that insurers' conduct in denying its fire claims was result of insurers' generally applicable settlement practices or that insurers' conduct had broader impact on public at large could not recover under New York consumer statute protecting against deceptive acts or practices; there was no evidence that actions of insurers in denying claim either for failure to present proof of loss or for suspected arson affected or could affect general public. Infostar Inc. v. Worcester Ins. Co., 1996, 924 F.Supp. 25.

Under New York law, bad faith could not be inferred from primary insurer's failure to settle action against its insured when no discovery had occurred and complaint had not yet even been filed against its insured and, therefore, primary insurer could not be held liable for failure to settle underlying action in manner that would have reduced excess insurer's liability. California Union Ins. Co. v. Excess Ins. Co., Ltd., 1991, 780 F.Supp. 1010.

New York court would not hold excess insurer liable for bad faith in failing to settle litigation against insured where excess carrier knew of primary insurer's refusal to settle and did not object, even if primary insurer did not make counteroffer to claimant or explicitly inform excess carrier that it was relinquishing control of litigation in favor of excess carrier. California Union Ins. Co. v. Excess Ins. Co., Ltd., 1991, 780 F.Supp. 1010.

Punitive damage award against an insured is not proper element of compensatory damages recoverable against insurer for bad-faith refusal to settle within policy limits. Soto v. State Farm Ins. Co., 1994, 83 N.Y.2d 718, 613 N.Y.S.2d 352, 635 N.E.2d 1222.
Causes of action of insured under insolvency risk insurance policy alleging that, as part of larger pattern of unfair claim settlement practices, insurer and underwriter acted in bad faith and failed to deal fairly with insured's claim under policy were barred by insured's negotiation and execution of release and assignment which released company from all causes of action related to policy; insured failed to establish any traditional basis for setting aside release such as duress, illegality, fraud, or mutual mistake. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Automobile insurer's failure to respond to plaintiff's time-restricted demand for settlement within full policy limits, at time when insured's liability remained under investigation, was insufficient to establish prima facie case of bad faith. Pavia v. State Farm Mut. Auto. Ins. Co., 1993, 82 N.Y.2d

445, 605 N.Y.S.2d 208, 626 N.E.2d 24, reargument denied 83 N.Y.2d 779, 611 N.Y.S.2d 126, 633 N.E.2d 480.

Evidence that settlement offer was made and not accepted is not dispositive of insurer's bad faith; insurer cannot be compelled to concede liability and settle questionable claim simply because opportunity to do so is presented, rather, plaintiff must show that insured lost actual opportunity to settle claim at time when all serious doubts about insured's liability were removed. Pavia v. State Farm Mut. Auto. Ins. Co., 1993, 82 N.Y.2d 445, 605 N.Y.S.2d 208, 626 N.E.2d 24, reargument denied 83 N.Y.2d 779, 611 N.Y.S.2d 126, 633 N.E.2d 480.

In order to establish prima facie case against insurer of bad faith in refusing settlement offer within policy limits, plaintiff must establish that insurer's conduct constituted "gross disregard" of insured's interests, that is, deliberate or reckless failure to place on equal footing the interests of its insured with its own interests when considering settlement offer; in other words, plaintiff must establish that insurer engaged in pattern of behavior evincing conscious or knowing indifference to probability that insured would be held personally accountable for large judgment if settlement offer were not accepted. Pavia v. State Farm Mut. Auto. Ins. Co., 1993, 82 N.Y.2d 445, 605 N.Y.S.2d 208, 626 N.E.2d 24, reargument denied 83 N.Y.2d 779, 611 N.Y.S.2d 126, 633 N.E.2d 480.

Arbitrators' finding that an insurer acted in bad faith would not, without more, justify a judicial award of punitive damages to an insured. American Transit Ins. Co. v. Associated International Ins. Co. (1 Dept. 1999) ___ A.D.2d ___, 690 N.Y.S.2d 237.

Automobile liability insurer in suit involving multiple victims and derivative claim by one victim's parents did not act in bad faith by refusing to settle for more than the per person policy limits for two victims, even if the insurer knew that liability for a judgment in excess of the policy limits was certain; insurer correctly concluded that the derivative claim was not separate and had a bona fide basis to conclude that the third victim's injuries were not serious. Redcross v. Aetna Cas. & Sur. Co. (3 Dept. 1999) ___ A.D.2d ___, 688 N.Y.S.2d 817.

A liability insurer confronted with multiple claims arising out of the same accident is not required, in order to forestall a bad-faith settlement claim, to accept a package deal within the overall policy limits if, in doing so, it would be overpaying on some of the claims in order that in the other claims, as to which the insurer is ready to pay the full policy limit, the insured would not be exposed to liability that exceeds the policy limit. Redcross v. Aetna Cas. & Sur. Co. (3 Dept. 1999) ___ A.D.2d ___, 688 N.Y.S.2d 817.

An inference of bad faith may arise even though the claimant's settlement offer equals or exceeds the liability policy limits, if the insured is not informed of the right to contribute to the excess in order to achieve a settlement. Redcross v. Aetna Cas. & Sur. Co. (3 Dept. 1999) ___ A.D.2d ___, 688 N.Y.S.2d 817.

Primary liability insurer did not act in bad faith by failing to inform insured or excess umbrella insurer of insured's possible exposure to liability in excess of primary policy's limits, where it did not act deliberately or even recklessly, did not put its own interests ahead of insured's interests, and kept insured informed of all relevant facts so that insured and primary insurer had essentially same information with which to form opinion about need to notify excess insurer; at most, primary insurer had made error in judgment. Monarch Cortland, Div. of Monarch Mach. Tool Co., Inc. v. Columbia Cas. Co. (3 Dept. 1996) 224 A.D.2d 135, 646 N.Y.S.2d 904, leave to appeal denied 89 N.Y.2d 807, 655 N.Y.S.2d 887, 678 N.E.2d 500.

Although it was arguably negligent for insurance company to have exhausted policy by paying all of automobile insurance policy proceeds to first two of three claimants under policy limiting liability to $10,000 per person/$20,000 per occurrence, such action did not rise to level of gross disregard so as to constitute bad faith. State Farm Ins. Co. v. Credle (1 Dept. 1996) 228 A.D.2d 191, 643

N.Y.S.2d 97.

Hospital's primary liability insurer's failure, in underlying malpractice action, to offer additional amount to settle claim against doctor who was additional insured under policy's "moonlighting" endorsement, after offering policy limits early in the proceedings, was not bad faith failure to settle, where insurer was acting on belief that coverage provided by the endorsement was excess to coverage provided by doctor's own insurer, and thus insurer.was, at most, negligent. Affiliated F.M. Ins. Co., Inc. v. Hartford Acc. and Indem. Co. (1 Dept. 1996) 226 A.D.2d 292, 642 N.Y.S.2d 211, leave to appeal dismissed in part, denied in part 89 N.Y.2d 932, 654 N.Y.S.2d 712, 677 N.E.2d 283.
Insured's allegations failed to state claim against insurer based on theory of bad faith premised on unfair claim settlement practices, absent demonstration of pattern of bad faith or unfair practices. Rein Monroe Associates v. Royal Ins. Co. of America (4 Dept. 1991) 175 A.D.2d 582, 572 N.Y.S.2d 247.

In determining whether punitive damages should be awarded against insured for bad-faith failure to settle claim, process of meting out punishment for wrongdoing could not be divorced from process of deciding whether wrongdoing occurred; thus consideration of bad-faith issue by arbitrator who lacked authority to award punitive damages was not binding on court. Belco Petroleum Corp. v. AIG Oil Rig, Inc. (1 Dept. 1991) 164 A.D.2d 583, 565 N.Y.S.2d 776, on subsequent appeal 179 A.D.2d 516, 579 N.Y.S.2d 24.

Material issues of fact precluding summary judgment existed as to whether insurance company's conduct constituted actionable bad faith and, if bad faith, whether it constituted criminal indifference to civil obligations warranting punitive damages; company stated in open court that there was $500,000 in total coverage, allowed that representation to stand uncorrected for three years, and then stated, on eve of trial, that it did not know whether there was more than $100,000 in coverage. Jolicoeur v. American Transit Ins. Co. (1 Dept. 1990) 159 A.D.2d 236, 552 N.Y.S.2d 215.

Evidence that insurer for State made offer to settle claim against State for wrongful death resulting from collision between pickup truck and state-owned snowplow at figure which was substantially lower than liability it could reasonably expect to incur supported finding that insurer was acting in bad faith, thereby justifying imposition of excess liability on it. State v. Merchants Ins. Co. of New Hampshire (3 Dept. 1985) 109 A.D.2d 935, 486 N.Y.S.2d 412.

Insurance carrier can be held to be in bad faith in not resolving claim within policy limits where it was highly probable that insured would be subject to personal liability. Soto v. State Farm Ins. Co., 1992, 155 Misc.2d 447, 588 N.Y.S.2d 505, affirmed 195 A.D.2d 992, 600 N.Y.S.2d 407, leave to appeal granted 82 N.Y.2d 659, 604 N.Y.S.2d 558, 624 N.E.2d 696, affirmed 83 N.Y.2d 718, 613 N.Y.S.2d 352, 635 N.E.2d 1222.

3. Delay of settlement

Damages for severe mental and emotional distress by reason of undue delay in processing insurance claim and subsequent delay of payment are not recoverable if policy does not create relationship out of which springs duty to insured separate and apart from the contractual obligation. Warhoftig v. Allstate Ins. Co. (2 Dept. 1993) 199 A.D.2d 258, 604 N.Y.S.2d 245.

Evidence supported dismissal of cause of action alleging insurer which had issued homeowner's policy willfully failed to pay claim, where at trial insured presented no proof to establish that insurer acted dishonestly or disingenuously in failing to settle claim on timely basis. Meiselman v. Allstate Ins. Co. (2 Dept. 1990) 166 A.D.2d 562, 560 N.Y.S.2d 845, appeal denied 77 N.Y.2d 808, 570 N.Y.S.2d 489, 573 N.E.2d 577, reargument denied 78 N.Y.2d 909, 573 N.Y.S.2d 469, 577 N.E.2d 1061.

Where insurance company undertook its estimate of repair costs to damaged automobile, settled automobile collision claim, and mailed check to insured within 30 days, and some of delay in handling claim resulted from vacation of company employee, administrative law judge erred in holding that insurance company engaged in course of conduct which unreasonably delayed or impeded consumer's fair recovery under policy of insurance. Allstate Ins. Co. v. Foschio (2 Dept. 1983) 93 A.D.2d 328, 462 N.Y.S.2d 44.

4. Malice

Evidence established that fire insurer acted with malice in "low-balling" insured's claim by suggesting that insured was guilty of arson and offering less than one-third of provable claim. Frizzy Hairstylists, Inc. v. Eagle Star Ins. Co., 1977, 89 Misc.2d 822, 392 N.Y.S.2d 554, modified on other grounds 93 Misc.2d 59, 403 N.Y.S.2d 389.

5. Partial payment, duty to offer

Insurer was under no obligation to offer or make partial payment to insureds under fire policy pending settlement discussions. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

Even if insurer concedes, after review of claim and investigation of damage to premises, that additional casualty loss has been incurred it is still not bound to make immediate payment particularly when an honest dispute exists as to amount of loss. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.
Insurance Law of 1939 s 40-d [now this section] prohibiting insurers from engaging in unfair claim settlement practices and enumerating specific prescribed acts does not impose on an insurer an affirmative duty to make a partial payment simply because insured claims that further damage will occur. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

6. Punitive damages--Availability of

Issues of whether New York law permitted insureds to recover punitive damages from insurer in first party suit premised on unfair and deceptive claims practices in violation of insurance contract and whether insureds adduced sufficient evident to support award would be certified to New York Court of Appeals, where there was split of authority in New York courts on issue of whether punitive damages could be recovered, and language of administrative remedies provision of New York Insurance Law did not indicate whether preemption of punitive damages was intended. Riordan v. Nationwide Mut. Fire Ins. Co., C.A.2 (N.Y.)1992, 977 F.2d 47, certified question withdrawn 984 F.2d 69.

Statute prohibiting unfair claim settlement practices by insurer does not permit private right of action in favor of insured and, therefore, does not impose tort duty of care flowing to insured separate and apart from insurance policy; thus, punitive damages are not available for violation of the statute. New York University v. Continental Ins. Co., 1995, 87 N.Y.2d 308, 639 N.Y.S.2d 283, 662 N.E.2d 763.

Punitive damages are available where conduct constituting, accompanying, or associated with breach of contract is first actionable as independent tort for which compensatory damages are ordinarily available, and is sufficiently egregious to warrant additional imposition of exemplary damages. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Absent valid claim for compensatory damages, there could be none for punitive damages, even if insurer's refusal to pay benefit due under policy could be said to be such gross disregard of its contractual obligations as to constitute morally culpable conduct for which punitive damages

might be claimed. Hubbell v. Trans World Life Ins. Co. of New York, 1980, 50 N.Y.2d 899, 430 N.Y.S.2d 589, 408 N.E.2d 918.

Insured could not get punitive damages for an insurer's wrongful conduct where the conduct was focused upon the insured and not aimed systematically at the general public. American Transit Ins. Co. v. Associated International Ins. Co. (1 Dept. 1999) ___ A.D.2d ___, 690 N.Y.S.2d 237.

Private party may not recover punitive damages for unfair claim settlement practices by insurer. Warhoftig v. Allstate Ins. Co. (2 Dept. 1993) 199 A.D.2d 258, 604 N.Y.S.2d 245.

Claims of persistent unfair settlement practices by insurer are within the exclusive province of superintendent of insurance and do not give rise to an independent action for punitive damages. Mavroudis v. State Wide Ins. Co. (2 Dept. 1986) 121 A.D.2d 433, 503 N.Y.S.2d 133, appeal dismissed 68 N.Y.2d 997, 510 N.Y.S.2d 1028, 503 N.E.2d 125.

Provision of Insurance Law which defines, and refers to penalties for, insurers' unfair claim settlement practices performs disciplinary function and obviates necessity for punitive damages in first-party coverage cases; these types of complaints are more properly province of Superintendent of Insurance. Riffat v. Continental Ins. Co. (1 Dept. 1984) 104 A.D.2d 301, 478 N.Y.S.2d 635.

Punitive damages may not be recovered for claimed violation of Insurance Law of 1939 s 40-d [now this section] pertaining to unfair claim settlement practices by insurers. LTS Contractors, Inc. v. Hartford Ins. Co. (4 Dept. 1984) 99 A.D.2d 644, 472 N.Y.S.2d 222.

Insurer's conduct was sufficiently culpable to authorize allowance of claim by insured for punitive damages, where insurer was aware of incredible costs of insured's prolonged hospital stay, surgery, and follow-up procedures and that insured was self-employed single mother of two children, and despite continued pleas for reconsideration of cancellation of policy due to incorrect information, insurer continued to rely on hospital report completed by medical student.White v. Blue Cross and Blue Shield of Greater New York, 1989, 146 Misc.2d 125, 549 N.Y.S.2d 598.

In action against insurance company for failure to pay on claim for water damage, partnership had no private right of action for collection of punitive damages. Sulner v. General Acc. Fire and Life Assur. Corp., Ltd., 1984, 122 Misc.2d 597, 471 N.Y.S.2d 794.

Insurance Law of 1939 s 40-d [now this section] prohibiting insurer from repeatedly engaging in unfair claims settlement practices and providing for imposition of appropriate monetary penalties performed disciplinary function and obviated necessity for maintenance of causes of action for punitive damages against insurer engaging in unfair settlement practices. Cosmopolitan Mut. Ins. Co. v. Nassau Ins. Co., 1979, 99 Misc.2d 1018, 417 N.Y.S.2d 835.

7. Fault of insured

Allowing recovery of punitive damages for willful misconduct on insurer's part when insured itself has not shown compliance with all its obligations under standard fire policy works unconscionable result. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

8. Jurisdiction to award

Even if insurer entered into course of conduct to issue false disclaimers under policy with its insureds, thus compelling other insurers as subrogees of adverse property damage claimants to resort to unnecessary litigation, punishment of offending insurer was more properly within province and jurisdiction of state superintendent of insurance than through award of punitive damages to competing insurers. Cosmopolitan Mut. Ins. Co. v. Nassau Ins. Co., 1979, 99 Misc.2d

1018, 417 N.Y.S.2d 835.

Insurer was not liable for punitive damages where the complaint merely alleged that the insurer refused to pay under the terms of a policy issued to plaintiff after due demand therefor was made; while the conduct of the insurer was not to be condoned, its punishment was more properly within the province and jurisdiction of the State Superintendent of Insurance. Frizzy Hairstylists, Inc. v. Eagle Star Ins. Co., 1977, 93 Misc.2d 59, 403 N.Y.S.2d 389.

9. Necessary showing

Insured under disability income policy whose policy was rescinded after he filed claim could not maintain action for punitive damages for breach of implied covenant of good faith and fair dealing; insured failed to demonstrate that he was personally aggrieved by tortious conduct arising out of his contractual relationship with insurer, and no inference of fraudulent intent could be drawn from mere compilation of 124 "vignettes" of policyholder "difficulties" with insurer. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Absent evidentiary proof in admissible form of general business practice on part of insurer or proof of gross disregard of insured's rights, plaintiffs were not entitled to recover punitive damages under Insurance Law of 1939 s 40-d [now this section] for insurer's breach of its duty to settle claims in good faith. Dano v. Royal Globe Ins. Co., 1983, 59 N.Y.2d 827, 464 N.Y.S.2d 741, 451 N.E.2d 488.

Claim for punitive damages against insurer is cognizable only in circumstances where plaintiff has made sufficient evidentiary allegations of ultimate facts of fraudulent and deceitful scheme in dealing with general public as to imply criminal indifference to civil obligations. Porter v. Allstate Ins. Co. (2 Dept. 1992) 184 A.D.2d 685, 585 N.Y.S.2d 465.

Punitive damages could not be recovered for insurer's refusal to honor life insurance policy, absent allegation of facts that would support finding of wanton dishonesty as to imply criminal indifference to civil obligations. McLaughlin v. American Intern. Life Assur. Co. of New York (1 Dept. 1992) 181 A.D.2d 444, 580 N.Y.S.2d 763.

Plaintiffs may not recover punitive damages in actions for breach of insurance contract without submitting factual allegations that insurer, in its dealings with general public, engaged in fraudulent scheme which demonstrates such wantondishonesty as to imply criminal indifference to civil obligations. Fleming v. Allstate Ins. Co. (2 Dept. 1984) 106 A.D.2d 426, 482 N.Y.S.2d 519, affirmed 66 N.Y.2d 838, 498 N.Y.S.2d 365, 489 N.E.2d 252, certiorari denied 106 S.Ct. 1493, 475 U.S. 1096, 89 L.Ed.2d 894.

In order for insured to be allowed to attempt to recover punitive damages from insurance company for improper claim settlement practices, there must be showing of such morally culpable conduct and wanton dishonesty as to imply criminal indifference to civil obligations. Royal Globe Ins. Co. v. Chock Full O'Nuts Corp. (1 Dept. 1982) 86 A.D.2d 315, 449 N.Y.S.2d 740, appeal dismissed 58 N.Y.2d 605, 459 N.Y.S.2d 1028, 445 N.E.2d 655, appeal dismissed 58 N.Y.2d 800, 459 N.Y.S.2d 266, 445 N.E.2d 649.

Even where insurer acts in bad faith, punitive damages will not be awarded unless there is also proof of malice. Frizzy Hairstylists, Inc. v. Eagle Star Ins. Co., 1977, 89 Misc.2d 822, 392 N.Y.S.2d 554, modified on other grounds 93 Misc.2d 59, 403 N.Y.S.2d 389.

10. Denial in particular cases

Assuming that private damage action lies under Insurance Law of 1939 s 40- d [now this section], the instance of unfair settlement practice pleaded would not constitute general business practice within meaning of said section and, thus, punitive damage claim could not be sustained under

said section. Halpin v. Prudential Ins. Co. of America, 1979, 48 N.Y.2d 906, 425 N.Y.S.2d 48, 401 N.E.2d 171, reargument denied 49 N.Y.2d 801, 426 N.Y.S.2d 1029, 403 N.E.2d 466.

Allegations of insured that insurer had carelessly, negligently, recklessly and incorrectly determined actual cash value of insured vehicle and amount necessary to repair or replace it and had fraudulently induced insured to employ services of certain automobile repair shop, were insufficient as matter of law to support award of punitive damages. Kinnarney v. Natale Auto Body (3 Dept. 1990) 157 A.D.2d 938, 550 N.Y.S.2d 194.

Where insurer promptly investigated claimed fire loss, which was considered suspicious by fire department, it hired experts to determine actual cash value on basis of which it offered $37,500 against policy limit of $50,000 on building and $13,000 for loss of rental value, and insured failed to cite any specific instance of unlawful conduct or disingenuous and dishonest failure to perform its obligations under policy, insured was not entitled to award of punitive damages in action to recover under fire policy. Pitrock Realty Corp. v. New York Property Ins. Underwriting Ass'n (1 Dept. 1983) 96 A.D.2d 1021, 467 N.Y.S.2d 49.

Alleged violation of Insurance Law of 1939 s 40-d [now this section] governing fire insurer's duty to negotiate and settle claim in good faith did not provide basis for recovery of punitive damages from insurer. Dano v. Royal Globe Ins. Co. (4 Dept. 1982) 89 A.D.2d 817, 453 N.Y.S.2d 528, affirmed 59 N.Y.2d 827, 464 N.Y.S.2d 741, 451 N.E.2d 488.

In action by insurer seeking insurance premiums and service charges allegedly due, counterclaims raised by insured alleging that insurer breached its contractual obligation under service agreement, that insurer breached its fiduciary duty to insured, that insured was induced to enter into agreement based upon misrepresentations and that insurer committed various unfair claim settlement practices constituted damages action for breach of contract and possibly negligence in handling claims, with usual remedies and relief available for such actions, but did not provide basis for punitive damages, either on basis of Insurance Law of 1939 s 40-d [now this section] relating to unfair claim settlement practices by insurers or otherwise. Royal Globe Ins. Co. v. Chock Full O'Nuts Corp. (1 Dept. 1982) 86 A.D.2d 315, 449 N.Y.S.2d 740, appeal dismissed 58 N.Y.2d 605, 459 N.Y.S.2d 1028, 445 N.E.2d 655, appeal dismissed 58 N.Y.2d 800, 459 N.Y.S.2d 266, 445 N.E.2d 649.

Even though additional damage was incurred due to insurer's failure to make prompt repairs to insured building damaged by fire, where insurer and insureds were in dispute from the beginning as to extent of loss, hiatus of two months between the loss and insurer's first settlement offer under standard fire policy and three-week lapse between letter from New York Board of Fire Underwriters recommending that insurer pay $65,000 and insurer's first settlement offer, were not inordinate or unreasonable so that such actions together with insurer's cancellation of policy upon finding that building was uninsurable did not render it liable to insureds for punitive damages. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

11. Costs, imposition of

Insured is not entitled to recover costs and expenses of bringing affirmative action to settle his rights, but may recover only when he has been cast in defensive posture by action of insurer in effort to absolve itself from policy obligations. Hershberger by Hershberger v. Schwartz (4 Dept. 1993) 198 A.D.2d 859, 604 N.Y.S.2d 428.

Costs of proceeding to enforce arbitrator's award were assessed against insurer where, without any good reason, insurer chose to delay payment for more than one year. Grabowski v. Allstate Ins. Co., 1976, 85 Misc.2d 845, 380 N.Y.S.2d 587.

12. Pleadings

Claim for fraud in inducement was not stated by insured's allegations that insurer and servicing agent induced insured to purchase and maintain policy notwithstanding intent ab initio to refuse claims for indemnification and then terminate policy and that they misrepresented integrity of a company through advertising and by conducting business under statute that requires insurers to deal with insureds fairly and in good faith; complaint did not state specific promises or omissions of material fact allegedly made by insurer, and it alleged nothing more than breach of contract and any implied covenants. New York University v. Continental Ins. Co., 1995, 87 N.Y.2d 308, 639 N.Y.S.2d 283, 662 N.E.2d 763.

Insureds could amend their contract complaint against insurer to amplify their cause of action with allegations of violation of insurance statute prohibiting unfair claim settlement practices, despite insurer's contention that insureds were trying to add separate cause of action. Bristol Harbour Associates, L.P. v. Home Ins. Co. (4 Dept. 1997) 244 A.D.2d 885, 665 N.Y.S.2d 142.

Complaint adequately sets forth prima facie case against insurer for liability in excess of policy limits where it is asserted that insured lost actual opportunity to settle negligence claim against him within coverage limits of his policy by reason of insurer's purported bad faith. State v. Merchants Ins. Co. of New Hampshire (3 Dept. 1985) 109 A.D.2d 935, 486 N.Y.S.2d 412.

13. Evidence

In State's action against its snowplow insurer for bad faith, testimony of expert witness as to accepted standard in insurance industry for settlement practices and procedures by liability insurer was not necessary where issues before jury were within ambit of common knowledge and experience of laymen. State v. Merchants Ins. Co. of New Hampshire (3 Dept. 1985) 109 A.D.2d 935, 486 N.Y.S.2d 412.

14. Private right of action

Private right of action is not recognized under New York insurance statute governing unfair claim settlement practices. Northwestern Mut. Life Ins. Co. v. Wender, 1996, 940 F.Supp. 62.

Although sections of New York Insurance Law protecting customers from generally deceptive business practices did not create private right of action, the provisions could provide basis for corporation's fraud and antitrust action against insurer following its cancellation of officers and directors policy, as expression of public policy and as evidence of insurer's duties to its insureds. PepsiCo, Inc. v. Continental Cas. Co., 1986, 640 F.Supp. 656.

Statute prohibiting unfair claim settlement practices by insurer does not permit private right of action in favor of insured and, therefore, does not impose tort duty of care flowing to insured separate and apart from insurance policy; thus, punitive damages are not available for violation of the statute. New York University v. Continental Ins. Co., 1995, 87 N.Y.2d 308, 639 N.Y.S.2d 283, 662 N.E.2d 763.

No private cause of action can be maintained for unfair insurance settlement practices. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Regulations defining unfair claims settlement practices do not give rise to a private right of action. Aetna Cas. & Sur. Co. v. ITT Hartford Ins. Co. (1 Dept. 1998) 249 A.D.2d 241, 672 N.Y.S.2d 310.

There is no private right of action under section of Insurance Law proscribing unfair claim settlement practices and authorizing a money penalty; enforcement is within the jurisdiction of the State Superintendent of Insurance and administrative review procedures under Insurance Law s 2403 et seq., are the exclusive remedies for determining a violation. Kurrus v. CNA Ins. Co. (2 Dept. 1985) 115 A.D.2d 593, 496 N.Y.S.2d 255.

Insurance law and underlying regulations setting standard by which insurers are to process claims create private rights of action where party seeks no more than compensatory damages, but only affords public right of redress by Department of Insurance where party seeks damages that are punitive in nature. Dunrite Auto Body & Motor Works, Inc. v. Liberty Mut. Ins. Co., 1992, 153 Misc.2d 440, 590 N.Y.S.2d 152, on remand 160 Misc.2d 168, 607 N.Y.S.2d 1005.

McKinney's Insurance Law s 2601
NY INS s 2601

END OF DOCUMENT

NY INS Ch. 28, Art. 26, Refs & Annos
McKinney's Insurance Law Ch. 28, Art. 26, Refs & Annos

McKinney's Consolidated Laws Of New York Annotated Insurance Law

Chapter 28 Of The Consolidated Laws
Article 26--Unfair Claim Settlement Practices; Other Misconduct; Discrimination

Current through L.1999, ch. 659
NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- 1984 CODIFICATION NOTES
1984 CODIFICATION NOTES
1985 Main Volume

By Jule E. Stocker, John P. Gemma and Mendes Hershman
N.B. References herein (1) to the "new" Law (or the like) are to the Insurance Law, as recodified without substantive change, by L.1984, c. 367 and c. 805, effective September 1, 1984; and (2) to the "old" Law (or the like) are to the Insurance Law immediately preceding the "new" Law. Attention is directed to the four part Introduction set out preceding Article 1 of the new Law, namely: I. History of 1974-1984 Recodification Project; II. The 1984 Enacting Legislation; III. Structure of the Recodified Law; IV. Scope of Codification Notes on Specific Articles.

The Note on Scope contains general comments of simplifying, clarifying and systematizing the entire old Law, but without substantive change, that are generally applicable to this Article and should be deemed incorporated by reference. Comments which are specially applicable to this Article follow.

Article 26 is a new Article in the sense that it combines therein seven sections, and portions of two other sections, from three Articles of the old Law. With two exceptions (ss 2609 and 2610), all of the foregoing, constituting eight new sections, came from old Article 4 on "Organization, Licensing and Corporate Procedure of Insurers" and were moved to new Article 26 because they had no direct bearing on the subject matter of old Article 4, as indicated by its above-mentioned title. (Similarly, with respect to the two exceptions, as detailed below.) Instead, those provisions from old Article 4 dealt with a number of prohibitions against unfair claim settlement practices, rebates, false statements regarding the business which a corporation may conduct or regarding the financial standing of any insurer, in this state, failure to comply with the Workers' Compensation Law, and various categories of discrimination, chiefly, in connection with insurance policies, because of race, color, creed, national origin, sex, marital status or treatment for mental disability.

About half of the sections in new Article 26 prohibiting such practices are listed in Article 24 (Unfair Methods of Competition and Unfair and Deceptive Acts and Practices) under the definition of "defined violations" in new s 2402(b). Thus, not all of the prohibitions in new Article 26

constitute unfair practices under Article 24 which the Superintendent can order stopped. Instead, he would have to have the Attorney General bring court action therefor.

It was felt desirable to put all such prohibitions together, as the first eight sections of one new Article, namely Article 26, following Article 25 on "Prohibitions against Controlled Business", and close to Article 24 on "Unfair...Practices."

The two exceptions mentioned near the beginning of this Note constitute the last two sections of Article 26. New s 2609 replaces s 315-a of the old Law which prohibited discrimination in issuing performance or surety bonds solely because of race, creed, color, sex, national origin, age or martial status of the applicant. The section is accordingly closely related to earlier sections of Article 26. The section fits better in Article 26 than in the location in the old Law of the corresponding section.

Similarly, the last section of new Article 26, s 2610, replaces old s 167- c prohibiting insurers from requiring, or even suggesting, unless the insured requested, motor vehicle repairs should be made. Old s 167-c had been in a rather unlikely location in old Article 7 on "the Insurance Contract."

A number of the old Law provisions were phrased in the form of a declaration that any person who did a specified act, but without any direct prohibition thereof, was guilty of a misdemeanor. The corresponding new provisions are cast in the form of specific prohibitions, without mentioning "misdemeanor". It is unnecessary to refer to "misdemeanor" since new s 109, like old s 5, specifies that "Every violation of any provision of this chapter [that is, the insurance law] shall, unless the same constitutes a felony, be a misdemeanor". Note, in contrast, that new s 2601, like old s 40-d on "Unfair Claim Settlement Practices" expressly states that "A violation of this section shall not be a misdemeanor".

Another example of simplification is the use of "entity" in new s 2606(a) in place of a repeated list of nine specific categories in old s 40(10) which can be subsumed in the single word "entity". The same change appears in new ss 2607 and 2608. Although the Recodification endeavored to omit unnecessary words, it did not hesitate to make appropriate additions. Thus, the exception at the beginning of new s 2606(a) is repeated in s 2606(b) as a useful cross reference for purposes of clarifying the Law.

The substitution of the word "of" for "by" near the end of s 2608(a) corrects an obvious inadvertence.

Note that the reference to Public Law 15, 79th Congress in new s 2401, omits the phrase "as amended" which appeared in old s 270, in view of the general definitional rule on construction of references to other laws in new s 107(b). Similarly, the separability provision in old s 282 is omitted in view of the general provision thereon in s 4 of the enacting statute. L.1984, c 367.

The definition of "determined violation" in s 2402(c) may seem somewhat circular but it is necessarily so because of the structure of the Article.

The Derivation and Distribution Tables set forth in L.1984, c. 805 indicate that old Article 24 was carried over into new Article 24. Except for necessary changes in cross-reference numbers and in format, that is correct. However, the "old" Article 24 had been enacted in 1982 as part of the Recodification Project. (See the Introductory Note on History of the Recodification Project, set out preceding Article 1.) The 1982 enactment, while making no change of substance in prior Article 9-D which was replaced, recast such 9-D into a more logical whole, clarifying among other things, the difference in enforcement of the prohibitions against determined violations as contrasted with defined violations.

NY INS Ch. 28, Art. 26, Refs & Annos

REFERENCES -- CROSS REFERENCES
CROSS REFERENCES
Discrimination in civil rights prohibited, see McKinney's Const. Art. 1, s 11.
Unfair methods of competition and unfair and deceptive acts and practices, see Insurance Law s 2401 et seq.
Unlawful discriminatory practices, see Executive Law s 296.

NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- NEW YORK CODES, RULES AND REGULATIONS
NEW YORK CODES, RULES AND REGULATIONS
1985 Main Volume
Standard claim forms, see 11 NYCRR 17.0 et seq.
Unfair trade practices generally, see 11 NYCRR 215.1 et seq.

NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- LIBRARY REFERENCES
LIBRARY REFERENCES
1985 Main Volume
Insurance k4.2, 27 to 30, 563 to 570.10.
C.J.S. Insurance ss 57, 86, 88 to 90, 1098 to 1120.

NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- UNITED STATES CODE ANNOTATED
UNITED STATES CODE ANNOTATED
Civil rights, generally, see 42 USCA s 1981 et seq.
Equal protection of laws, see USCA Const. Amend. XIV s 1.
McKinney's Insurance Law Ch. 28, Art. 26, Refs & Annos
NY INS Ch. 28, Art. 26, Refs & Annos

END OF DOCUMENT

I I NY ADC 216.0
11 NYCRR 216.0
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.0

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK
TITLE 11. INSURANCE DEPARTMENT
CHAPTER IX. UNFAIR TRADE PRACTICES
PART 216. UNFAIR CLAIMS SETTLEMENT PRACTICES AND CLAIM COST CONTROL MEASURES

Text is current through May 31, 1999, and annotations are current through April 1999.

Section 216.0 Preamble.

(a) Section 2601 of the Insurance Law prohibits insurers doing business in this State from engaging in unfair claims settlement practices and provides that, if any insurer performs any of the acts or practices proscribed by that section without just cause and with such frequency as to indicate a general business practice, then those acts shall constitute unfair claims settlement practices. This Part contains claim practice rules which insurers must apply to the processing of all first- and third-party claims arising under policies subject to this Part. In addition, specific rules are provided for the processing of first-party motor vehicle physical damage claims and third-party property damage claims arising under motor vehicle liability insurance contracts.

(b) This Part is issued for the purpose of defining certain minimum standards which, if violated without just cause and with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices. This Part is not exclusive, and other acts, not herein specified, may also be found to constitute such practices.

(c) Section 3411 (i) of the Insurance Law has been implemented by section 216.7 of this Part.

(d) Section 3412 of the Insurance Law has been implemented by section 216.8 of this Part.

(e) Claim practice principles to be followed by all insurers.

(1) Have as your basic goal the prompt and fair settlement of all claims.

(2) Assist the claimant in the processing of a claim.

(3) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible.

(4) Clearly inform the claimant of the insurer's position regarding any disputed matter.

(5) Respond promptly, when response is indicated, to all communications from insureds, claimants, attorneys and any other interested persons.

(6) Every insurer shall distribute copies of this regulation to every person directly responsible for the supervision, handling and settlement of claims subject to this regulation, and every insurer shall satisfy itself that all such personnel are thoroughly conversant with, and are complying with, this regulation.

Historical Note

Sec. filed Dec. 5, 1972; amd. filed Jan. 14, 1975; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1, 1984. Amended (a), (c) and (d).

CASE NOTES:

11 NY ADC 216.0

Court granted leave to amend complaint where violation by insurance company of §§216.0, 216.3 and 216.6, prohibiting misrepresentation of policy provisions and requiring prompt and fair claim settlement, if proven would constitute deceptive business practice and injury to public would be inherent where company provides services to public on large scale and is obligated to deal in good faith. Riordan v. Nationwide Mut. Fire Ins. Co., 1990, 756 F.Supp. 732, affirmed in part, question certified 977 F.2d 47, certified question withdrawn 984 F.2d 69

11 NY ADC 216.0
END OF DOCUMENT

I I NY ADC 216.1
11 NYCRR 216.1
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.1

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MEASURES
Text is current through May 31, 1999, and annotations are current through April 1999.

Section 216.1 Definitions.

The definitions set forth in this section shall govern the construction of the terms used in this Part.

(a) Agent shall mean any person, firm, association or corporation authorized to act as the representative of an insurer and licensed pursuant to the provisions of article 21 of the Insurance Law. With respect to group life and group accident and health policies, the group policyholder shall be the agent of the insurer to the extent such policyholder has been authorized to act on behalf of such insurer.

(b) Claimant shall mean any person who attempts to obtain a benefit from an insurer.

(c) Investigation shall mean any procedure adopted by an insurer to determine whether to accept or reject a claim.

(d) Business day shall mean a day other than Saturday, Sunday or a New York State legal holiday.

(e) Notice of claim shall mean any notification, whether in writing or otherwise, to an insurer or its agent, by any claimant who reasonably apprises the insurer of the facts pertinent to a claim.

Historical Note

See. filed Dec. 5, 1972; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1, 1984. Amended (a).

11 NY ADC 216.1
END OF DOCUMENT

I I NY ADC 216.2
I I NYCRR 216.2
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.2

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Text is current through May 31, 1999, and annotations are current through April 1999.

Section 216.2 Applicability.

This Part shall apply to all insurers licensed to do business in this State.

(a) It shall not be applicable to policies of workers' compensation insurance issued pursuant to the provisions of section 1113(a)(15) of the Insurance Law; credit insurance issued pursuant to the provisions of section 1113(a)(17); title insurance issued pursuant to the provisions of section 1113(a)(I 8); inland marine insurance issued pursuant to the provisions of section 1113(a)(20); unless such insurance is subject to the provisions of section 3425 of the Insurance Law; and ocean marine insurance issued pursuant to the provisions of section 1113(a)(20) and (21).

(b) Subdivisions (a) and (b) of section 216.6 of this Part shall not be applicable to policies of life insurance written pursuant to the provisions of section 1113 (a)(1) of the Insurance Law. Subdivision (b) of section 216.6 of this Part shall not be applicable to accident and health policies written pursuant to the provisions of section 1113(a)(3) and the provisions of article 43 of the Insurance Law.

(c) Sections 216.4 and 216.5 and subdivision (c) of section 216.6 of this Part shall not be applicable to policies of accident and health insurance written pursuant to the provisions of section 1113(a)(3) and the provisions of article 43 of the Insurance Law, where the claimant is neither a policyholder, a certificate holder under a policy of group insurance, nor a relative or member of the household of such policy or certificate holder.

(d) Subdivision (b) of section 216.3, subdivision (b) of section 216.4 and subdivision (a) of section 216.5 of this Part shall not be applicable to policies of insurance where the claimant is represented by a public adjuster or a person acting in the capacity of a public adjuster pursuant to the provisions of article 21 of the Insurance Law.

Historical Note

Sec. filed Dec. 5, 1972; amd. filed Jan. 14, 1974; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1,1984.

11 NY ADC 216.2
END OF DOCUMENT

I I NY ADC 216.3
11 NYCRR 216.3
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.3

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Section 216.3 Misrepresentation of policy provisions.

(a) No insurer shall knowingly misrepresent to a claimant the terms, benefits or advantages of the insurance policy pertinent to the claim.

(b) No insurer shall deny any element of a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is made in writing.

(c) Any payment, settlement or offer of settlement which, without explanation, does not include all amounts which should be included according to the claim filed by the claimant and investigated by the insurer shall, provided it is within the policy limits, be deemed to be a communication which misrepresents a pertinent policy provision.

Historical Note

Sec. filed Dec. 5, 1972; repealed, new filed May 12, 1982 eff. Aug. 15, 1982.

CASE NOTES:

Court granted leave to amend complaint where violation by insurance company of §§216.0, 216.3 and 216.6, prohibiting misrepresentation of policy provisions and requiring prompt and fair claim settlement, if proven would constitute deceptive business practice and injury to public would be inherent where company provides services to public on large scale and is obligated to deal in good faith. Riordan v. Nationwide Mut. Fire Ins. Co., 1990, 756 F.Supp. 732, affirmed in part, question certified 977 F.2d 47, certified question withdrawn 984 F.2d 69

CASE NOTES:

I I NYCRR §216.3 specifies unfair claims settlement practices and does not suggest any further reading which would imply a private cause of action. Newsom v. Republic Financial Services, Inc., 1985, 497 N.Y.S.2d 830, 130 Misc.2d 780

11 NY ADC 216.3
END OF DOCUMENT
I I NY ADC 216.4
11 NYCRR 216.4
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.4

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Text is current through May 31, 1999, and annotationsare current through April 1999.

Section 216.4 Failure to acknowledge pertinent communications.

(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing. If an acknowledgment is made by other means, an appropriate notation shall be made in the claim file of the insurer. Notification given to an agent of an insurer shall be notification to the insurer. If notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent notifies the claimant that the agent is not authorized to receive notices of claims.

(b) An appropriate reply shall be made within 15 business days on all other pertinent communications.

(c) Every insurer shall establish an internal department specifically designated to investigate and resolve complaints filed with the Insurance Department and to take action necessitated as a result of its complaint investigation findings. Such internal department is to operate in a staff capacity to the entire company with authority to question and change the position taken in individual instances or company practices generally. Responsibility for such department is to be vested in a corporate officer who is also to be entrusted with the duty of executing the Insurance Departments directives. If the Insurance Department requests the appearance of an insurer representative to discuss a pending matter, the individual whom the company sends shall be authorized to make any determination warranted after all the facts are elicited at such conference. Each insurer must furnish the superintendent with the name and title of the corporate officer responsible for its internal consumer services department.

(d) Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim, shall, within 10 business days, furnish the department with the available information requested

respecting the claim.

(e) As part of its complaint handling function, an insurer's consumer services department shall maintain an ongoing central log to register and monitor all complaint activity.

Historical Note

Sec. filed Dec. 5, 1972; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1, 1984.

11 NY ADC 216.4
END OF DOCUMENT

I I NY ADC 216.5
11 NYCRR 216.5
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.5

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Text is current through May 31, 1999, and annotations are current through April 1999.

Section 216.5 Standards for prompt investigation of claims.

(a) Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within 15 business days of receipt of notice of claim. An insurer shall furnish to every claimant, or claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim. A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent notifies the person filing the claim that the agent is not authorized to receive notices of claim.

(b) Where there is a reasonable basis, supported by specific information available for review by Insurance Department examiners, that the claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this Part. The provisions of this Part are suspended for the period required to investigate the alleged fraudulent aspects of the claim. The insurer must submit the report required by Part 86 (Insurance Frauds Bureau) of this Title when an insurer determines that a loss is suspect.

Historical Note

See. filed Dec. 5, 1972; repealed, new filed May 12, 1982 eff. Aug. 15, 1982.

I I NY ADC 216.5
END OF DOCUMENT

I I NY ADC 216.6
11 NYCRR 216.6
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.6

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CLAIM COST CONTROL MEASURES
Text is current through May 31, 1999, and annotations are current through April 1999.

Section 216.6 Standards for prompt, fair and equitable settlements.

(a) In any case where there is no dispute as to coverage, it shall be the duty of every insurer to offer claimants, or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions.

(b) Actual cash value, unless otherwise specifically defined by law or policy, means the lesser of the amounts for which the claimant can reasonably be expected to:

(1) repair the property to its condition immediately prior to the loss; or

(2) replace it with an item substantially identical to the item damaged. Such amount shall include all monies paid or payable as sales taxes on the item repaired or replaced. This shall not be construed to prevent an insurer from issuing a policy insuring against physical damage to property, where the amount of damages to be paid in the event of a total loss to the property is a specified dollar amount.

(c) Within 15 business days after receipt by the insurer of a properly executed proof of loss and/or receipt of all items, statements and forms which the insurer requested from the claimant, the claimant, or the claimant! s authorized representative, shall be advised in writing of the acceptance or rejection of the claim by the insurer. When the insurer suspects that the claim involves arson, the foregoing 15 business days shall be read as 30 business days pursuant to section 2601 of the Insurance Law. If the insurer needs more time to determine whether the claim should be accepted or rejected, it shall so notify the claimant, or the claimant's authorized representative, within 15 business days after receipt of such proof of loss, or requested information. Such notification shall include the reasons additional time is needed for investigation. If the claim remains unsettled, unless the matter is in litigation or arbitration, the insurer shall, 90 days from the date of the initial letter setting forth the need for further time to investigate, and every 90 days thereafter, send to the claimant, or the claimant! s authorized representative, a letter setting forth the reasons additional time is needed for investigation. If the claim is accepted, in whole or in part, the claimant, or the claimants authorized representative, shall be advised in writing of the amount offered. In any case where the claim is rejected, the insurer shall notify the claimant, or the claimants authorized representative, in writing, of any applicable policy provision limiting the claimant's right to sue the insurer.

(d) The company shall inform the claimant in writing as soon as it is determined that there was no policy in force or that it is disclaiming liability because of a breach of policy provisions by the policyholder. The insurer must also explain its specific reasons for disclaiming coverage.

(e) In any case where there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

(f) Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than five business days from the receipt of such agreement by the insurer, or from the date of the performance by the claimant of any condition set by such agreement, whichever is later, except as provided in section 331 of the Insurance Law as respects liens by tax districts on fire insurance proceeds.

(g) Checks or drafts in payment of claims; releases. No insurer shall issue a check or draft in payment of a first-partyclaim or any element thereof, arising under any policy subject to this Part, that contains any language or provision that expressly or impliedly states that acceptance of such check or draft shall constitute a final settlement or release of any or all future obligations arising out of the loss. No insurer shall require execution of a release on a first- or third-party claim that is broader than the scope of the settlement.

(h) Any notice rejecting any element of a claim involving personal property insurance shall contain the identity and the claims processing address of the insurer, the insured's policy number, the claim number, and the following statement prominently set out:

"Should you wish to take this matter up with the New York State Insurance Department, you may write or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; Agency Building One, Governor Nelson A. Rockefeller Empire State Plaza, Albany, NY 12257; or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202."

Historical Note

Sec. filed Dec. 5, 1972; amds. filed: April 5, 1973; Jan. 14, 1975; repealed, new filed May 12, 1982; amds. filed: Sept. 4, 1984; April 7, 1997; Nov. 6, 1997 as emergency measure; Jan. 16, 1998 eff. Feb. 4, 1998. Amended (h).

CASE NOTES:

Court granted leave to amend complaint where violation by insurance company of §§216.0, 216.3 and 216.6, prohibiting misrepresentation of policy provisions and requiring prompt and fair claim settlement, if proven would constitute deceptive business practice and injury to public would be inherent where company provides services to public on large scale and is obligated to deal in good faith. Riordan v. Nationwide Mut. Fire Ins. Co., 1990, 756 F.Supp. 732, affirmed in part, question certified 977 F.2d 47, certified question withdrawn 984 F.2d 69

CASE NOTES:

Regulation I I NYCRR §216.6(g) prohibiting provisions in insurer's first- party claim check that acceptance is final settlement, does not result in accord and satisfaction by reason of insured's uncomplaining acceptance of check. Dunrite Auto Body & Motor Works, Inc. v. Liberty Mut. Ins. Co., 1992, 590 N.Y.S.2d 152, 153 Misc.2d 440, on remand 607 N.Y.S.2d 1005, 160 Misc.2d 168

11 NY ADC 216.6
END OF DOCUMENT

New Jersey Unfair Claim Regulations

1. NJ Trade Practices and Discriminations
2. NJ Trade Practices Regulated
3. NJ Unfair Claims Settlement Practices

NJ ST 17B:30-13.1
N.J.S.A. 17B:30-13.1
TEXT

NEW JERSEY STATUTES ANNOTATED
TITLE 17B. INSURANCE
SUBTITLE 3. LIFE AND HEALTH INSURANCE CODE
CHAPTER 30. TRADE PRACTICES AND DISCRIMINATIONS
Current through L.1999, c. 198

17B:30-13.1. Unfair claim settlement practices

No person shall engage in unfair claim settlement practices in this State. Unfair claim settlement practices which shall be unfair practices as defined in N.J.S. 17B:30-2, shall include the following practices:

Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

e. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

j. Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

l. Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

m. Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

CREDIT
CREDIT(S)
1996 Main Volume
L.1975, c. 101, s 1, eff. July 21, 1975.
<General Materials (GM) - References, Annotations, or Tables>

HISTORICAL AND STATUTORY NOTES

1996 Main Volume
Title of Act:
An Act prohibiting insurance companies from engaging in unfair claims settlement practices, concerning life and health insurance, supplementing chapter 30 of Title 17B of New Jersey Statutes, and making an appropriation therefor. L.1975, c. 101.

ADMINISTRATIVE CODE REFERENCES

Unfair claim settlement practices, see N.J.A.C. 11:2-17.1 et seq.

AMERICAN LAW REPORTS

Insurer's liability for consequential or punitive damages for wrongful delay or refusal to make payments due under contracts, 47 ALR3d 314@ec.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim, 33 ALR4th 579@ec.

Recoverability of punitive damages in action by insured against liability insurer for failure to settle claim against insured, 85 ALR3d 1211@ec.

Limitation of action against liability insurer for failure to settle claim or action against insured, 68 ALR2d 892@ec.

UNITED STATES SUPREME COURT

Equal protection, punitive damages, bad faith refusal to pay insurance claims, see Bankers Life and Cas. Co. v. Crenshaw (U.S.Miss. 1988) 108 S.Ct. 1645, 486 U.S. 71, 100 L.Ed.2d 62.

NOTES OF DECISIONS
Constitutionality 1
Costs and fees 5
Damages 4
Jurisdiction 2
Remedies available 3

1. Constitutionality

Standards of performance for insurance companies articulated in s 17B:30-1 et seq. are neither so imprecise nor so vague as to offend due process; rather guidelines contained in Unfair Claim Settlement Practices Act are sufficiently informative to instruct insurance companies in regulation of their business practices and to adequately guide department of insurance in its review of those practices. Sheeran v. Progressive Life Ins. Co., 182 N.J.Super. 237, 440 A.2d 469 (A.D.1981).

2. Jurisdiction

Jurisdiction to adjudicate insurance benefit payments claims, involving as they did interpretation of contractual rights and remedies, was originally cognizable in the law division where such plenary proceedings as may have been necessary could be provided; nevertheless, administrative tribunal was also required to deal with each count alleging unfair settlement practices, including those charging failure to pay legitimate claims and since detailed evidence was taken and specific findings of fact were made, it would have been imprudent and wasteful to require each claimant to institute a new action at law for breach of contract and produce same evidence heard by administrative law judge, therefore action instituted at law division by the commissioner of insurance was appropriate vehicle for prosecution of 17 individual claims as limited class action. Sheeran v. Progressive Life Ins. Co., 182 N.J.Super. 237, 440 A.2d 469 (A.D.1981).

3. Remedies available

Most states recognize two types of remedies when insurer fails to settle claims made against it by insured party, and traditional remedy is for breach of contract, but under recent developments in court law, insurer can also be sued in tort for failure to settle claims in good faith. Polito v. Continental Cas. Co., C.A.3 (N.J.)1982, 689 F.2d 457.

4. Damages

Under contract theory, insured is generally denied consequential damages for failure to pay loss, recovery being limited to debt plus interest, and New Jersey does not appear to depart from general rule excluding consequential damages. Polito v. Continental Cas. Co., C.A.3 (N.J.)1982, 689 F.2d 457.

Health insurer could not be held liable for consequential and punitive damages for alleged emotional and physical distress suffered by insureds arising from insurer's alleged breach of fiduciary duty and bad faith in failing to pay first-party insurance claim "fairly and expeditiously." Garden State Community Hosp. v. Watson, 191 N.J.Super. 225, 465 A.2d 1225 (A.D.1982), certification denied 94 N.J. 518, 468 A.2d 176.

5. Costs and fees

Under New Jersey law, although insureds did not ultimately prevail in obtaining verdict from jury in action against fire insurer, they were entitled to attorney fee award where their lawsuit was what brought about payment of the claims, and insureds at minimum should have been allowed fees for portion of legal services necessary to secure payment of policy benefits, and also

reasonable fee for taking appeal on fee issue. Polito v. Continental Cas. Co., C.A.3 (N.J.)1982, 689 F.2d 457.

N. J. S. A. 17B:30-13.1
NJ ST 17B:30-13.1
END OF DOCUMENT

NJ ST 17:29B-4
N.J.S.A. 17:29B-4
TEXT

NEW JERSEY STATUTES ANNOTATED
TITLE 17. CORPORATIONS AND INSTITUTIONS FOR FINANCE AND INSURANCE
SUBTITLE 3. INSURANCE
PART 1. INSURANCE COMPANIES GENERALLY
CHAPTER 29B. TRADE PRACTICES REGULATED
Current through L.1999, c. 198

17:29B-4. Unfair methods of competition and unfair or deceptive acts or practices defined

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of policy contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance, or resulting in or tending to result in unreasonable influence being exerted upon any producer that has an in-force contract as of the effective date of P.L.1997, c. 151 for the purpose of replacing the in-force contract with a UEZ agent contract pursuant to section 22 of P.L.1997, c. 151 (C.17:3C-4).

(5) False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive.

Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who was authorized by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

(6) Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common- law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Unfair discrimination.

(a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatsoever.

(c) Making or permitting any discrimination against any person or group of persons because of race, creed, color, national origin or ancestry of such person or group of persons in the issuance, withholding, extension or renewal of any policy of insurance, or in the fixing of the rates, terms or conditions therefor, or in the issuance or acceptance of any application therefor.

(d) Making or permitting discrimination in the use of any form of policy of insurance which expresses, directly or indirectly, any limitation or discrimination as to race, creed, color, national origin or ancestry or any intent to make any such limitation or discrimination.

(e) Making or permitting any unfair discrimination solely because of age in the issuance, withholding, extension or renewal of any policy or contract of automobile liability insurance or in the fixing of the rates, terms or conditions therefor, or in the issuance or acceptance of any application therefor, provided, that nothing herein shall be construed to interfere with the application of any applicable rate classification filed with and approved by the commissioner pursuant to P.L.1944, c. 27 (C.17:29A-1 to 17:29A-28), or any amendment or supplement thereof, which is in effect with respect to such policy or contract of insurance.

(8) Rebates.

(a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or

inducement whatsoever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in clause 7 or paragraph (a) of this clause 8 shall be construed as including within the definition of discrimination or rebates any of the following practices (i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided, that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (ii) in the caseof life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; (iii) readjustment of the rate of premium for a group policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(n) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Failure to maintain complaint handling procedures. Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.

(11) The enumeration of this act of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or any court of review under the provisions of section 9 of this act [FN1].

CREDIT
CREDIT(S)
1994 Main Volume
L.1947, c. 379, s 4, eff. July 3, 1947. Amended by L.1965, c. 139, s 1; L.1975, c. 100, s 1, eff. July 21, 1975.
1999 Electronic Update
Amended by L.1997, c. 151, s 29, eff. Jan. 1, 1998.
[FN1] N.J.S.A. s 17:29B-9.
<General Materials (GM) - References, Annotations, or Tables>

REPEALED IN PART

<Repealed insofar as applicable to company authorized to do life insurance, health insurance and annuities business by L.1971, c. 144, eff. Jan. 1, 1972. See section 17B:36-3.>

ADMINISTRATIVE CODE REFERENCES

Standards of conduct for insurance producers and limited insurance representatives, see N.J.A.C. 11:17A-1.1 et seq.
Unfair claims settlement practices, see N.J.A.C. 11:2-17.1 et seq.

AMERICAN LAW REPORTS

Insurance anti-rebate statutes: validity and construction, 90 ALR4th213@ec.
Liability of insurer, or insurance agent or adjuster, for infliction of emotional distress, 6 ALR5th 297@ec.

LAW REVIEW AND JOURNAL COMMENTARIES

Strict liability in excess liability cases. 6 Seton Hall L.Rev. 662 (1975).

LIBRARY REFERENCES

1994 Main Volume
American Digest System
Prohibition of unfair or deceptive trade practices in insurance industry, see Insurance k11.
Unfair advertising and unfair trade practices prohibited in general, see Trade Regulation k767, 861 et seq.
Encyclopedias
Prohibition of unfair or deceptive trade practices in insurance industry, see C.J.S. Insurance ss 44 to 45.
Unfair advertising and unfair trade practices prohibited in general, see C.J.S. Trade-Marks, Trade-Names, and Unfair Competition ss 228, 237 et seq.
Forms
14A Am Jur Pl & Pr Forms, Rev, Insurance, Forms 386.1, 413.
Texts and Treatises
43 Am Jur 2d, Insurance s 35.
18 Am Jur Proof of Facts 3d 323, Punitive Damages Against an Insurer for the Bad-Faith Handling of a First-Party Claim.
31 Am Jur Proof of Facts 2d 323, Insurer's Breach of Covenant of Good Faith and Fair Dealing, First Party Claims.
12 Am Jur Trials 549, Actions on Life Insurance Policies.
45 Am Jur Trials 475, Handling a First-Party Insurance Bad-Faith Case for the Plaintiff.

NOTES OF DECISIONS
Bad faith delay 2
Boycott, coercion and intimidation 3
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Construction 1
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1. Construction

This section concerning unfair claims settlement practices applies to bail bond companies and thus imposes burden on them to attempt to settle promptly reasonable clear claims. In re Midland Ins. Co., 167 N.J.Super. 237, 400 A.2d 813 (A.D.1979).

Section 17:29B-1 et seq. regulating trade practices in business of insurance and forbidding unfair discrimination are not read into contracts of insurance so as to create cause of civil action for breach of contract for individual policyholder. Retail Clerks Welfare Fund, Local No. 1049, AFL-CIO v. Continental Cas. Co., 71 N.J.Super. 221, 176 A.2d 524 (A.D.1961).

2. Bad faith delay
Insurer's bad-faith delay in processing payment of first-party benefits is established by showing that no valid reasons existed to delay processing claim and that insurer knew or recklessly disregarded fact that no valid reasons supported delay. Pickett v. Lloyd's, 131 N.J. 457, 621 A.2d 445 (1993).

3. Boycott, coercion and intimidation

An unlawful boycott will not result from a buyer's refusal to pay a higher price for goods or services where it can buy them at a lower price. Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., 168 N.J.Super. 68, 401 A.2d 722 (L.1979), affirmed 176 N.J.Super. 320, 423 A.2d 311.

4. Private cause of action

Cause of action exists for insurer's bad-faith denial or withholding of first- party benefits to insured if the reasons are not even debatably valid and policyholder's economic losses are clearly within contemplation of insurer. Pickett v. Lloyd's, 131 N.J. 457, 621 A.2d 445 (1993).

No individual or private cause of action exists under Insurance Trade Practices Act [N.J.S.A. 17:29B-1 et seq.]. Pierzga v. Ohio Cas. Group of Ins. Companies, 208 N.J.Super. 40, 504 A.2d 1200 (A.D.1986), certification denied 104 N.J. 399, 517 A.2d 402.

5. Unfair claim settlement

Judgment against unidentified permissive user would not be required for passenger to make a claim for automobile liability insurance; if there was a "covered person" who was operating the car, the insurance company was contractually required to provide indemnity for that person's fault, and both law and regulatory policy bound insurer to negotiate in good faith with passenger. Samuel v. Doe, 158 N.J. 134, 727 A.2d 1016 (1999).

Statute governing unfair claims settlement practices does not impose requirements in addition to or independent of rule that insured will not have cause of action for bad faith against insurer if reasons for denial of benefits were fairly debatable. Universal-Rundle Corp. v. Commercial Union Ins. Co., 319 N.J.Super. 223, 725 A.2d 76 (A.D.1999), certification denied 161 N.J. 149, 735 A.2d 574.

Practice of an automobile insurer to calculate reimbursement for its insured based upon lowest prevailing price in market place, and to insure integrity of an estimate by having an open list of competing body repair shops which will generally accept it, is very essence of competition and is not violative of antitrust laws. Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., 168 N.J.Super. 68, 401 A.2d 722 (L.1979), affirmed 176 N.J.Super. 320, 423 A.2d 311.

Bail bond surety's failure to engage in prompt affirmative conduct in either paying judgment or moving for its vacation supported conclusion that it failed to make good-faith attempt to effectuate prompt, fair and equitable settlement and authorized a finding of liability, under this section requiring fair claims settlement practices, and resulting order to cease and desist. In re Midland Ins. Co., 167 N.J.Super. 237, 400 A.2d 813 (A.D.1979).

6. Punitive damages

In the highly regulated area of personal injury protection, wrongful failure to pay benefits, wrongful withholding of benefits, or other violation of statute does not give rise to claim for punitive damages. Pickett v. Lloyd's, 131 N.J. 457, 621 A.2d 445 (1993).

7. Cancellation

Insurer's cancellation of paid-up insurance mid-term for "underwriting reasons" after giving 30 days' notice or for no reason violates public policy. Harvester Chemical Corp. v. Aetna Cas. & Sur. Co., 277 N.J.Super. 421, 649 A.2d 1296 (A.D.1994), certification denied 139 N.J. 441, 655 A.2d 443.

N. J. S. A. 17:29B-4
NJ ST 17:29B-4
END OF DOCUMENT

NJ ADC 11:2-17.1
N.J.A.C. 11:2-17.1
N.J. Admin. Code tit. 11, § 2-17.1

NEW JERSEY ADMINISTRATIVE CODE
TITLE 11. DEPARTMENT OF INSURANCE
CHAPTER 2. INSURANCE GROUP
SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES
Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.1 Purpose

N.J.S.A. 17:29B-4(9) and 1713:30-13.1 prohibit insurers from engaging in unfair claims settlement practices. The purpose of this subchapter is to promote the fair and equitable treatment of claimants by defining certain minimum standards for the settlement of claims which, if violated with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices in the business of insurance.

CASE NOTES

Immunity provided to New Jersey Full Insurance Underwriting Association servicing carriers for judgments arising from policy claims does not extend to acts outside scope of duties under contract that rise to level of bad faith. Miglicio v. HCM Claim Management Corp., 288 N.J.Super. 331, 672 A.2d. 266 (L. 1995).

NJ ADC 11:2-17.1
END OF DOCUMENT

NJ ADC 11:2-17.2
N.J.A.C. 11:2-17.2
N.J. Admin. Code tit. 11, § 2-17.2

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11:2-17.2 Scope

This subchapter applies to all persons and all policies except the following: ocean marine, fidelity and surety, boiler and machinery and workers'compensation. It shall also not apply to commercial property and liability policies for which the annual premium is more than $10,000 and where the claim is made by the commercial insured. This subchapter is not exclusive, and other acts, not herein specified, may also be found to constitute unfair claims settlement practices. This subchapter is not intended to supersede any other rule or regulation.

NJ ADC 11:2-17.2
END OF DOCUMENT

NJ ADC 11:2-17.3
N.J.A.C. 11:2-17.3
N.J. Admin. Code tit. 11, § 2-17.3

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Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.3 Definitions

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

"After market part" means sheet metal or plastic parts which constitute the exterior of an automobile, including inner and outer panels, manufactured by any manufacturer other than the original manufacturer of the part. Examples of after market parts include, but are not limited to, the following: doors, hoods, fenders, trunk lids, grills and bumper components.

"Catastrophe" means a calamity or other disastrous event that causes widespread losses resulting in excessive claims volume.

"Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant! s designated legal representative and includes a member of the claimant's immediate family designated by the claimant.

"Claims settlement" means all the activities of an insurer relating directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy, and which result in a claim payment or acceptance, compromise or rejection.

"First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or less covered by such policy or contract.

"Insurer" means any person, corporation, association, partnership, company, fraternal benefit society, eligible unauthorized surplus lines insurer and any other legal entity engaged as an indemnitor or contractor in the business of insurance. For the purposes of this subchapter, "insurer" shall include any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

"Investigation" means all activities of an insurer related directly or indirectly to the determination of liabilities under coverages afforded by an insurance policy.

"Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.

"Pertinent communication" means all correspondence as well as conversations or other forms of communication that are materially related to the handling of a claim.

"Policy" means any contract of insurance and includes, but is not limited to, all policies, contracts, certificates, riders and endorsements which provide insurance coverage.

"Proof of loss" means the necessary documentation required from a claimant to establish entitlement to payment or benefits under a policy.

"Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

"Workers' compensation" includes, but is not limited to, Longshoreman' s and Harbor Workers' Compensation.

Amended by R.1988 d.480, effective October 17, 1988.

See: 20 N.J.R. I I 59(a), 20 N.J.R. 2578(a).

Added definition "after market part".

Petition for Rulemaking.

See: 25 N.J.R. 6065(a).

NJ ADC 11:2-17.4
N.J.A.C. 11:2-17.4
N.J. Admin. Code tit. 11, § 2-17.4

NEW JERSEY ADMINISTRATIVE CODE
TITLE 11. DEPARTMENT OF INSURANCE
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SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES
Current through September 7, 1999; 31 N.J. Reg. No. 11:2-17.4 Miscellaneous rules

(a) Every insurer shall distribute copies of this subchapter to every person directly responsible for the handling and settlement of claims subject to this subchapter. Every insurer shall satisfy itself that all such responsible persons are thoroughly conversant with and are complying with this subchapter.

(b) All correspondence to a claimant required of an insurer pursuant to this subchapter shall be written in easy to read and understandable terms. This subsection shall not apply to correspondence to a claimant's legal representative.

NJ ADC 11:2-17.4
END OF DOCUMENT

NJ ADC 11:2-17.5
N.J.A.C. 11:2-17.5
N.J. Admin. Code tit. 11, § 2-17.5

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11:2-17.5 Misrepresentation of policy provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent, broker, or insurer shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(c) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(d) No insurer shall request a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(e) No insurer shall issue checks or drafts in partial settlement of a loss or claim using language which releases the insurer or its insured from its total liability.

NJ ADC 11:2-17.5
END OF DOCUMENT

NJ ADC 11:2-17.6
N.J.A.C. 11:2-17.6
N.J. Admin. Code tit. 11, § 2-17.6

NEW JERSEY ADMINISTRATIVE CODE
TITLE 11. DEPARTMENT OF INSURANCE
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Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.6 Rules for replying to pertinent communications

(a) All claims must be reported to the designated insurer by a broker no later than three working days following receipt of notification of claim by the broker. For the purposes of this subsection, "broker" shall include a producer of record with respect to any residual market mechanism created by statute.

(b) Every insurer, upon receiving notification of claim shall, within 10 working days, acknowledge receipt of such notice unless payment is made within such period of time. This acknowledgement shall include the address and telephone number of the insurer claims office or authorized claim representative which will handle the claim. Notification given to an agent of an insurer shall be considered notice to the insurer.

(c) Every insurer, upon receiving notification of claim, shall promptly provide first party claimants with necessary claim forms, instructions, and reasonable assistance so that such claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subsection (c) within 10 working days of notification of a claim shall constitute compliance with (b) above.

(d) Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim shall, within 15 working days of receipt of such inquiry furnish the Department with, based on the information available to the insurer, a complete and accurate written response to the inquiry.

(e) An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

Amended by R. 1991 d.4, effective January 7, 199 1.

See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).

Deleted references to "New Jersey Automobile Insurance Plan and the New Jersey Insurance Underwriting Association".

NJ ADC 11:2-17.6
END OF DOCUMENT

NJ ADC 11:2-17.7

N.J.A.C. 11:2-17.7
N.J. Admin. Code tit. 11, § 2-17.7

NEW JERSEY ADMINISTRATIVE CODE
TITLE 11. DEPARTMENT OF INSURANCE
CHAPTER 2. INSURANCE GROUP
SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES
Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.7 Rules for prompt investigation and settlement of claims

(a) Every insurer shall commence an investigation on all claims other than auto physical damage within 10 working days of receipt of notification of claim.

(b) The maximum payment period for all personal injury protection (PIP) claims shall be 60 calendar days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same; provided, however, that an insurer may secure a 45-day extension in accordance with N.J.S.A. 39:6A-5.

(c) Unless a clear justification exists, or unless otherwise provided by law, the maximum payment periods for property/liability claims shall be as follows:

1. For all first party claims other than personal injury protection (PIP) and auto physical damage (see N.J.A.C. 11:3-10.5(a)), 30 calendar days from receipt by the insurer of properly executed proofs of loss.

2. For all third party property damage claims, 45 calendar days from receipt by the insurer of notification of claim.

3. For all third party bodily injury claims, 90 calendar days from receipt by the insurer of notification of claim.

(d) Unless a clear justification exists, or unless otherwise provided by the policy, all life insurance claims shall be paid within a maximum payment period of 30 calendar days. The payment period is defined as the period between the date proof of loss is received by the insurer and the date of claims settlement.

(e) Except as provided in (e) I below, all health insurance claims shall be paid no later than 60 calendar days after the insurer receives written notice of the claim.

1. The maximum payment period for health insuranceclaims may be extended under the following circumstances:

i. The health insurer contests a claim, and the insurer sends written notice of such fact to the insured or insured's assignee within 45 calendar days of the insurer's receipt of the claim. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. If only a portion of a claim is contested, the insurer shall remit payment for the uncontested portion in accordance with (e) above; or

ii. The health insurer requests additional information from the insured concerning a claim that the insurer is contesting. After the insurer receives the additional information requested, the insurer shall either pay or deny the claim within 90 calendar days of the insurer's receipt of the additional information.

2. Payment of a health insurance claim shall be considered to have been made either:

i. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or

ii. If not posted pursuant to (e)2i above, on the date of delivery of a draft or other valid instrument equivalent to payment.

3. If the health insurer fails to make payment on a claim within the time limits set forth in this subsection, the insurer shall pay simple interest on the amount of the overdue payment at the rate of 10 percent per year.

(f) If the insurer is unable to settle the claim within the time periods specified in (c) through (e) above, the insurer must send the claimant written notice by the end of the payment periods specified in (c) through (e) above. The written notice must state the reasons additional time is needed, and must include the address of the office responsible for handling the claim and the insured's policy number and claim number. This notice shall also include a telephone number which is toll free, or which can be called collect, or which is within the claimant's area code. This number shall provide direct access to the responsible claims office or shall enable the claimant to gain such access at no greater expense than the cost of a telephone call within his or her area code. An updated written notice setting forth the reasons additional time is needed shall be sent within 45 days after the initial notice and within every 45 days thereafter until all elements of the claim are either honored or rejected. The written notifications required under this subsection shall not continue to apply to that aspect of a claim for which the claimant has become represented by an attorney, as evidenced by a letter of representation.

(g) Unless otherwise provided by law, every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than 10 working days from either the receipt of such agreement by the insurer or the date of the performance by the claimant of any conditions set by such agreement, whichever is later.

(h) Where there is a reasonable basis supported by specific information available for review by the Department of Insurance that the first party claimant has fraudulently caused or contributed to the loss by arson, or other fraudulent schemes, the insurer shall be relieved from the requirements of (c) through (f) above. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

Amended by R.1982 d.400, effective November 15, 1982.

See: 14 N.J.R. 966(a), 14 N.J.R. 1307(b).

Amended by R. 1992 d.93, effective February 18, 1992.

See: 23 N.J.R. 2830(a), 24 N.J.R. 622(a).

Maximum payment period for personal claims specified at (b).

Amended by R. 1992 d.493, effective December 7, 1992.

See: 23 N.JR. 3196(c), 24 N.J.R. 4391(a).

Subsection (d) added to provide for payment of all health insurance claims within 60 days, with certain exceptions as specified.

Petition for Rulemaking.

See: 25 N.J.R. 6065(a).

Amended by R.1996 d.497, effective October 21, 1996.

See: 28 N.J.R. 3703(a), 28 N.J.R. 4585(a).

Petition for Rulemaking: Notice of Receipt of and Action on a Petition for Rulemaking.

See: 28 N.J.R. 5509(a), 29 N.J.R. 264(c), 29 N.J.R. 2188(a), 29 N.JR. 4722(b).

<General Materials (GM) - References, Annotations,
or Tables>

NJ ADC 11:2-17.7
END OF DOCUMENT

NJ ADC 11:2-17.8
N.J.A.C. 11:2-17.8
N.J. Admin. Code tit. 11, § 2-17.8

NEW JERSEY ADMINISTRATIVE CODE
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Current through September 7,1999; 31 N.J. Reg. No. 17

11:2-17.8 Rules for fair and equitable settlements and reasonable explanations applicable to all insurance

(a) No insurer shall deny or offer to compromise a claim because of a policy provision, including any concerning liability, a condition, or an exclusion without providing a specific reference to such language and a statement of the facts which make that language operative.

(b) Any denial or offers of compromise to the claimant shall be confirmed in writing and shall be kept in the appropriate claim file.

(c) In any case where a first party claim is denied or a compromise is offered, the insurer shall notify the first party claimant of any applicable policy provision limiting such claimant' s right to sue the insurer.

(d) Insurer shall not fail to settle first party claims on the basis that responsibility for payment should be assured by others except as may otherwise be provided by law or policy provisions such as Workers' Compensation exclusions, or coordination of benefits provisions.

(e) If a claimant is actively negotiating with an insurer for settlement of a claim, and the claimants rights may be affected by a statute of limitations or a policy time limit, the insurer shall provide the claimant with written notice that the time limit may be expiring and may affect the claimants rights. Such notice shall be given to claimants 60 calendar days before the date on which such time limit may expire. This rule shall only apply if the insurer is negotiating a claims settlement with a person who is neither an attorney nor represented by an attorney.

(f) No insurer shall make statements which indicate that the rights of a claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the claimant of any applicable law or policy provision.

(g) Unless otherwise provided by law, in any case where there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of

disputes as to other elements of the claim where such payment can be made without prejudice to either party.

(h) An insurer shall not compel claimants to institute litigation to recover amounts due under an insurance policy by offering substantially less than amounts recovered in actions brought by such claimants.

(i) No insurer shall deny payment of a claim when it is reasonably clear that either fall or partial benefits are payable.

0) No claim shall be denied or compromised based on an exclusion, reduction or limitation in a policy unless documentation of facts rendering the exclusion, reduction or limitation operative can be obtained. If such documentation is not made a part of the claim file, the insurer shall place in the claim file a written notation explaining how documentation may be obtained.

(k) With respect to first party claims, insurers shall make claim payments by check or draft with a statement setting forth the coverage under which payment is made and in sufficient detail so that first party claimants can reasonably understand the benefits included within the claim payment. The details should include an explanation of how the benefit payment was calculated. This subsection shall not apply to claims in which the claim payment figure was arrived at through negotiations between the insurer and the first party claimant.

(1) If a first party claimant or a third party claimant not represented by an attorney does not submit sufficient information to establish his or her entitlement to the benefits claimed, then the insurer shall provide the claimant with a general description of the information and documentation needed to establish such entitlement.

LAW REVIEWS AND JOURNAL
COMMENTARIES

Proving Bad Faith in Environmental Coverage Actions. Patrick Nucciarone, Jeffrey A. Cohen, Alexa

NJ ADC 11:2-17.9
N.J.A.C. 11:2-17.9
N.J. Admin. Code tit. 11, § 2-17.9

NEW JERSEY ADMINISTRATIVE CODE
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Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.9 Rules for fair and equitable settlements applicable to life and health insurance

(a) No insurer shall indicate on a payment draft, check or in any accompanying cover letter that said payment is "final" if additional benefits relating to the claim for which benefits are being paid are payable under the policy.

(b) When it is apparent to the insurer that additional benefits would be payable under a policy upon receipt of additional proofs of loss from the claimant, the insurer shall explain to the claimant in writing or by telephone the additional proofs or information needed to establish entitlement to additional benefits.

(c) No insurer shall undertake any activity that has the effect of coercing the insured to settle a disability claim on a lump sum basis.

(d) No insurer shall pay a claim involving both a covered and noncovered condition on a percentage basis of contributing loss, unless said percentage is reasonable.

(e) Settlement of claims for a fraction of an indemnity period shall be on a pro rata basis unless the policy specifically excludes pro-rata payments.

(f) If it is found that an insureds age is overstated on an individual life or health policy or understated on an annuity, benefits shall be adjusted upward under a policy which contains a misstatement of age provision specified in N.J.S.A. 1713:25-6 and N.J.S.A. 17B:26-18.

(g) No insurer shall request a claimant to sign an agreement which releases the insurer from all future claims under an insurance policy unless no other benefits are payable under it.

(h) Unless otherwise provided by the policy, no insurer may terminate disability benefits based solely on lack of regular medical attendance when the disability has been verified by a physician and can reasonably be expected to continue beyond the date through which benefits have been paid.

(i) No policy shall be rescinded and claim denied for loss incurred during the contestable period based on material misrepresentation by the applicant unless the application is a part of the contract.

(j) No policy shall be rescinded and claim denied for loss incurred during the contestable period based on omission of material information when such information is not specifically requested on the application.

(k) When an application for a life/health policy contains only one medical question or declaration as to general status of the insureds health, such as, "Are you now in good health?", an insurer shall not rescind a policy or deny a claim for loss incurred during the contestable period on the basis of material misrepresentation, if based on the totality of circumstances, the insured responded to the best of his/ her knowledge and belief that the general status of his/ her health was satisfactory.

Petition for Rulemaking.

See: 25 N.J.R. 6065(a).

NJ ADC 11:2-17.9
END OF DOCUMENT

NJ ADC 11:2-17.12
N.J.A.C. 11:2-17.12
N.J. Admin. Code tit. 11, § 2-17.12

NEW JERSEY ADMINISTRATIVE CODE
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Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.12 Examinations

(a) Each insurer's claim files are subject to examination and inspection by the Commissioner or by his duly appointed designees pursuant to N.J.S.A. 17:234,17:29B-5,17B:21-3 and 1713:30-16.

(b) Detailed. documentation and/or evidence shall be contained in each claim file in order to permit the Commissioner or his designated examiners or investigators to reconstruct the company's activities relative to the claims settlement. Such documentation shall include but is not necessarily limited to all investigative reports, payment vouchers, transactions, notices, memoranda and work papers. With respect to automobile damage claims, file documentation also shall include the name, address, telephone number and license number of any auto body repair facility that has been utilized by the insurer in the adjustment of the loss or repair of the automobile. All such documentation shall be properly dated and, for investigative reports, notes, memoranda and work papers, the parties preparing such documents shall be identified.

(c) Every insurer shall maintain records of all pertinent communications relating to a claim. The records must identify the date of the communication and the parties, and describe the substance of the communication.

Amended by R. 1987 d.249, effective June 15, 1987.

See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).

Inserted new text in (b) "With respect to ... of the automobile."

Recodified from 11:2-17.11 by R.1993 d.681, effective December 20, 1993.

See: 25 N.J.R. 3921(a), 25 N.J.R. 5929(b).

NJ ADC 11:2-17.12
END OF DOCUMENT

NJ ADC 11:2-17.13
N.J.A.C. 11:2-17.13
N.J. Admin. Code tit. 11, § 2-17.13

NEW JERSEY ADMINISTRATIVE: CODE
TITLE 11. DEPARTMENT OF INSURANCE
CHAPTER 2. INSURANCE GROUP
SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES
Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.13 Special claims reports

(a) If the Department of Insurance observes that an insurer's claims settlement practices are not meeting the standards established by statute or by this subchapter, the Department may require such insurer to file periodic reports. Depending on the nature and extent of an insurer's deviations from such standards and with due consideration of the insurer's data capabilities, the Commissioner in his discretion may require the report to include some or all of the statistics listed below:

1. The total number of claims submitted;
2. The original amount claimed;
3. The classification by line or insurance of each individual claim;
4. The total number of claims denied;
5. The total number of claims paid;
6. The total number of claims compromised;
7. The amount of each settlement;
8. The total number of claims for which lawsuits are instituted against the insurer, the reason for the lawsuit, and the amount of the final adjudication; and
9. An individual listing showing the disposition and other information for each claim.

Recodified from 11:2-17.12 by R.1993 d.681, effective December 20, 1993.

See: 25 N.J.R. 3921(a), 25 N.J.R. 5929(b).

NJ ADC 11:2-17.13
END OF DOCUMENT

NJ ADC 11:2-17.15
N.J.A.C. 11:2-17.15
N.J. Admin. Code tit. 11, § 2-17.15

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Current through September 7, 1999; 31 N.J. Reg. No.17

11:2-17.15 Penalties

(a) If, after notice and hearing, the Commissioner finds that a person has violated this subchapter, he shall make his findings in writing and shall issue and cause to be served upon the person charged with the violation an order requiring such person to cease and desist from engaging in such violation. The Commissioner may order payment of a penalty not to exceed $ 1,000 for each and every violation unless the person knew or reasonably should have known he was in violation of this subchapter, in which case the penalty shall not be more than $5,000 for every violation. The Commissioner shall collect the penalty in the name of the State in a summary proceeding in accordance with "the penalty enforcement law" (N.J.S.A. 2A:58-1 et seq.).

(b) Any person who violates a cease and desist order of the Commissioner under (a) above, after it has become final, and while such order is in effect, shall be liable to a penalty not exceeding $5,000 for each violation, which may be recovered in a civil action. In determining the amount of the penalty the question of whether the violation was willful shall be taken into consideration.

(c) The penalties provided herein shall be in addition to any other penalties authorized by law.

Repeal and New Rule, R.1987 d.249, effective June 15,1987.

See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).

Petition for Rulemaking.

See: 25 N.J.R. 6065(a).

Recodified from 11:2-17.14 by R.1993 d.681,
effective December 20, 1993.

See: 25 N.J.R. 392 1 (a), 25 N.J.R. 5929(b).

NJ ADC 11:2-17.15
END OF DOCUMENT

NY Unfair Claims Settlement Practices Law

1. NY Circular Letter 1991-11 (September 5, 1991)
2. NY Circular Letter No. 1996-15 (October 16, 1996)
3. McKinney's Insurance Law Ch. 28, Art. 26
4. McKinney's Insurance Law Ch. 28, Art. 26, Refs & Annos
5. Unfair Claims Settlement Practices and Claim Cost Control Measures

NY Circular Letter 1991-11
NY Circular Letter No. 1991-11 (September 5, 1991)

This document supplements1989-5
This document is supplemented by1996-15

NEW YORK INSURANCE BULLETINS AND RELATED MATERIALS
CIRCULAR LETTERS
Circular Letter 1991-11
September 5, 1991

TO: All Insurers and Risk Retention Groups Doing Business in New York State
FROM: Salvatore R. Curiale
Superintendent of Insurance
DATE: September 5, 1991
RE: SCOPE OF REGULATION 64 ON CLAIMS SETTLEMENT PRACTICES

Regulation No. 64 (11 NYCRR 216) establishes minimum standards for claims- handling practices. These standards, if violated without just cause and with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices pursuant to Article 26 of the Insurance Law. When settling claims, insurers are expected to adhere to all pertinent Regulation 64 standards.

It has come to the Department's attention that there may be confusion on the part of some insurers concerning the kinds of insurance to which Regulation 64 applies. Several sections of the Regulation, in defining minimum standards for prompt, fair and equitable settlements, pertain only to motor vehicle property damage liability and physical damage claims, including verification and reporting requirements.

The other sections of Regulation 64 apply to all lines of business except those specifically exempted by s 216.2: workers' compensation, credit, title, inland marine (unless subject to the provisions of s 3425 of the Insurance Law), and ocean marine insurance. In addition:
subdivisions (a) and (b) of s 216.6 do not apply to life insurance;
subdivision (b) of s 216.6 does not apply to accident and health insurance; and
ss 216.4 and 216.5 and subdivision (c) of s 216.6 do not apply to accident and health insurance (where the claimant is not a policyholder, certificate holder under a group insurance policy, or relative or member of the household of such policyholder or certificate holder).

Thus, subject to the above parameters, sections in Regulation 64 that apply to all lines of insurance include:
s 216.0--Preamble
s 216.1--Definitions
s 216.3--Misrepresentation of Policy Provisions
s 216.4--Failure to Acknowledge Pertinent Communications
s 216.5--Standards For Prompt Investigation of Claims

s 216.6--Standards For Prompt, Fair and Equitable Settlements
s 216.9--Written Notice to Claimants of Payment of Claim in Third-party Settlements
s 216.11-Examinations

While a number of market conduct investigations into insurer claim practices have focused upon auto insurance, emphasis in the future will also be placed on determining compliance with minimum claims settlement standards in regard to other applicable lines of business. Appropriate actions, as outlined-in annexed Circular Letter No. 5 (1989), will continue to be taken in all instances where market conduct investigations reveal unfair claims settlement practices.

The executive in charge of claims should send written acknowledgement of this Circular Letter, no later than September 20, 1991, to:

David Holstein
Supervising Insurance Examiner
Market Conduct Unit
Property & Casualty Insurance Bureau
New York State Insurance Department
160 West Broadway
New York, New York 10013-3393.

NY Circular Letter 1991-11

END OF DOCUMENT

NY Circular Letter 1996-15
NY Circular Letter No. 1996-15 (October 16, 1996)
This document supplements1991-11

NEW YORK INSURANCE BULLETINS AND RELATED MATERIALS
CIRCULAR LETTERS
Circular Letter 1996-15
October 16, 1996

TO: All Authorized Property Insurers Writing Business in New York State
FROM: Stewart Keir
Assistant Deputy Superintendent and Chief--Property/Casualty Insurance Bureau
DATE: October 16, 1996
RE: INSURANCE COVERAGE FOR LOSSES RESULTING FROM FLOODS

Insurance coverage for losses resulting from floods is for the most part not covered under any property insurance policy whether it be on the home or business. In 1968 the National Flood Insurance Program (NFIP) was created specifically to provide financial security for both home and business owners in flood prone areas.

The NFIP provides affordable, easily obtainable flood insurance for residents and property owners who are located in areas designated by the Federal government as a special flood hazard community which implements and enforces measures to reduce future flood risks. The majority of New York State towns, villages and cities are participants in the NFIP. This program allows insureds to purchase insurance that will protect their property against direct loss by flood, loss resulting from flood-related erosion, and damage caused by mudslide. Coverage can be obtained up to $185,000 for a single family dwelling and up to $200,000 for a non-residential building. Contents coverage can be obtained on a residential structure for up to $60,000 and on a small business up to $300,000.

Property owners can obtain flood insurance directly through the Federal Insurance Administration or through private insurance companies who participate in the "Write Your Own" program allowed under federal regulation. This program was started in 1981 by the Federal Insurance Administrator to reinvolve the private sector insurance companies in the flood program. This program allows the private insurer to directly write a flood policy and be reimbursed by the federal government for claims and expenses which exceed the premiums they receive from policyholders. . .

Section 2601-NYIL and Regulation 64, in part, prohibits insurers doing business in this State from engaging in unfair claims settlement practices and provides that, if any insurer performs any of the acts or practices proscribed by that section without just cause and with such frequency as to indicate a general business practice, then those acts shall constitute unfair claims settlement practices, subject to Departmental disiplinary actions, as warranted.

The purpose of this Circular Letter is to direct your attention once again to Circular Letter No. 11 (1991) "Scope of Regulation 64 on Claims Settlement Practices" (attached) [FN1] and to advise that flood insurance policies written under the "Write Your Own Program" are subject to the claims paying practices provisions of Section 2601 and Regulation 64.

Kindly acknowledge receipt of this Circular Letter to:
David Holstein
Supervising Insurance Examiner
New York State Insurance Department
160 West Broadway
Property/Casualty Bureau, 13th floor
New York, NY 10013
(212) 602-8745

NY Circular Letter 1996-15

END OF DOCUMENT

NY INS s 2601
McKinney's Insurance Law s 2601
TEXT

McKinney's Consolidated Laws Of New York Annotated Insurance Law
Chapter 28 Of The Consolidated Laws
Article 26--Unfair Claim Settlement Practices; Other Misconduct; Discrimination
Current through L.1999, ch. 659

s 2601. Unfair claim settlement practices; penalties
(a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:
(1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;
(2) failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies;
(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;
(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear, except where there is a reasonable basis supported by specific information available for review by the department that the claimant

has caused the loss to occur by arson. After receiving a properly executed proof of loss, the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days;
(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; or
(6) failing to promptly disclose coverage pursuant to subparagraph (A) of paragraph two of subsection (f) of section three thousand four hundred twenty of this chapter.

(b) Evidence as to numbers and types of complaints to the department against an insurer and as to the department's complaint experience with other insurers writing similar lines of insurance shall be admissible in evidence in any administrative or judicial proceeding under this section or article twenty-four or seventy-four of this chapter, but no insurer shall be deemed in violation of this section solely by reason of the numbers and types of such complaints.

(c) If it is found, after notice and an opportunity to be heard, that an insurer has violated this section, each instance of noncompliance with subsection (a) hereof may be treated as a separate violation of this section for purposes of ordering a monetary penalty pursuant to subsection (b) of section one hundred nine of this chapter. A violation of this section shall not be a misdemeanor.

CREDIT
CREDIT(S)
1999-2000 Electronic Pocket Part Update
(As amended L.1997, c. 547, s 1, eff. Jan. 8, 1998.)
<General Materials (GM) - References, Annotations, or Tables>

HISTORICAL AND STATUTORY NOTES
HISTORICAL NOTES -- HISTORICAL AND STATUTORY NOTES
1999-2000 Electronic Pocket Part Update
1997 Legislation
L.1997, c. 547 amendment:
Subsec. (a), par. (6). L.1997, c. 547, s 1 added the paragraph.
1985 Main Volume
Derivation. L.1939, c. 882, s 40-d, added L.1970, c. 296, s 1; amended L.1981, c. 711, s4.

LEGISLATIVE HISTORIES
L.1997, c. 547: For Legislative, Executive or Judicial memorandum relating to this law, see the Table of Contents in McKinney's 1997 Session Laws of New York.

CROSS REFERENCES
Fire insurance; appraisal of loss; procedure for selection of umpire on failure to agree, see Insurance Law s 3408.
Notice of claim
Individual accident and health insurance policies, provisions regarding, see Insurance Law s 3216.
Liability insurance, see Insurance Law s 3420.
Property insurance, see Insurance Law s 3407.
Standard claim forms for fire losses, see Insurance Law s 3413.
Violation of this section defined as an unfair method of competition or an unfair and deceptive act or practice, see Insurance Law s 2402.

NEW YORK CODES, RULES AND REGULATIONS
1985 Main Volume
Claims for personal injury benefits under the Comprehensive Automobile Insurance Act, see 11 NYCRR 65.6, 11 NYCRR 65.15.
Standard fire claim form, see 11 NYCRR 62-3.0 et seq.
Unfair claims settlement practices and claim cost control measures, see 11 NYCRR 216.0 et seq.

WEST'S MCKINNEY'S FORMS
The following forms appear in Selected Consolidated Laws under Insurance Law s 2601:
Notice of motion to dismiss complaint against insurer for unfair claim settlement practices, see SCL, INS s 2601, Form 1.
Affirmation in support of motion to dismiss complaint against insurer for unfair claim settlement practices, see SCL, INS s 2601, Form 2.
Affidavit in support of motion to dismiss complaint against insurer for unfair claim settlement practices, see SCL, INS s 2601, Form 3.

AMERICAN LAW REPORTS
Emotional or mental distress as element of damages for liability insurer's wrongful refusal to settle. 57 ALR4th 801.

LAW REVIEW AND JOURNAL COMMENTARIES
Bad faith litigation: a window period on the horizon. Scahill. 63 N.Y.St.B.J. 31 (Nov. 1991).
Can the puzzle be solved: Are punitive damages awardable in New York for first-party bad faith? Neil A. Goldberg, Thomas F. Segalla and Richard J. Cohen, 44 Syracuse L.Rev. 723 (1993).
Disciplining the recalcitrant insurer: punitive damages for breach of contract. Riley, 57 N.Y.St.B.J. 30 (February 1985).
Punitive damages after "Rocanova." Evan H. Krinick, 211 N.Y.L.J. 1 (June 1, 1994).
Punitive damages and attorney's fees against insurers before Court of Appeals. James P. Tenney, 214 N.Y.L.J. 1 (Oct. 18, 1995).
Punitive damages and Insurance Law s 2601. Evan H. Krinick, 211 N.Y.L.J. 1 (March 17, 1994).

LIBRARY REFERENCES
1985 Main Volume
Texts and Treatises
29 NY Jur, Insurance s 119.5.
2A Couch on Insurance 2d, Penalties for Vexatious Delay or Refusal to Pay Loss ss 21:41, 21:42.

NOTES OF DECISIONS

1/2. Preemption

Under New York law, unfair claims settlement statute does not preempt common law claim for breach of covenant of good faith and fair dealing, even if alleged breaches consist of conduct cumulatively meeting statutory definition of unfair claim settlement practice. Greenspan v. Allstate Ins. Co., 1996, 937 F.Supp. 288.

Plaintiff's claims that his former employer and its parent company failed to provide him with insurance coverage for home health care as required by his employee benefits plan constituted unfair insurance claim settlement practice in violation of New York law was preempted under ERISA; relief that plaintiff sought was available to him under ERISA. Shackelton v. Connecticut General Life Ins. Co., 1993, 817 F.Supp. 277.

Cross claim for punitive damages against insurer, brought by claimant to insurance policy benefits, to extent it alleged that insurer failed to promptly investigate competing claims and failed to make good faith effort to effectuate prompt settlement of claims, was preempted by statutory provision limiting prosecution of such claims to state insurance department. Matter of Bernstein (2 Dept. 1989) 156 A.D.2d 683, 549 N.Y.S.2d 446.

1. Nature of remedy

Insured's action against insurer predicated on violation of McKinney's Insurance Law s 40-d [now this section] was properly dismissed, since redress under that statute by way of action for damages is not available to individual litigant. J & B Schoenfeld, Fur Merchants, Inc. v. Albany Ins. Co. (1 Dept. 1985) 109 A.D.2d 370, 492 N.Y.S.2d 38.

Insurance Law of 1939 s 40-d [now this section] setting standard by which insurers are to process claims does not create private right of action but rather affords public right of redress by insurance department for violations after a hearing and determination. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

2. Frequency of practice

Even if Insurance Law of 1939 s 40-d [now this section] proscribing unfair business practices of insurers could be read to create private cause of action, allegations of complaint were insufficient to bring case within said section in that, in particular, nothing demonstrated that conduct complained of by plaintiff occurred in more than one isolated instance. Hubbell v. Trans World Life Ins. Co. of New York, 1980, 50 N.Y.2d 899, 430 N.Y.S.2d 589, 408 N.E.2d 918.

Liability insurers were not estopped from relying on their untimely and purportedly defective notice of disclaimer as a defense in an action brought by their insured's judgment creditor to satisfy the judgment, where no coverage existed and the judgment creditor did not plead or prove a deceptive business practice or unfair claims settlement practice or show any actual prejudice flowing from the disclaimer. Aetna Cas. & Sur. Co. v. ITT Hartford Ins. Co. (1 Dept. 1998) 249 A.D.2d 241, 672 N.Y.S.2d 310.

Insured could not recover for alleged unfair claims practices based on allegation of isolated deceptive business practice aimed at insured alone, rather than on allegation of recurrent deceptive business practice aimed at public at large; insured's allegations did not amount to claim that challenged practice was "general business practice," within meaning of statute authorizing recovery. Myers, Smith & Granady, Inc. v. New York Property Ins. Underwriting Ass'n (1 Dept. 1994) 201 A.D.2d 312, 607 N.Y.S.2d 288, leave to appeal granted in part, dismissed in part 83 N.Y.2d 942, 615 N.Y.S.2d 870, 639 N.E.2d 410, affirmed 85 N.Y.2d 832, 623 N.Y.S.2d 840, 647 N.E.2d 1348.

Causes of action predicated upon violation of insurance statute defining unfair claim settlement practices and request for punitive damages and attorney fees in connection with fire loss claim should have been dismissed, where complaint contained no allegation that insurer engaged in

any conduct or transactions affecting general public. Piduch v. Lumbermens Mut. Cas. Co. (4 Dept. 1986) 124 A.D.2d 999, 508 N.Y.S.2d 790.

2A. Bad faith

Under New York law, insured who could not demonstrate that insurers' conduct in denying its fire claims was result of insurers' generally applicable settlement practices or that insurers' conduct had broader impact on public at large could not recover under New York consumer statute protecting against deceptive acts or practices; there was no evidence that actions of insurers in denying claim either for failure to present proof of loss or for suspected arson affected or could affect general public. Infostar Inc. v. Worcester Ins. Co., 1996, 924 F.Supp. 25.

Under New York law, bad faith could not be inferred from primary insurer's failure to settle action against its insured when no discovery had occurred and complaint had not yet even been filed against its insured and, therefore, primary insurer could not be held liable for failure to settle underlying action in manner that would have reduced excess insurer's liability. California Union Ins. Co. v. Excess Ins. Co., Ltd., 1991, 780 F.Supp. 1010.

New York court would not hold excess insurer liable for bad faith in failing to settle litigation against insured where excess carrier knew of primary insurer's refusal to settle and did not object, even if primary insurer did not make counteroffer to claimant or explicitly inform excess carrier that it was relinquishing control of litigation in favor of excess carrier. California Union Ins. Co. v. Excess Ins. Co., Ltd., 1991, 780 F.Supp. 1010.

Punitive damage award against an insured is not proper element of compensatory damages recoverable against insurer for bad-faith refusal to settle within policy limits. Soto v. State Farm Ins. Co., 1994, 83 N.Y.2d 718, 613 N.Y.S.2d 352, 635 N.E.2d 1222.

Causes of action of insured under insolvency risk insurance policy alleging that, as part of larger pattern of unfair claim settlement practices, insurer and underwriter acted in bad faith and failed to deal fairly with insured's claim under policy were barred by insured's negotiation and execution of release and assignment which released company from all causes of action related to policy; insured failed to establish any traditional basis for setting aside release such as duress, illegality, fraud, or mutual mistake. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Automobile insurer's failure to respond to plaintiff's time-restricted demand for settlement within full policy limits, at time when insured's liability remained under investigation, was insufficient to establish prima facie case of bad faith. Pavia v. State Farm Mut. Auto. Ins. Co., 1993, 82 N.Y.2d 445, 605 N.Y.S.2d 208, 626 N.E.2d 24, reargument denied 83 N.Y.2d 779, 611 N.Y.S.2d 126, 633 N.E.2d 480.

Evidence that settlement offer was made and not accepted is not dispositive of insurer's bad faith; insurer cannot be compelled to concede liability and settle questionable claim simply because opportunity to do so is presented, rather, plaintiff must show that insured lost actual opportunity to settle claim at time when all serious doubts about insured's liability were removed. Pavia v. State Farm Mut. Auto. Ins. Co., 1993, 82 N.Y.2d 445, 605 N.Y.S.2d 208, 626 N.E.2d 24, reargument denied 83 N.Y.2d 779, 611 N.Y.S.2d 126, 633 N.E.2d 480.

In order to establish prima facie case against insurer of bad faith in refusing settlement offer within policy limits, plaintiff must establish that insurer's conduct constituted "gross disregard" of insured's interests, that is, deliberate or reckless failure to place on equal footing the interests of its insured with its own interests when considering settlement offer; in other words, plaintiff must establish that insurer engaged in pattern of behavior evincing conscious or knowing indifference to probability that insured would be held personally accountable for large judgment if settlement offer were not accepted. Pavia v. State Farm Mut. Auto. Ins. Co., 1993, 82 N.Y.2d 445, 605

N.Y.S.2d 208, 626 N.E.2d 24, reargument denied 83 N.Y.2d 779, 611 N.Y.S.2d 126, 633 N.E.2d 480.

Arbitrators' finding that an insurer acted in bad faith would not, without more, justify a judicial award of punitive damages to an insured. American Transit Ins. Co. v. Associated International Ins. Co. (1 Dept. 1999) ___ A.D.2d ___, 690 N.Y.S.2d 237.

Automobile liability insurer in suit involving multiple victims and derivative claim by one victim's parents did not act in bad faith by refusing to settle for more than the per person policy limits for two victims, even if the insurer knew that liability for a judgment in excess of the policy limits was certain; insurer correctly concluded that the derivative claim was not separate and had a bona fide basis to conclude that the third victim's injuries were not serious. Redcross v. Aetna Cas. & Sur. Co. (3 Dept. 1999) ___ A.D.2d ___, 688 N.Y.S.2d 817.

A liability insurer confronted with multiple claims arising out of the same accident is not required, in order to forestall a bad-faith settlement claim, to accept a package deal within the overall policy limits if, in doing so, it would be overpaying on some of the claims in order that in the other claims, as to which the insurer is ready to pay the full policy limit, the insured would not be exposed to liability that exceeds the policy limit. Redcross v. Aetna Cas. & Sur. Co. (3 Dept. 1999) ___ A.D.2d ___, 688 N.Y.S.2d 817.

An inference of bad faith may arise even though the claimant's settlement offer equals or exceeds the liability policy limits, if the insured is not informed of the right to contribute to the excess in order to achieve a settlement. Redcross v. Aetna Cas. & Sur. Co. (3 Dept. 1999) ___ A.D.2d ___, 688 N.Y.S.2d 817.

Primary liability insurer did not act in bad faith by failing to inform insured or excess umbrella insurer of insured's possible exposure to liability in excess of primary policy's limits, where it did not act deliberately or even recklessly, did not put its own interests ahead of insured's interests, and kept insured informed of all relevant facts so that insured and primary insurer had essentially same information with which to form opinion about need to notify excess insurer; at most, primary insurer had made error in judgment. Monarch Cortland, Div. of Monarch Mach. Tool Co., Inc. v. Columbia Cas. Co. (3 Dept. 1996) 224 A.D.2d 135, 646 N.Y.S.2d 904, leave to appeal denied 89 N.Y.2d 807, 655 N.Y.S.2d 887, 678 N.E.2d 500.

Although it was arguably negligent for insurance company to have exhausted policy by paying all of automobile insurance policy proceeds to first two of three claimants under policy limiting liability to $10,000 per person/$20,000 per occurrence, such action did not rise to level of gross disregard so as to constitute bad faith. State Farm Ins. Co. v. Credle (1 Dept. 1996) 228 A.D.2d 191, 643 N.Y.S.2d 97.

Hospital's primary liability insurer's failure, in underlying malpractice action, to offer additional amount to settle claim against doctor who was additional insured under policy's "moonlighting" endorsement, after offering policy limits early in the proceedings, was not bad faith failure to settle, where insurer was acting on belief that coverage provided by the endorsement was excess to coverage provided by doctor's own insurer, and thus insurer was, at most, negligent. Affiliated F.M. Ins. Co., Inc. v. Hartford Acc. and Indem. Co. (1 Dept. 1996) 226 A.D.2d 292, 642 N.Y.S.2d 211, leave to appeal dismissed in part, denied in part 89 N.Y.2d 932, 654 N.Y.S.2d 712, 677 N.E.2d 283.

Insured's allegations failed to state claim against insurer based on theory of bad faith premised on unfair claim settlement practices, absent demonstration of pattern of bad faith or unfair practices. Rein Monroe Associates v. Royal Ins. Co. of America (4 Dept. 1991) 175 A.D.2d 582, 572 N.Y.S.2d 247.

In determining whether punitive damages should be awarded against insured for bad-faith failure to settle claim, process of meting out punishment for wrongdoing could not be divorced from process of deciding whether wrongdoing occurred; thus consideration of bad-faith issue by arbitrator who lacked authority to award punitive damages was not binding on court. Belco Petroleum Corp. v. AIG Oil Rig, Inc. (1 Dept. 1991) 164 A.D.2d 583, 565 N.Y.S.2d 776, on subsequent appeal 179 A.D.2d 516, 579 N.Y.S.2d 24.

Material issues of fact precluding summary judgment existed as to whether insurance company's conduct constituted actionable bad faith and, if bad faith, whether it constituted criminal indifference to civil obligations warranting punitive damages; company stated in open court that there was $500,000 in total coverage, allowed that representation to stand uncorrected for three years, and then stated, on eve of trial, that it did not know whether there was more than $100,000 in coverage. Jolicoeur v. American Transit Ins. Co. (1 Dept. 1990) 159 A.D.2d 236, 552 N.Y.S.2d 215.

Evidence that insurer for State made offer to settle claim against State for wrongful death resulting from collision between pickup truck and state-owned snowplow at figure which was substantially lower than liability it could reasonably expect to incur supported finding that insurer was acting in bad faith, thereby justifying imposition of excess liability on it. State v. Merchants Ins. Co. of New Hampshire (3 Dept. 1985) 109 A.D.2d 935, 486 N.Y.S.2d 412.

Insurance carrier can be held to be in bad faith in not resolving claim within policy limits where it was highly probable that insured would be subject to personal liability. Soto v. State Farm Ins. Co., 1992, 155 Misc.2d 447, 588 N.Y.S.2d 505, affirmed 195 A.D.2d 992, 600 N.Y.S.2d 407, leave to appeal granted 82 N.Y.2d 659, 604 N.Y.S.2d 558, 624 N.E.2d 696, affirmed 83 N.Y.2d 718, 613 N.Y.S.2d 352, 635 N.E.2d 1222.

3. Delay of settlement

Damages for severe mental and emotional distress by reason of undue delay in processing insurance claim and subsequent delay of payment are not recoverable if policy does not create relationship out of which springs duty to insured separate and apart from the contractual obligation. Warhoftig v. Allstate Ins. Co. (2 Dept. 1993) 199 A.D.2d 258, 604 N.Y.S.2d 245.

Evidence supported dismissal of cause of action alleging insurer which had issued homeowner's policy willfully failed to pay claim, where at trial insured presented no proof to establish that insurer acted dishonestly or disingenuously in failing to settle claim on timely basis. Meiselman v. Allstate Ins. Co. (2 Dept. 1990) 166 A.D.2d 562, 560 N.Y.S.2d 845, appeal denied 77 N.Y.2d 808, 570 N.Y.S.2d 489, 573 N.E.2d 577, reargument denied 78 N.Y.2d 909, 573 N.Y.S.2d 469, 577 N.E.2d 1061.

Where insurance company undertook its estimate of repair costs to damaged automobile, settled automobile collision claim, and mailed check to insured within 30 days, and some of delay in handling claim resulted from vacation of company employee, administrative law judge erred in holding that insurance company engaged in course of conduct which unreasonably delayed or impeded consumer's fair recovery under policy of insurance. Allstate Ins. Co. v. Foschio (2 Dept. 1983) 93 A.D.2d 328, 462 N.Y.S.2d 44.

4. Malice

Evidence established that fire insurer acted with malice in "low-balling" insured's claim by suggesting that insured was guilty of arson and offering less than one-third of provable claim. Frizzy Hairstylists, Inc. v. Eagle Star Ins. Co., 1977, 89 Misc.2d 822, 392 N.Y.S.2d 554, modified on other grounds 93 Misc.2d 59, 403 N.Y.S.2d 389.

5. Partial payment, duty to offer

Insurer was under no obligation to offer or make partial payment to insureds under fire policy pending settlement discussions. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

Even if insurer concedes, after review of claim and investigation of damage to premises, that additional casualty loss has been incurred it is still not bound to make immediate payment particularly when an honest dispute exists as to amount of loss. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

Insurance Law of 1939 s 40-d [now this section] prohibiting insurers from engaging in unfair claim settlement practices and enumerating specific prescribed acts does not impose on an insurer an affirmative duty to make a partial payment simply because insured claims that further damage will occur. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

6. Punitive damages--Availability of

Issues of whether New York law permitted insureds to recover punitive damages from insurer in first party suit premised on unfair and deceptive claims practices in violation of insurance contract and whether insureds adduced sufficient evident to support award would be certified to New York Court of Appeals, where there was split of authority in New York courts on issue of whether punitive damages could be recovered, and language of administrative remedies provision of New York Insurance Law did not indicate whether preemption of punitive damages was intended. Riordan v. Nationwide Mut. Fire Ins. Co., C.A.2 (N.Y.)1992, 977 F.2d 47, certified question withdrawn 984 F.2d 69.

Statute prohibiting unfair claim settlement practices by insurer does not permit private right of action in favor of insured and, therefore, does not impose tort duty of care flowing to insured separate and apart from insurance policy; thus, punitive damages are not available for violation of the statute. New York University v. Continental Ins. Co., 1995, 87 N.Y.2d 308, 639 N.Y.S.2d 283, 662 N.E.2d 763.

Punitive damages are available where conduct constituting, accompanying, or associated with breach of contract is first actionable as independent tort for which compensatory damages are ordinarily available, and is sufficiently egregious to warrant additional imposition of exemplary damages. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Absent valid claim for compensatory damages, there could be none for punitive damages, even if insurer's refusal to pay benefit due under policy could be said to be such gross disregard of its contractual obligations as to constitute morally culpable conduct for which punitive damages might be claimed. Hubbell v. Trans World Life Ins. Co. of New York, 1980, 50 N.Y.2d 899, 430 N.Y.S.2d 589, 408 N.E.2d 918.

Insured could not get punitive damages for an insurer's wrongful conduct where the conduct was focused upon the insured and not aimed systematically at the general public. American Transit Ins. Co. v. Associated International Ins. Co. (1 Dept. 1999) ___ A.D.2d ___, 690 N.Y.S.2d 237.

Private party may not recover punitive damages for unfair claim settlement practices by insurer. Warhoftig v. Allstate Ins. Co. (2 Dept. 1993) 199 A.D.2d 258, 604 N.Y.S.2d 245.

Claims of persistent unfair settlement practices by insurer are within the exclusive province of superintendent of insurance and do not give rise to an independent action for punitive damages. Mavroudis v. State Wide Ins. Co. (2 Dept. 1986) 121 A.D.2d 433, 503 N.Y.S.2d 133, appeal dismissed 68 N.Y.2d 997, 510 N.Y.S.2d 1028, 503 N.E.2d 125.

Provision of Insurance Law which defines, and refers to penalties for, insurers' unfair claim settlement practices performs disciplinary function and obviates necessity for punitive damages in first-party coverage cases; these types of complaints are more properly province of Superintendent of Insurance. Riffat v. Continental Ins. Co. (1 Dept. 1984) 104 A.D.2d 301, 478 N.Y.S.2d 635.

Punitive damages may not be recovered for claimed violation of Insurance Law of 1939 s 40-d [now this section] pertaining to unfair claim settlement practices by insurers. LTS Contractors, Inc. v. Hartford Ins. Co. (4 Dept. 1984) 99 A.D.2d 644, 472 N.Y.S.2d 222.

Insurer's conduct was sufficiently culpable to authorize allowance of claim by insured for punitive damages, where insurer was aware of incredible costs of insured's prolonged hospital stay, surgery, and follow-up procedures and that insured was self-employed single mother of two children, and despite continued pleas for reconsideration of cancellation of policy due to incorrect information, insurer continued to rely on hospital report completed by medical student.White v. Blue Cross and Blue Shield of Greater New York, 1989, 146 Misc.2d 125, 549 N.Y.S.2d 598.

In action against insurance company for failure to pay on claim for water damage, partnership had no private right of action for collection of punitive damages. Sulner v. General Acc. Fire and Life Assur. Corp., Ltd., 1984, 122 Misc.2d 597, 471 N.Y.S.2d 794.

Insurance Law of 1939 s 40-d [now this section] prohibiting insurer from repeatedly engaging in unfair claims settlement practices and providing for imposition of appropriate monetary penalties performed disciplinary function and obviated necessity for maintenance of causes of action for punitive damages against insurer engaging in unfair settlement practices. Cosmopolitan Mut. Ins. Co. v. Nassau Ins. Co., 1979, 99 Misc.2d 1018, 417 N.Y.S.2d 835.

7. Fault of insured

Allowing recovery of punitive damages for willful misconduct on insurer's part when insured itself has not shown compliance with all its obligations under standard fire policy works unconscionable result. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

8. Jurisdiction to award

Even if insurer entered into course of conduct to issue false disclaimers under policy with its insureds, thus compelling other insurers as subrogees of adverse property damage claimants to resort to unnecessary litigation, punishment of offending insurer was more properly within province and jurisdiction of state superintendent of insurance than through award of punitive damages to competing insurers. Cosmopolitan Mut. Ins. Co. v. Nassau Ins. Co., 1979, 99 Misc.2d 1018, 417 N.Y.S.2d 835.

Insurer was not liable for punitive damages where the complaint merely alleged that the insurer refused to pay under the terms of a policy issued to plaintiff after due demand therefor was made; while the conduct of the insurer was not to be condoned, its punishment was more properly within the province and jurisdiction of the State Superintendent of Insurance. Frizzy Hairstylists, Inc. v. Eagle Star Ins. Co., 1977, 93 Misc.2d 59, 403 N.Y.S.2d 389.

9. Necessary showing

Insured under disability income policy whose policy was rescinded after he filed claim could not maintain action for punitive damages for breach of implied covenant of good faith and fair dealing; insured failed to demonstrate that he was personally aggrieved by tortious conduct arising out of his contractual relationship with insurer, and no inference of fraudulent intent could be drawn from

mere compilation of 124 "vignettes" of policyholder "difficulties" with insurer. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Absent evidentiary proof in admissible form of general business practice on part of insurer or proof of gross disregard of insured's rights, plaintiffs were not entitled to recover punitive damages under Insurance Law of 1939 s 40-d [now this section] for insurer's breach of its duty to settle claims in good faith. Dano v. Royal Globe Ins. Co., 1983, 59 N.Y.2d 827, 464 N.Y.S.2d 741, 451 N.E.2d 488.

Claim for punitive damages against insurer is cognizable only in circumstances where plaintiff has made sufficient evidentiary allegations of ultimate facts of fraudulent and deceitful scheme in dealing with general public as to imply criminal indifference to civil obligations. Porter v. Allstate Ins. Co. (2 Dept. 1992) 184 A.D.2d 685, 585 N.Y.S.2d 465.

Punitive damages could not be recovered for insurer's refusal to honor life insurance policy, absent allegation of facts that would support finding of wanton dishonesty as to imply criminal indifference to civil obligations. McLaughlin v. American Intern. Life Assur. Co. of New York (1 Dept. 1992) 181 A.D.2d 444, 580 N.Y.S.2d 763.

Plaintiffs may not recover punitive damages in actions for breach of insurance contract without submitting factual allegations that insurer, in its dealings with general public, engaged in fraudulent scheme which demonstrates such wantondishonesty as to imply criminal indifference to civil obligations. Fleming v. Allstate Ins. Co. (2 Dept. 1984) 106 A.D.2d 426, 482 N.Y.S.2d 519, affirmed 66 N.Y.2d 838, 498 N.Y.S.2d 365, 489 N.E.2d 252, certiorari denied 106 S.Ct. 1493, 475 U.S. 1096, 89 L.Ed.2d 894.

In order for insured to be allowed to attempt to recover punitive damages from insurance company for improper claim settlement practices, there must be showing of such morally culpable conduct and wanton dishonesty as to imply criminal indifference to civil obligations. Royal Globe Ins. Co. v. Chock Full O'Nuts Corp. (1 Dept. 1982) 86 A.D.2d 315, 449 N.Y.S.2d 740, appeal dismissed 58 N.Y.2d 605, 459 N.Y.S.2d 1028, 445 N.E.2d 655, appeal dismissed 58 N.Y.2d 800, 459 N.Y.S.2d 266, 445 N.E.2d 649.

Even where insurer acts in bad faith, punitive damages will not be awarded unless there is also proof of malice. Frizzy Hairstylists, Inc. v. Eagle Star Ins. Co., 1977, 89 Misc.2d 822, 392 N.Y.S.2d 554, modified on other grounds 93 Misc.2d 59, 403 N.Y.S.2d 389.

10. Denial in particular cases

Assuming that private damage action lies under Insurance Law of 1939 s 40- d [now this section], the instance of unfair settlement practice pleaded would not constitute general business practice within meaning of said section and, thus, punitive damage claim could not be sustained under said section. Halpin v. Prudential Ins. Co. of America, 1979, 48 N.Y.2d 906, 425 N.Y.S.2d 48, 401 N.E.2d 171, reargument denied 49 N.Y.2d 801, 426 N.Y.S.2d 1029, 403 N.E.2d 466.

Allegations of insured that insurer had carelessly, negligently, recklessly and incorrectly determined actual cash value of insured vehicle and amount necessary to repair or replace it and had fraudulently induced insured to employ services of certain automobile repair shop, were insufficient as matter of law to support award of punitive damages. Kinnarney v. Natale Auto Body (3 Dept. 1990) 157 A.D.2d 938, 550 N.Y.S.2d 194.

Where insurer promptly investigated claimed fire loss, which was considered suspicious by fire department, it hired experts to determine actual cash value on basis of which it offered $37,500 against policy limit of $50,000 on building and $13,000 for loss of rental value, and insured failed to cite any specific instance of unlawful conduct or disingenuous and dishonest failure to perform its obligations under policy, insured was not entitled to award of punitive damages in action to

recover under fire policy. Pitrock Realty Corp. v. New York Property Ins. Underwriting Ass'n (1 Dept. 1983) 96 A.D.2d 1021, 467 N.Y.S.2d 49.

Alleged violation of Insurance Law of 1939 s 40-d [now this section] governing fire insurer's duty to negotiate and settle claim in good faith did not provide basis for recovery of punitive damages from insurer. Dano v. Royal Globe Ins. Co. (4 Dept. 1982) 89 A.D.2d 817, 453 N.Y.S.2d 528, affirmed 59 N.Y.2d 827, 464 N.Y.S.2d 741, 451 N.E.2d 488.

In action by insurer seeking insurance premiums and service charges allegedly due, counterclaims raised by insured alleging that insurer breached its contractual obligation under service agreement, that insurer breached its fiduciary duty to insured, that insured was induced to enter into agreement based upon misrepresentations and that insurer committed various unfair claim settlement practices constituted damages action for breach of contract and possibly negligence in handling claims, with usual remedies and relief available for such actions, but did not provide basis for punitive damages, either on basis of Insurance Law of 1939 s 40-d [now this section] relating to unfair claim settlement practices by insurers or otherwise. Royal Globe Ins. Co. v. Chock Full O'Nuts Corp. (1 Dept. 1982) 86 A.D.2d 315, 449 N.Y.S.2d 740, appeal dismissed 58 N.Y.2d 605, 459 N.Y.S.2d 1028, 445 N.E.2d 655, appeal dismissed 58 N.Y.2d 800, 459 N.Y.S.2d 266, 445 N.E.2d 649.

Even though additional damage was incurred due to insurer's failure to make prompt repairs to insured building damaged by fire, where insurer and insureds were in dispute from the beginning as to extent of loss, hiatus of two months between the loss and insurer's first settlement offer under standard fire policy and three-week lapse between letter from New York Board of Fire Underwriters recommending that insurer pay $65,000 and insurer's first settlement offer, were not inordinate or unreasonable so that such actions together with insurer's cancellation of policy upon finding that building was uninsurable did not render it liable to insureds for punitive damages. Cohen v. New York Property Ins. Underwriting Ass'n (1 Dept. 1978) 65 A.D.2d 71, 410 N.Y.S.2d 597.

11. Costs, imposition of

Insured is not entitled to recover costs and expenses of bringing affirmative action to settle his rights, but may recover only when he has been cast in defensive posture by action of insurer in effort to absolve itself from policy obligations. Hershberger by Hershberger v. Schwartz (4 Dept. 1993) 198 A.D.2d 859, 604 N.Y.S.2d 428.

Costs of proceeding to enforce arbitrator's award were assessed against insurer where, without any good reason, insurer chose to delay payment for more than one year. Grabowski v. Allstate Ins. Co., 1976, 85 Misc.2d 845, 380 N.Y.S.2d 587.

12. Pleadings

Claim for fraud in inducement was not stated by insured's allegations that insurer and servicing agent induced insured to purchase and maintain policy notwithstanding intent ab initio to refuse claims for indemnification and then terminate policy and that they misrepresented integrity of a company through advertising and by conducting business under statute that requires insurers to deal with insureds fairly and in good faith; complaint did not state specific promises or omissions of material fact allegedly made by insurer, and it alleged nothing more than breach of contract and any implied covenants. New York University v. Continental Ins. Co., 1995, 87 N.Y.2d 308, 639 N.Y.S.2d 283, 662 N.E.2d 763.

Insureds could amend their contract complaint against insurer to amplify their cause of action with allegations of violation of insurance statute prohibiting unfair claim settlement practices, despite insurer's contention that insureds were trying to add separate cause of action. Bristol Harbour Associates, L.P. v. Home Ins. Co. (4 Dept. 1997) 244 A.D.2d 885, 665 N.Y.S.2d 142.

Complaint adequately sets forth prima facie case against insurer for liability in excess of policy limits where it is asserted that insured lost actual opportunity to settle negligence claim against him within coverage limits of his policy by reason of insurer's purported bad faith. State v. Merchants Ins. Co. of New Hampshire (3 Dept. 1985) 109 A.D.2d 935, 486 N.Y.S.2d 412.

13. Evidence

In State's action against its snowplow insurer for bad faith, testimony of expert witness as to accepted standard in insurance industry for settlement practices and procedures by liability insurer was not necessary where issues before jury were within ambit of common knowledge and experience of laymen. State v. Merchants Ins. Co. of New Hampshire (3 Dept. 1985) 109 A.D.2d 935, 486 N.Y.S.2d 412.

14. Private right of action

Private right of action is not recognized under New York insurance statute governing unfair claim settlement practices. Northwestern Mut. Life Ins. Co. v. Wender, 1996, 940 F.Supp. 62.

Although sections of New York Insurance Law protecting customers from generally deceptive business practices did not create private right of action, the provisions could provide basis for corporation's fraud and antitrust action against insurer following its cancellation of officers and directors policy, as expression of public policy and as evidence of insurer's duties to its insureds. PepsiCo, Inc. v. Continental Cas. Co., 1986, 640 F.Supp. 656.

Statute prohibiting unfair claim settlement practices by insurer does not permit private right of action in favor of insured and, therefore, does not impose tort duty of care flowing to insured separate and apart from insurance policy; thus, punitive damages are not available for violation of the statute. New York University v. Continental Ins. Co., 1995, 87 N.Y.2d 308, 639 N.Y.S.2d 283, 662 N.E.2d 763.

No private cause of action can be maintained for unfair insurance settlement practices. Rocanova v. Equitable Life Assur. Soc. of U.S., 1994, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 634 N.E.2d 940.

Regulations defining unfair claims settlement practices do not give rise to a private right of action. Aetna Cas. & Sur. Co. v. ITT Hartford Ins. Co. (1 Dept. 1998) 249 A.D.2d 241, 672 N.Y.S.2d 310.

There is no private right of action under section of Insurance Law proscribing unfair claim settlement practices and authorizing a money penalty; enforcement is within the jurisdiction of the State Superintendent of Insurance and administrative review procedures under Insurance Law s 2403 et seq., are the exclusive remedies for determining a violation. Kurrus v. CNA Ins. Co. (2 Dept. 1985) 115 A.D.2d 593, 496 N.Y.S.2d 255.

Insurance law and underlying regulations setting standard by which insurers are to process claims create private rights of action where party seeks no more than compensatory damages, but only affords public right of redress by Department of Insurance where party seeks damages that are punitive in nature. Dunrite Auto Body & Motor Works, Inc. v. Liberty Mut. Ins. Co., 1992, 153 Misc.2d 440, 590 N.Y.S.2d 152, on remand 160 Misc.2d 168, 607 N.Y.S.2d 1005.

McKinney's Insurance Law s 2601
NY INS s 2601

END OF DOCUMENT

NY INS Ch. 28, Art. 26, Refs & Annos
McKinney's Insurance Law Ch. 28, Art. 26, Refs & Annos

McKinney's Consolidated Laws Of New York Annotated Insurance Law
Chapter 28 Of The Consolidated Laws
Article 26--Unfair Claim Settlement Practices; Other Misconduct; Discrimination

Current through L.1999, ch. 659
NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- 1984 CODIFICATION NOTES
1984 CODIFICATION NOTES
1985 Main Volume

By Jule E. Stocker, John P. Gemma and Mendes Hershman
N.B. References herein (1) to the "new" Law (or the like) are to the Insurance Law, as recodified without substantive change, by L.1984, c. 367 and c. 805, effective September 1, 1984; and (2) to the "old" Law (or the like) are to the Insurance Law immediately preceding the "new" Law. Attention is directed to the four part Introduction set out preceding Article 1 of the new Law, namely: I. History of 1974-1984 Recodification Project; II. The 1984 Enacting Legislation; III. Structure of the Recodified Law; IV. Scope of Codification Notes on Specific Articles.

The Note on Scope contains general comments of simplifying, clarifying and systematizing the entire old Law, but without substantive change, that are generally applicable to this Article and should be deemed incorporated by reference. Comments which are specially applicable to this Article follow.

Article 26 is a new Article in the sense that it combines therein seven sections, and portions of two other sections, from three Articles of the old Law. With two exceptions (ss 2609 and 2610), all of the foregoing, constituting eight new sections, came from old Article 4 on "Organization, Licensing and Corporate Procedure of Insurers" and were moved to new Article 26 because they had no direct bearing on the subject matter of old Article 4, as indicated by its above-mentioned title. (Similarly, with respect to the two exceptions, as detailed below.) Instead, those provisions from old Article 4 dealt with a number of prohibitions against unfair claim settlement practices, rebates, false statements regarding the business which a corporation may conduct or regarding the financial standing of any insurer, in this state, failure to comply with the Workers' Compensation Law, and various categories of discrimination, chiefly, in connection with insurance policies, because of race, color, creed, national origin, sex, marital status or treatment for mental disability.

About half of the sections in new Article 26 prohibiting such practices are listed in Article 24 (Unfair Methods of Competition and Unfair and Deceptive Acts and Practices) under the definition of "defined violations" in new s 2402(b). Thus, not all of the prohibitions in new Article 26 constitute unfair practices under Article 24 which the Superintendent can order stopped. Instead, he would have to have the Attorney General bring court action therefor.

It was felt desirable to put all such prohibitions together, as the first eight sections of one new Article, namely Article 26, following Article 25 on "Prohibitions against Controlled Business", and close to Article 24 on "Unfair...Practices."

The two exceptions mentioned near the beginning of this Note constitute the last two sections of Article 26. New s 2609 replaces s 315-a of the old Law which prohibited discrimination in issuing performance or surety bonds solely because of race, creed, color, sex, national origin, age or martial status of the applicant. The section is accordingly closely related to earlier sections of Article 26. The section fits better in Article 26 than in the location in the old Law of the corresponding section.

Similarly, the last section of new Article 26, s 2610, replaces old s 167- c prohibiting insurers from requiring, or even suggesting, unless the insured requested, motor vehicle repairs should be

made. Old s 167-c had been in a rather unlikely location in old Article 7 on "the Insurance Contract."

A number of the old Law provisions were phrased in the form of a declaration that any person who did a specified act, but without any direct prohibition thereof, was guilty of a misdemeanor. The corresponding new provisions are cast in the form of specific prohibitions, without mentioning "misdemeanor". It is unnecessary to refer to "misdemeanor" since new s 109, like old s 5, specifies that "Every violation of any provision of this chapter [that is, the insurance law] shall, unless the same constitutes a felony, be a misdemeanor". Note, in contrast, that new s 2601, like old s 40-d on "Unfair Claim Settlement Practices" expressly states that "A violation of this section shall not be a misdemeanor".

Another example of simplification is the use of "entity" in new s 2606(a) in place of a repeated list of nine specific categories in old s 40(10) which can be subsumed in the single word "entity". The same change appears in new ss 2607 and 2608. Although the Recodification endeavored to omit unnecessary words, it did not hesitate to make appropriate additions. Thus, the exception at the beginning of new s 2606(a) is repeated in s 2606(b) as a useful cross reference for purposes of clarifying the Law.

The substitution of the word "of" for "by" near the end of s 2608(a) corrects an obvious inadvertence.

Note that the reference to Public Law 15, 79th Congress in new s 2401, omits the phrase "as amended" which appeared in old s 270, in view of the general definitional rule on construction of references to other laws in new s 107(b). Similarly, the separability provision in old s 282 is omitted in view of the general provision thereon in s 4 of the enacting statute. L.1984, c 367.

The definition of "determined violation" in s 2402(c) may seem somewhat circular but it is necessarily so because of the structure of the Article.

The Derivation and Distribution Tables set forth in L.1984, c. 805 indicate that old Article 24 was carried over into new Article 24. Except for necessary changes in cross-reference numbers and in format, that is correct. However, the "old" Article 24 had been enacted in 1982 as part of the Recodification Project. (See the Introductory Note on History of the Recodification Project, set out preceding Article 1.) The 1982 enactment, while making no change of substance in prior Article 9-D which was replaced, recast such 9-D into a more logical whole, clarifying among other things, the difference in enforcement of the prohibitions against determined violations as contrasted with defined violations.

NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- CROSS REFERENCES
CROSS REFERENCES
Discrimination in civil rights prohibited, see McKinney's Const. Art. 1, s 11.
Unfair methods of competition and unfair and deceptive acts and practices, see Insurance Law s 2401 et seq.
Unlawful discriminatory practices, see Executive Law s 296.

NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- NEW YORK CODES, RULES AND REGULATIONS
NEW YORK CODES, RULES AND REGULATIONS
1985 Main Volume
Standard claim forms, see 11 NYCRR 17.0 et seq.
Unfair trade practices generally, see 11 NYCRR 215.1 et seq.

NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- LIBRARY REFERENCES

LIBRARY REFERENCES
1985 Main Volume
Insurance k4.2, 27 to 30, 563 to 570.10.
C.J.S. Insurance ss 57, 86, 88 to 90, 1098 to 1120.

NY INS Ch. 28, Art. 26, Refs & Annos
REFERENCES -- UNITED STATES CODE ANNOTATED
UNITED STATES CODE ANNOTATED
Civil rights, generally, see 42 USCA s 1981 et seq.
Equal protection of laws, see USCA Const. Amend. XIV s 1.
McKinney's Insurance Law Ch. 28, Art. 26, Refs & Annos
NY INS Ch. 28, Art. 26, Refs & Annos

END OF DOCUMENT

I I NY ADC 216.0
11 NYCRR 216.0
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.0

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS
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TITLE 11. INSURANCE DEPARTMENT
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PART 216. UNFAIR CLAIMS SETTLEMENT PRACTICES AND
CLAIM COST CONTROL MEASURES
Text is current through May 31, 1999, and annotations are current through April 1999.

Section 216.0 Preamble.

(a) Section 2601 of the Insurance Law prohibits insurers doing business in this State from engaging in unfair claims settlement practices and provides that, if any insurer performs any of the acts or practices proscribed by that section without just cause and with such frequency as to indicate a general business practice, then those acts shall constitute unfair claims settlement practices. This Part contains claim practice rules which insurers must apply to the processing of all first- and third-party claims arising under policies subject to this Part. In addition, specific rules are provided for the processing of first-party motor vehicle physical damage claims and third-party property damage claims arising under motor vehicle liability insurance contracts.

(b) This Part is issued for the purpose of defining certain minimum standards which, if violated without just cause and with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices. This Part is not exclusive, and other acts, not herein specified, may also be found to constitute such practices.

(c) Section 3411 (i) of the Insurance Law has been implemented by section 216.7 of this Part.

(d) Section 3412 of the Insurance Law has been implemented by section 216.8 of this Part.

(e) Claim practice principles to be followed by all insurers.

(1) Have as your basic goal the prompt and fair settlement of all claims.

(2) Assist the claimant in the processing of a claim.

(3) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible.

(4) Clearly inform the claimant of the insurer's position regarding any disputed matter.

(5) Respond promptly, when response is indicated, to all communications from insureds, claimants, attorneys and any other interested persons.

(6) Every insurer shall distribute copies of this regulation to every person directly responsible for the supervision, handling and settlement of claims subject to this regulation, and every insurer shall satisfy itself that all such personnel are thoroughly conversant with, and are complying with, this regulation.

Historical Note

Sec. filed Dec. 5, 1972; amd. filed Jan. 14, 1975; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1, 1984. Amended (a), (c) and (d).

CASE NOTES:

11 NY ADC 216.0

Court granted leave to amend complaint where violation by insurance company of §§216.0, 216.3 and 216.6, prohibiting misrepresentation of policy provisions and requiring prompt and fair claim settlement, if proven would constitute deceptive business practice and injury to public would be inherent where company provides services to public on large scale and is obligated to deal in good faith. Riordan v. Nationwide Mut. Fire Ins. Co., 1990, 756 F.Supp. 732, affirmed in part, question certified 977 F.2d 47, certified question withdrawn 984 F.2d 69

11 NY ADC 216.0
END OF DOCUMENT

I I NY ADC 216.1
11 NYCRR 216.1
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.1

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Section 216.1 Definitions.

The definitions set forth in this section shall govern the construction of the terms used in this Part.

(a) Agent shall mean any person, firm, association or corporation authorized to act as the representative of an insurer and licensed pursuant to the provisions of article 21 of the Insurance Law. With respect to group life and group accident and health policies, the group policyholder shall be the agent of the insurer to the extent such policyholder has been authorized to act on behalf of such insurer.

(b) Claimant shall mean any person who attempts to obtain a benefit from an insurer.

(c) Investigation shall mean any procedure adopted by an insurer to determine whether to accept or reject a claim.

(d) Business day shall mean a day other than Saturday, Sunday or a New York State legal holiday.

(e) Notice of claim shall mean any notification, whether in writing or otherwise, to an insurer or its agent, by any claimant who reasonably apprises the insurer of the facts pertinent to a claim.

Historical Note

See. filed Dec. 5, 1972; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1, 1984. Amended (a).

11 NY ADC 216.1
END OF DOCUMENT

I I NY ADC 216.2
I I NYCRR 216.2
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.2

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Section 216.2 Applicability.

This Part shall apply to all insurers licensed to do business in this State.

(a) It shall not be applicable to policies of workers' compensation insurance issued pursuant to the provisions of section 1113(a)(15) of the Insurance Law; credit insurance issued pursuant to the provisions of section 1113(a)(17); title insurance issued pursuant to the provisions of section 1113(a)(I 8); inland marine insurance issued pursuant to the provisions of section 1113(a)(20); unless such insurance is subject to the provisions of section 3425 of the Insurance Law; and ocean marine insurance issued pursuant to the provisions of section 1113(a)(20) and (21).

(b) Subdivisions (a) and (b) of section 216.6 of this Part shall not be applicable to policies of life insurance written pursuant to the provisions of section 1113 (a)(1) of the Insurance Law. Subdivision (b) of section 216.6 of this Part shall not be applicable to accident and health policies written pursuant to the provisions of section 1113(a)(3) and the provisions of article 43 of the Insurance Law.

(c) Sections 216.4 and 216.5 and subdivision (c) of section 216.6 of this Part shall not be applicable to policies of accident and health insurance written pursuant to the provisions of section 1113(a)(3) and the provisions of article 43 of the Insurance Law, where the claimant is neither a policyholder, a certificate holder under a policy of group insurance, nor a relative or member of the household of such policy or certificate holder.

(d) Subdivision (b) of section 216.3, subdivision (b) of section 216.4 and subdivision (a) of section 216.5 of this Part shall not be applicable to policies of insurance where the claimant is represented by a public adjuster or a person acting in the capacity of a public adjuster pursuant to the provisions of article 21 of the Insurance Law.

Historical Note

Sec. filed Dec. 5, 1972; amd. filed Jan. 14, 1974; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1,1984.

11 NY ADC 216.2
END OF DOCUMENT

I I NY ADC 216.3
11 NYCRR 216.3
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.3

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Section 216.3 Misrepresentation of policy provisions.

(a) No insurer shall knowingly misrepresent to a claimant the terms, benefits or advantages of the insurance policy pertinent to the claim.

(b) No insurer shall deny any element of a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is made in writing.

(c) Any payment, settlement or offer of settlement which, without explanation, does not include all amounts which should be included according to the claim filed by the claimant and investigated by the insurer shall, provided it is within the policy limits, be deemed to be a communication which misrepresents a pertinent policy provision.

Historical Note

Sec. filed Dec. 5, 1972; repealed, new filed May 12, 1982 eff. Aug. 15, 1982.

CASE NOTES:

Court granted leave to amend complaint where violation by insurance company of §§216.0, 216.3 and 216.6, prohibiting misrepresentation of policy provisions and requiring prompt and fair claim settlement, if proven would constitute deceptive business practice and injury to public would be inherent where company provides services to public on large scale and is obligated to deal in good faith. Riordan v. Nationwide Mut. Fire Ins. Co., 1990, 756 F.Supp. 732, affirmed in part, question certified 977 F.2d 47, certified question withdrawn 984 F.2d 69

CASE NOTES:

I I NYCRR §216.3 specifies unfair claims settlement practices and does not suggest any further reading which would imply a private cause of action. Newsom v. Republic Financial Services, Inc., 1985, 497 N.Y.S.2d 830, 130 Misc.2d 780

11 NY ADC 216.3
END OF DOCUMENT

I I NY ADC 216.4
11 NYCRR 216.4

N.Y. Comp. Codes R. & Regs. tit. 11, § 216.4

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Section 216.4 Failure to acknowledge pertinent communications.

(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing. If an acknowledgment is made by other means, an appropriate notation shall be made in the claim file of the insurer. Notification given to an agent of an insurer shall be notification to the insurer. If notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent notifies the claimant that the agent is not authorized to receive notices of claims.

(b) An appropriate reply shall be made within 15 business days on all other pertinent communications.

(c) Every insurer shall establish an internal department specifically designated to investigate and resolve complaints filed with the Insurance Department and to take action necessitated as a result of its complaint investigation findings. Such internal department is to operate in a staff capacity to the entire company with authority to question and change the position taken in individual instances or company practices generally. Responsibility for such department is to be vested in a corporate officer who is also to be entrusted with the duty of executing the Insurance Departments directives. If the Insurance Department requests the appearance of an insurer representative to discuss a pending matter, the individual whom the company sends shall be authorized to make any determination warranted after all the facts are elicited at such conference. Each insurer must furnish the superintendent with the name and title of the corporate officer responsible for its internal consumer services department.

(d) Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim, shall, within 10 business days, furnish the department with the available information requested respecting the claim.

(e) As part of its complaint handling function, an insurer's consumer services department shall maintain an ongoing central log to register and monitor all complaint activity.

Historical Note

Sec. filed Dec. 5, 1972; repealed, new filed May 12, 1982; amd. filed Sept. 4, 1984 eff. Oct. 1, 1984.

11 NY ADC 216.4
END OF DOCUMENT

I I NY ADC 216.5
11 NYCRR 216.5
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.5

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Section 216.5 Standards for prompt investigation of claims.

(a) Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within 15 business days of receipt of notice of claim. An insurer shall furnish to every claimant, or claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim. A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent notifies the person filing the claim that the agent is not authorized to receive notices of claim.

(b) Where there is a reasonable basis, supported by specific information available for review by Insurance Department examiners, that the claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this Part. The provisions of this Part are suspended for the period required to investigate the alleged fraudulent aspects of the claim. The insurer must submit the report required by Part 86 (Insurance Frauds Bureau) of this Title when an insurer determines that a loss is suspect.

Historical Note

See. filed Dec. 5, 1972; repealed, new filed May 12, 1982 eff. Aug. 15, 1982.

I I NY ADC 216.5
END OF DOCUMENT

I I NY ADC 216.6
11 NYCRR 216.6
N.Y. Comp. Codes R. & Regs. tit. 11, § 216.6

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Section 216.6 Standards for prompt, fair and equitable settlements.

(a) In any case where there is no dispute as to coverage, it shall be the duty of every insurer to offer claimants, or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions.

(b) Actual cash value, unless otherwise specifically defined by law or policy, means the lesser of the amounts for which the claimant can reasonably be expected to:

(1) repair the property to its condition immediately prior to the loss; or

(2) replace it with an item substantially identical to the item damaged. Such amount shall include all monies paid or payable as sales taxes on the item repaired or replaced. This shall not be construed to prevent an insurer from issuing a policy insuring against physical damage to property, where the amount of damages to be paid in the event of a total loss to the property is a specified dollar amount.

(c) Within 15 business days after receipt by the insurer of a properly executed proof of loss and/or receipt of all items, statements and forms which the insurer requested from the claimant, the claimant, or the claimant! s authorized representative, shall be advised in writing of the acceptance or rejection of the claim by the insurer. When the insurer suspects that the claim involves arson, the foregoing 15 business days shall be read as 30 business days pursuant to section 2601 of the Insurance Law. If the insurer needs more time to determine whether the claim should be accepted or rejected, it shall so notify the claimant, or the claimant's authorized representative, within 15 business days after receipt of such proof of loss, or requested information. Such notification shall include the reasons additional time is needed for investigation. If the claim remains unsettled, unless the matter is in litigation or arbitration, the insurer shall, 90 days from the date of the initial letter setting forth the need for further time to investigate, and every 90 days thereafter, send to the claimant, or the claimant! s authorized representative, a letter setting forth the reasons additional time is needed for investigation. If the claim is accepted, in whole or in part, the claimant, or the claimants authorized representative, shall be advised in writing of the amount offered. In any case where the claim is rejected, the insurer shall notify the claimant, or the claimants authorized representative, in writing, of any applicable policy provision limiting the claimant's right to sue the insurer.

(d) The company shall inform the claimant in writing as soon as it is determined that there was no policy in force or that it is disclaiming liability because of a breach of policy provisions by the policyholder. The insurer must also explain its specific reasons for disclaiming coverage.

(e) In any case where there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

(f) Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than five business days from the receipt of such agreement by the insurer, or from the date of the performance by the claimant of any condition set by such agreement, whichever is later, except as provided in section 331 of the Insurance Law as respects liens by tax districts on fire insurance proceeds.

(g) Checks or drafts in payment of claims; releases. No insurer shall issue a check or draft in payment of a first-partyclaim or any element thereof, arising under any policy subject to this Part, that contains any language or provision that expressly or impliedly states that acceptance of such check or draft shall constitute a final settlement or release of any or all future obligations arising out of the loss. No insurer shall require execution of a release on a first- or third-party claim that is broader than the scope of the settlement.

(h) Any notice rejecting any element of a claim involving personal property insurance shall contain the identity and the claims processing address of the insurer, the insured's policy number, the claim number, and the following statement prominently set out:

"Should you wish to take this matter up with the New York State Insurance Department, you may write or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; Agency Building One, Governor Nelson A. Rockefeller Empire State Plaza, Albany, NY 12257; or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202."

Historical Note

Sec. filed Dec. 5, 1972; amds. filed: April 5, 1973; Jan. 14, 1975; repealed, new filed May 12, 1982; amds. filed: Sept. 4, 1984; April 7, 1997; Nov. 6, 1997 as emergency measure; Jan. 16, 1998 eff. Feb. 4, 1998. Amended (h).

CASE NOTES:

Court granted leave to amend complaint where violation by insurance company of §§216.0, 216.3 and 216.6, prohibiting misrepresentation of policy provisions and requiring prompt and fair claim settlement, if proven would constitute deceptive business practice and injury to public would be inherent where company provides services to public on large scale and is obligated to deal in good faith. Riordan v. Nationwide Mut. Fire Ins. Co., 1990, 756 F.Supp. 732, affirmed in part, question certified 977 F.2d 47, certified question withdrawn 984 F.2d 69

CASE NOTES:

Regulation I I NYCRR §216.6(g) prohibiting provisions in insurer's first- party claim check that acceptance is final settlement, does not result in accord and satisfaction by reason of insured's uncomplaining acceptance of check. Dunrite Auto Body & Motor Works, Inc. v. Liberty Mut. Ins. Co., 1992, 590 N.Y.S.2d 152, 153 Misc.2d 440, on remand 607 N.Y.S.2d 1005, 160 Misc.2d 168

11 NY ADC 216.6
END OF DOCUMENT

California Workers' Compensation

Background

In the past our procedure was not to offset for Permanent Disability Benefits. Based on a review of court decisions and claim handling in California, we have made the decision to include the PD award as an offset. (Unemployment Insurance Code, Section 262a, as amended in 1993.)

This change is effective immediately on any California claims with a disability date on or after 1/1/94, where the PD has not yet been awarded, and where we have not indicated that it would be handled differently.

California has five basic types of Workers' Compensation Awards, described below.

Medical Benefits

Workers' Compensation will provide benefits for the medical treatment of a specific occupational injury. These medical benefits are not offset. When lump sum awards are made, review the award documents and differentiate medical benefits from all other types.

Temporary Total Disability (TTD)

TTD Benefits represent wage replacement benefits that are provided until the injured worker recovers or until a permanent and stationary status is declared. Offset for what ever inclusive dates and amounts are provided. The TTD maximum is $336 per week for injuries occurring prior to 7/1/94 and $406 for injuries thereafter. On 7/1/95, the maximum rate increased to $448. On 1/1/96, the rate increased to $490.

Vocational Rehabilitation Total Disability (VRTD)

These are benefits provided to an insured who is undergoing a formal retraining program sponsored by Workers' Compensation. The benefit amount is at the same rate as TTD Benefits. They are typically awarded after a permanent disability has been determined, and that can be before or after a lump sum was paid out. Offset for what ever inclusive dates and amounts are indicated. Workers' Comp TTD, weekly PD, lump sum PD and VRTD benefits should all dove tail each other. Just as with SSDI, attorney fees are not an offset.

Permanent Disability (PD)

When an injured worker's disability is declared permanent and stationary by a consensus of physicians, the claimant is provided PD benefits.

The total amount of PD benefits are based upon how severe the injury was (stated as a percentage of body function loss). The degree of loss may not be clear. Also the degree of PD is subject to negotiation between the insurance carrier and the claimant, who is typically represented by an attorney. The PD severity determination or negotiation may be protracted and if it is, PD is often provided as a weekly advance or draw against the eventual lump sum payoff. When the total amount of PD can be agreed to by the claimant and the carrier, final benefits are provided in a lump sum.

If the claimant and the carrier can not arrive at an agreement on PD, the matter is forwarded to the Workers' Compensation Appeal Board (WCAB) and an Administrative Law Judge (ALJ) to decide the matter. Award notices need to be obtained in order to establish what occurred.

The weekly PD indemnity is typically a maximum of $140 per week. Infrequently and for severe disability (rated at 25% or greater loss of
bodily function), the weekly rate is $148. Offset for whatever inclusive dates and amounts are provided.

When a lump sum PD benefit is awarded subsequent to a weekly benefit being paid, divide the lump sum total by the weekly PD amount to determine how many weeks the award was intended to cover. Offset the previous weekly rate for the number of weeks calculated.

If a weekly benefit was not provided prior to the PD lump sum payoff, divide the lump sum by $140 to determine how many weeks that equates to. Offset LTD by $140 per week (subject to minimum monthly benefit) for the number of weeks calculated.

Compromise and Release Benefits (C&R Settlement)

If the Workers' Compensation insurance carrier denies benefits and the insured appeals, they may settle with each other. C&R settlements are paid by the Workers' Compensation carrier without admitting liability, without designating what type of benefit it represents, and without inclusive dates being indicated.

If a settlement is not reached the matter will be referred to the WCAB. The ALJ may confirm the denial, or may decide a settlement amount is appropriate. Always get WCAB determinations and ALJ decisions as they sometimes lay out benefit information in terms of type of benefits being provided, amounts and dates. Do not offset for attorney fees. In determining offset amount follow guidelines for offsetting Workers' Comp lump sum awards.

When a lump sum payment is made, we should consider the C&R settlement to be retroactive to the last period paid by Workers' Compensation (PD or TTD date). If no prior payment has been made, then we assume that the covered period begins as of the date of the alleged injury/illness.

Connecticut Workers' Compensation

Connecticut Rights to a Lien on a Controverted Workers' Compensation Claim

This law, enacted June 29, 1981, gives UnumProvident the right to file a lien on a controverted Workers' Compensation claim where we are paying, or have paid, benefits under our non-occupational medical, hospital, and disability policies. (C.G.S.A. Section 38q – 470)

Currently, we do provide benefits in such situations subject to our insured signing an agreement to reimburse us if his claim is filed compensable. We should continue to take such agreements and in addition, file a lien.

This notice of lien, in duplicate, should be mailed certified or registered to the following:

- our insured.
- the Workers' Compension carrier at its principle place of business in the state of Connecticut if our policyholder/employer is self-insured for Workers' Compensation, notice of lien should be filed with the employer.
- Workers' Compensation Commissioner for the district in which the Workers' Compensation claim has been filed.

The lien notice should include sufficient information to identify the type of benefits provided under our policy, the name of the insured or ill employee, the name of the Workers' Compensation carrier, the amount of benefits paid to date and an estimate of further benefits to be provided.

Where we are continuing to provide periodic payments we should update the amount of our lien periodically, and when benefits cease, we should notify all parties of the total amount of our lien. The notice of lien may be made by means of a letter as Connecticut has not designated a specific form.

Louisiana Workers' Compensation

Introduction

This section provides an overview of the impact of Louisiana law, effective June 19, 1995, on treatment of offsets when both workers' compensation and disability benefits are paid to claimants. (L.R.S., Title 23, Section 1225)

Overview

Louisiana passed a law effective 6/29/95 which impact's UnumProvident's ability to offset Workers' Comp benefits. The bill makes Workers' Comp the secondary payor to any employer-funded portion of a disability benefit. UnumProvident may still offset Workers' Comp benefits, but only after Workers' Comp has offset against the employer-funded portion of the disability benefit. Three examples follow:

100%		**UnumProvident's Plan:**	**WC Plan:**
Employer Funded		$2000 monthly disability benefit	$1000 monthly WC benefit WC will offset entire amount
Disability Plan		**What UnumProvident pays:**	**What WC pays:**
		UnumProvident pays $2000	WC pays $0
Funded		**UnumProvident's Plan:**	**WC Plan:**
Disability Plan		$2000 monthly disability benefit $1000 employer funded portion	$1000 monthly WC benefit WC will offset $1000
		What UnumProvident pays:	**What WC pays:**
		UnumProvident pays $2000	WC will pay $0
50% Funded		**UnumProvident's Plan:**	**WC Plan:**
Disability Plan		$2000 monthly disability benefit $1000 employer funded portion	$1500 monthly WC benefit WC will offset $1000
		What UnumProvident pays:	**What WC pays:**
		UnumProvident pays $1500 ($500 WC offset)	WC pays $500

Maine Workers' Compensation

Maine Workers' Compensation Law: STRESS

Stress can be considered as compensable under Workers' Compensation Act in Maine subject to the following criteria:

Mental injuries resulting from work related stress does not arise out of and in the course of employment unless it is demonstrated by clear and convincing evidence that: (A) the work stress was extraordinary and unusual in comparison to pressures and tension experienced by the average employee; and (B) the work stress, and not some other source of stress was the predominant cause of mental injury.

The amount of work stress shall be measured by objective standards and actual events rather than any misperceptions by the employee.

A mental injury is not considered to arise out of in the course of employment if it results from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination or any similar action, taken in good faith by the employer. (39-A M.R.S.A. Section 201)

Maine Workers' Compensation Law: WITHHOLDING PAYMENTS

Maine law specifies that an employer cannot hold payments up under a medical or disability plan because an employee has applied for Workers' Compensation. 39-A M.R.S.A. Section 222). Although the law does not place any responsibility on UnumProvident, we will advance payment under certain conditions, if requested. Since the obligation is the employer's, an Agreement Concerning Benefits must be signed by the policyholder, not the employee. This form is entitled "Policyholder's Agreement Concerning Benefits" which was designed specifically to deal with the Maine legislation.

Michigan Workers' Compensation

Michigan Workers' Compensation Laws Section 418.356 of Michigan Compensation Laws Annotated Provides:

(1) The Section is applicable when either weekly or lump sum payments are made to an employee as the result of liability pursuant to Section 351,361, or 835 with respect to the same time period for which old-age insurance benefit payments under the Social Security Act, 42USC30121397; payments under a self-insurance plan, a wage continuation plan, or a disability insurance policy provided by the employer; or pension or retirement payments pursuant to a plan or program established or maintained by the employer, are also received or being received by the employee. Except as otherwise provided in this Section, the employer's obligation to pay or cause to be paid weekly benefits other than specified loss benefits under Section 361(2) and (3) shall be reduced by these amounts.

Thus, the employee's obligation to pay or cause to be paid weekly benefits other than specific loss of benefits under Section 361(2)(3) shall be reduced by the after tax amount of the payments received or being received under a self-insurance plan, a wage continuation, or under a disability insurance policy provided by the same employer. This is true if the employee did not contribute directly to the plan or to the payment of premiums regarding the disability insurance policy.

This law was reviewed in October, 1988 by our legal department and we have been advised to provide to the Workers' Compensation carrier, if asked, the net benefit we are providing to the claimant prior to a Workers' Compensation offset. The Workers' Compensation carrier does have the right to coordinate with our benefits so that their payment may be reduced or eliminated. If the comp carrier does stop paying entirely, we do not have a Workers' Compensation offset. If the comp carrier only reduces its payment, we can offset for whatever amount the carrier actually pays the claimant.

For a claimant eligible for benefits under Michigan law, do not solicit an inquiry from the Workers' Compensation carrier. The comp carrier may offset for our benefit but may choose not to do so and we are not required to notify the Workers' Compensation carrier of the LTD coverage.

Minnesota Workers' Compensation

Background

In Minnesota, when a claimant files for Workers' Compensation, UnumProvident must intervene in the Workers' Compensation proceedings if it wishes to recoup any disbility benefits it may have paid to the claimant. UnumProvident's motion to intervene can be denied for untimely filing. A motion to intervene must be served and filed within 30 days after a person has received notice that a petition has been filed. When a UnumProvident employee receives notice either by telephone or by mail that a claimant has filed a Workers' Compensation petition, a 30-day clock starts at that point. (M.S.A. Section 176.361)

Required Documentation

All notices that we receive for a right to file an intervention should be immediately forwarded to Mary Roy in the Legal Department with the following documentation:

- All documentation from claimant or claimant's attorney regarding the Workers' Compensation petition, including the petition itself, if we have it.
- The amount of benefits we have paid the claimant with computer printouts showing the benefit payments and totals.
- A copy of the policy. (At least a copy of the Benefits Section dealing with reductions and coordination of benefits.)
- A copy of the claims payment sheet.
- Whether or not claimant continues to receive benefits from UnumProvident.

Texas Workers' Compensation

In the state of Texas, Workers' Compensation insurance is optional to all employers. No Texas-situs employer is required to provide Workers' Compensation benefits to its employees. Employers who choose to opt out of Workers' Compensation are not required to provide their employees with equivalent (or any) coverage.

Texas Supplemental Income Benefit

The Texas Supplemental Income Benefit is an additional benefit that is required under the Texas Workers' Compensation statute. It is based on an employee having an impairment rating of 15% or more; having not returned to work or earning less than 80% of average weekly wage because of the impairment; and having attempted in good faith to obtain employment "commensurate with...ability to work."

Because it is disability-based and required under the Workers' Comp statute, it can be considered an amount the claimant is entitled to receive under a Workers' Comp law and taken as an offset.

Family Income Rider

This rider is also known as the Two-Year Survivor Benefit. The company will pay a benefit to the eligible survivor when proof is received that an insured died:

- after total disability had continued for twelve or more consecutive months, and
- while receiving a monthly benefit.

This benefit will be paid monthly for two years from the date of death.

If the disabled employee dies after having been totally disabled for at least twelve months and while receiving disability benefits, the eligible survivors will receive a monthly benefit equal to a percentage of the monthly benefit for an additional period, not to exceed 24 months.

If the disabled claimant is divorced at time of death, such benefits will be paid to the eligible children.

Refer to specific contract wording when processing a claim.

Eligibility: Teachers and School District Employees

Teachers and other employees of a school system are a special situation because they normally do not work two to three months per year. In this case, we continue their Group Long Term Disability coverage for their teaching position even though they are not actively at work for the entire year (typically summer vacations).

School district employees can elect to be paid their salary, from their employer, in 9 months during the school year or 12 months year round. If the Basic Monthly Earnings definition is 1/12th of the salary, we need to take 1/12 of the annual BME. Whether s/he is paid over 9 months or 12 months of the year pre-disability does not impact how we calculate the monthly benefit.

Refer to specific contract wording for eligibility and BME when evaluating a claim involving teachers or school district employees.

Business Overhead Expense

Purpose

The B.O.E. policy is designed to cover the overhead expenses of professional persons and owners of small and medium size businesses when disability occurs. Expenses to be covered are those which, in the absence of disability, are paid from earnings that can be attributed to the presence and individual effort of the insured, and which expenses would continue to accrue if the insured became disabled.

Policies

231
233-Introduced in 1968
333-Introduced in 1974
1633-Introduced in 1984
1733-Introduced in 1987
1737-Introduced in 1989

Benefits

A. Typical B.P. is 6 months to a maximum of 2 years.
B. Monthly benefits to a maximum of $15,000.00
C. Elimination Periods generally are 30, 60, or 90 days.

Policy provisions and definitions similar to D.I. policies

A. Total Disability
B. Occupation
C. Waiver of Premium
D. Contestability and Time Limit on Certain Defenses(1737)
E. Pre-Existing conditions and Exclusions

Policy provisions unique to BOE

A. Covered and Excluded expenses
B. Survivor Benefits: In the event of the policyholder's death while benefits are being paid, we will continue benefits to the Estate covering his portion of incurred expenses for the 2 month period immediately following the policyholder's death, so long as the policyholder's business interest is not sold.
C. Dual Coverage (applies to the 1633, 1733, 1737): Overhead expenses which would be covered are excluded if they are reimbursed under another B.O.E. or Disability policy issued prior to the effective date of this policy.
D. Accumulating Benefit (applies to the 1633, 1733, 1737):
    1. If covered overhead expenses incurred in one month are less than the monthly benefit, the excess amount may be carried forward and applied to expenses incurred in a later month when the monthly benefit is less than the covered overhead expense.
    2. If the covered overhead expenses you incur in one month are more than the monthly benefit, the excess expenses may be carried forward and reimbursed in a later month when the covered overhead expenses are less than the benefits which would have been payable. This provision may allow payment after the benefit period has expired if the maximum benefit limit has not been reached.
E. Conversion Privilege: Under certain circumstances, the policy may be converted to a disability policy (the insured can not be disabled at the time).

F. Partial Disability Benefits (applies to the 1633, 1733, 1737): If partial disability follows total disability for which a benefit is paid, we will pay up to 3 months as follows: 1st = 75% of the monthly benefit, 2nd month = 50% of the monthly benefit, 3rd month = 25% of the monthly benefit.

Optional Benefits

A. BVP (applies to the 1633, 1733, and 1737). For total disability only.
B. GPI
C. Residual (applies to the 1733 and 1737)

Documentation of Claim

New Claim*

1. To the policyholder:
   - Insured's Statement of Claim
   - Form G2466 (Insured's statement of business expenses)
   - Letter of explanation (B.O.E. letter)
   - Business Expense Questionnaire
2. Contestable and/or routine investigation
   - Medical, financial, and other coverage information
   - Database research
   - Field Representative referral.

* Utilize CPA for assistance before 1st BOE payment.

Guidelines

"Covered Overhead Expenses" means: Items of expense incurred by you that are usual and customary in the operation of your business or profession. They must be generally accepted as tax-deductible business overhead expenses. They include but are not limited to items such as:

1. employees' salaries (except as excluded below);
2. charges for utilities such as electricity, telephone, heat and water;
3. either a) rent, or b) an equivalent rental cost for space which you occupy In a building you own and which space you use in the operation of your business or profession, consisting of taxes, maintenance and mortgage interest payments plus the greater of scheduled depreciation for tax purposes or scheduled mortgage principal payments;
4. for furniture, equipment and implements of your business or profession; either a) leasing cost, or b) an equivalent cost consisting of taxes, maintenance and interest payments plus the greater of scheduled depreciation for tax purposes or scheduled principal payments
5. laundry, janitorial and maintenance services;
6. business insurance premiums (including professional liability insurance premiums); and
7. accounting, billing and collection service fees.

Covered Overhead Expenses do not include:

1. salaries, fees, drawing accounts, profits or other remuneration for:
   - you;
   - any person sharing your business expenses;
   - any member of your profession or occupation; or
   - any person employed to perform your duties;
2. additions to inventory or the costs of goods or merchandise purchased for sale;
3. any kind of expense for which you were not liable in the normal course of your business or profession prior to a covered disability;

4. more than your share of expenses when they are shared with one or more persons; and
5. overhead expenses which would otherwise be covered were it not for such expenses being reimbursable under another business overhead expense policy or disability policy issued prior to the Effective Date of this policy.

An expense covering more than one month will be prorated to determine the expense for one month.

Types of Business Entities

1. Sole Proprietorship
   - Not a separate legal entity.
   - Owner cannot receive W-2 wages from his sole proprietorship.
   - Income (loss) from this type of entity is reported on the individual income tax return, Form 1040, Schedule C.

2. Partnership (a pass-through entity)
   - Is a separate legal entity, with two or more **partners**, and files its own tax return, U.S. Partnership Tax Return, Form 1065, which includes a separate K-1 for each partner showing his/her share of the income (loss).
   - Partners cannot receive W-2 wages from the partnership; however, they can have guaranteed payments in addition to their share of the profit (loss).
   - The income (loss) from the partnership K-1 **passes through** to the individual income tax return and is reported on Form 1040, Schedule E, Part IL

3. Estates and Trusts (a pass-through entity)
   - Is a separate legal entity, with one or more beneficiaries, and files its own tax return, U.S. Fiduciary Tax Return, Form 1041, which includes a separate K-1 for each beneficiary showing their share of the income (loss).
   - Other business entities can be within an estate or trust.
   - Beneficiaries cannot receive W-2 wages from the estate or trust.
   - The income (loss) from the estate or trust K-1 passes through to the individual income tax return and is reported on Form 1040, Schedule E, Part III.

4. S Corporation (a pass-through entity)
   - Is a separate legal entity, with one or more shareholders, and files its own tax return, U. S. S Corporation Tax Return, Form I I 20S, which includes a separate K- 1 for each shareholder showing his/her share of the income (loss).
   - Shareholders can receive W-2 wages from the S corporation.
   - The income (loss) from the S Corporation K-1 **passes through** to the individual income tax return and is reported on Form 1040, Schedule E, Part II.

5. C Corporation
   - Is a separate legal entity, with one or more shareholders, and files its own tax return, U.S. Corporation Tax Return, Form 1120, and pays corporate income taxes on any profits.
   - Shareholders can receive W-2 wages from the C corporation.

Buy-Sell Agreements

Things to Consider

- Whether it is a reimbursement type agreement. Does the Stockholder's Agreement provide for payment to be made by the corporation before reimbursement by UnumProvident? Is so, upon such event, the loss payee should send UnumProvident a copy of the cancelled check.
- Does the definition of disability in the Stockholder's Agreement match the policy definition?
- Is disability mentioned in the agreement as a condition precedent to pay out?
- Is the amount of payment for the shares of stock commensurate with the aggregate buy-out expense in the policy?
- Does the method of funding in the Stockholder's Agreement match the method chosen in the policy (i.e., lump sum or monthly)?
- Does the insured actually own stock in the corporation or partnership?
- What if the insured dies, does the obligation to the corporation or partnership end? If so, then it should end for UnumProvident.
- Is the elimination period, set by the policy, followed by the Stockholder's Agreement?
- Does the buy-out occur after the elimination period?
- Does the agreement divest the insured of his/her complete interest in the Corporation?

Buy-Sell Agreements:

- should set out the terms of the agreement.
- would include the date and terms under which the agreement triggers.
- should include the purchase price, amount and schedule of payments, etc.

Proof of Loss

- The policy usually contains a long elimination period (12 or 24 months)
- The insured must be totally disabled for the entire length of the Elimination period (successive periods apply the same as individual disability policies).
- After the elimination period, total disability is no longer a requisite (it is important to resolve all questions of disability during the elimination period. Surveillance, verification of "full time employment prior to disability." Do IME, etc. on cross purchase agreements, ask for copies of cancelled checks on stock redemption agreements, ask for copies of cancelled checks as well as endorsed stock certificates.

Points to Remember

- The "Loss Payee" can be changed as ownership of the business changes. It must, however, be done in advance and by agreement between the Policy Owner and UnumProvident
- Some recent policies have an offset for Business Buy-Out Expense paid by another Buy-Out Policy issued prior to Provident's
- The Attending Physician cannot be the Insured, an owner or employee of the Business.
- The Policy cannot be renewed after the date that the Insured owns, or is in the process of obtaining more than 90% ownership interest in the business. On Cross-Purchase and Stock - Redemption, look to see how many owners there are.

Important Note

All buy-sell claims must be approved by an executive claim consultant. Do not make any promises in advance.

Provident Policy Series and Claim Termination At Age 65

On policies prior to the Provident 337 series, age 65 is defined as the term date immediately following the 65th birthday. Because we receive and hold premium beyond the 65th birthday, we are obligated to pay benefits beyond the 65th birthday. Benefits will continue to the next renewal period.

Policy 337 and subsequent series do refund, or may not collect, premium beyond the 65th birthday. Therefore benefits under those policy series would terminate at the 65th birthday.

Mental/Nervous Limitation on 338 and 338 LE Contracts

The 338 and 338LE contracts each contain an optional two-year limitation on mental/nervous type conditions. Specifically, the contracts state:

"Mental Disorders mean any disorder classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, most current as of the date of disability. Such disorders include, but are not limited to, psychotic, emotional, or behavioral disorders, or disorders relatable to stress or to substance abuse or dependency..."

Using the above language, degenerative diseases such as Alzheimer's disease, or dementia resulting from a stroke, trauma or infections would be excluded from coverage after two years, since these diseases are classified in the DSM. However, it was never our intent to exclude such conditions that were so obviously linked to a physical malady.

In fact, the Cornerstone and Foundation policy series specifically state that the above conditions are precluded from a two-year limitation. Therefore, we have made an administrative decision to adopt the Cornerstone/Foundation philosophy of exempting the above conditions on claims presented on 338 and 338LE contracts that contain the optional two-year mental/nervous limitation.

If you have any questions, please see your manager or senior consultant.

Reinsurance Procedures

As part of our reinsurance agreements, we must provide our reinsurance carriers with certain information. Our treaties are very specific and it is very important that we are aware of our reinsured claims and comply with our obligations. We could be denied reimbursement if we fail to meet the treaty provisions.

Please implement the following procedures immediately:

1. The claim assistant will determine if a policy is reinsured. For brokerage or private label, the coverage detail screen on CAPS tells whether or not a policy is reinsured, except for Centre. For National Life, the disability status sheet (example attached) shows a "6" for Lincoln Reinsurance and a "7" for North American (Swiss), under "RC". The reinsured amount shows under "BAS REIN AMNT." The claim assistant will then highlight the reinsurance field on the coverage information sheet.

There is a special-salmon colored payment sheet used to highlight reinsured claims. There will also be a bumper sticker placed on the front of the file by the claim assistant, with the words "reinsurance" and "carrier _____."

The claim assistant will photo the claim form and supporting information submitted and will put it in the appropriate mail slot at the mail stop. There will be slots at the mail stop labeled "Lincoln," "Drum," "Munich," and "Mercantile and General." This mail will be sent once a week to the reinsurer.

Please note you can also determine the reinsurer by number on CAPS by doing a lookup on the line beside the reinsurer if a number is indicated on claim inquiry.

2. If the specialist wants to look on Customax, additional information can be gained. It is extremely important when a file is settled and there is more than one policy, we need to be sure that we are calculating the appropriate settlement amount under each policy for appropriate reimbursement from the reinsurance carrier. To determine the reinsured amount, sign on to your customax system and type in "inq rein" in the "next response" field. Next type in the policy number and you will see the information that you will need (see attachment).

3. On this screen, you will see a field titled "RNS AGR"—this field displays the reinsurance carrier:
1=Lincoln
2=Drum
3=Munich, and Swiss Re (was Mercantile and General) NOTE: Up until 1/1/99, each policy reinsured is 50% reinsured with both companies—both need to be notified. After 1/1/99, the reinsurance is 100% Munich.
4=Paul Revere
5=Lone Star

For policies issued prior to 10/1/96:
If we are discussing settlement, or commutation with the insured, we need to notify the reinsurance carrier at least 20 days prior to the offer, if at all possible. If this is not possible, ASAP.

Lincoln National
1. Please send a copy of the file plan on all new claims reinsured with Lincoln.

2. Please send copies of itemized bills for extraordinary claims expenses—i.e, surveillance, independent medical exams, legal bills for outside counsel, forensic accounting, etc. to Lincoln National for reimbursement. The insured's name, policy number and claim number should be on the bill. The claim assistant will put the appropriate account number on the bill.

Drum
The clerical assistants will send a copy of the of the mark-up sheet on all new claims to Drum.

For policies issued after 10/1/96:
1. We have the ability to settle claims without obtaining the reinsurer's approval, as long as the settlement is for less than 85% of gaap reserve and is for a reinsured amount of $300,000 or less.
2. If the reinsured portion of the claim exceeds the retained portion (e.g., a claim exceeding $16,000 on LDP), we must consult with the reinsurers before accepting liability. This should be a very rare situation, since our issue limits are $15,000.
3. The reinsurers will share proportionately in unusual claims expenses (surveillance, Legal, independent medical examinations or opinions) for reinsured policies. This does not include salaries for UNUM employees. **Any bills for these items must be sent to the reinsurers. Please put a copy of the bill in Munich's and another in Swiss Re's (unless claim is after 1/1/99, which would be just Munich) basket, with a short note explaining what the bill is. Please note the clerks will not pay any bills for surveillance or OMEs without an indication on the bill if the policy is reinsured with Munich and Swiss Re or not.**
4. We must provide prompt notice of any lawsuits involving reinsured policies. This includes rescissions and reformations. If the reinsurers agree to participate in contesting the policy, then they will share in both expenses and reduction in liability. If they do not agree to the contest, then they will participate in neither the expenses, nor any savings.
5. The reinsurers will be liable for extra-contractual damages in special circumstances only, typically if they were a party to the conduct which resulted in the damages.

Centre reinsurance
This reinsurance is for the inforce block for all claims incurred after January 1, 1996. Send a copy of the serious disability/large loss referral for all claims over $6000.

Also, we cannot change claim handling practices in any way that would materially affect Centre without their prior written approval. Management will handle communications to Centre.

Old series private label reinsurance
For Indianapolis Life or National Life notify the carrier of settlements, rescissions, and over 3-4 month advance payments. Indianapolis Life reinsurers are Paul Revere, Lincoln National and Lone Star. National Life reinsurers are Lincoln National and North American (Swiss Reinsurance).

The claim assistants will be the contacts for forwarding the reinsurer's requests for information to the proper benefit specialist. They will copy this information for you, providing the information you require to be copied is flagged. The completed request for information then needs to be sent back to the claim assistant within a week. These photo requests can be given to your claims assistant. The claims assistant will give it to the appropriate clerk to photo.

Contacts
Mary Osborn/Lois Thompson (UNUM Or NLV) or Donna Childs/Rhonda Mcdonald (Indy)
Lincoln National Life Insurance Company
1300 So. Clinton St., P. O. Box 7854
Fort Wayne, IN 46801

Telephone: 219-455-4747/219-455-3832, or 1-800-248-0844, Fax: 1-219-455-3473

Randy Macdormand
Drum
John Hewitt and Associates
100 Commercial St., Ste. 210
Portland, ME 04101
Telephone: 207-874-2261, Fax 207-874-2265

Ricky Peterson
Munich America Reassurance Company
56 Perimeter Center East
Atlanta, GA 30346-2290
Telephone: 770-350-3200, X 264, Fax 770-350-3300

Curtis McDougall
Swiss Life Insurance Co. Of America (Formerly North American)
237 Park Ave.
New York, NY 10017
Telephone 212-907-8526, Fax 212-907-8553

Sandra Nunnally
Lone Star Life
P. O. Box 709009
Dallas, TX 75287
Telephone 214-447-6436

Judy Basiner
Paul Revere Life Insurance Company
18 Chestnut St.
Worcester, MA 01608-1528
Telephone 508-799-4441

Kelly Doucette
Centre Solutions
Zurich Centre, 90 Tits Bay Rd., P. O. Box Hm 1788
Pembroke Hm 08 Bermuda
Telephone: 441-298-3704, Fax: 441-295-3705

Criteria for reinsured cases
Use issue date to determine treaty in effect.

Type of coverage	Reinsurer	Policy Date	BMI
Customax DI policies	Lincoln	1/1/88 to 4/27/90	$8000 and over
	Drum	4/27/90 to 10/1/96	$8000 and over
	Swiss Re	10/1/96 to 1/1/99	$8000 and over*
	Munich	10/1/96 to 1/1/99	$8000 and over*
	Munich	1/1/99 to present	$8000 and over
Overhead policies	Lincoln	1/1/88 to 4/27/90	$15,000 and over
	Drum	4/27/90 to 10/1/96	$20,000 and over
	Swiss Re	10/1/96 to 1/1/99	$20,000 and over*
	Munich	10/1/96 to 1/1/99	$20,000 and over*
	Munich	1/1/99 to present	$20,000 and over

Buy-Sell policies	Lincoln	prior to 6/1/96	$30,000 and over
	Drum	6/1/92 to 10/1/96	$500,000 and over
	Swiss Re	10/1/96 to 1/1/99	$500,000 and over*
	Munich	10/1/96 to 1/1/99	$500,000 and over*
	Munich	1/1/99 to present	$500,000 and over
LDP	Drum	6-23-95-10-1-96	$8000 and over
	Swiss Re	10-1-96-1-1-99	$8000 and over*
	Munich	10-1-96-1-1-99	$8000 and over*
	Munich	1-1-99-present	$8000 and over
Use date of disability and policy series to determine if an additional treaty also applies:			
Prior series and	Centre	**all claims** after 1-1-96	Net of existing
Customax			reinsurance
*Half of each policy's reinsurance will go to Swiss Re and half to Munich.			

Review of Applications

The general purpose of reviewing the information contained in the application file and comparing it to the information contained in the initial claim form is to:

- learn as much about the circumstances surrounding the issuance of the policy and
- how that information compares to the current information that was submitted on the claim form.

When items are found in the application file that appear to be inconsistent with the information contained in the initial claim form further research is needed to determine the nature of the differences and what impact they have on the claim investigation process. If policies involved are determined to be contestable or if fraud language is applicable, further investigation may be warranted.

1. Review application for the following information and compare to the Insured's Statement of Claim
   - Name
   - Age
   - Occupation /Duties
   - Income
   - Other Coverage
   - Medical History

2. Review application to determine how coverage was issued:
   - Standard as applied for
   - Standard
   - Guaranteed Issue
   - With Waivers
   - Is there a risk group involved?
   - Has coverage been reinstated?

3. Determine who pays the premiums
   - Employer Paid
   - Employee Paid-Was premium paid with pre-tax (sec 125 plan) or post-tax dollars?
   - Employer/Employee Paid: Determine percentage paid by each

4. Have benefits been assigned? BOE policies are often assigned.

5. Has benefit amount been changes since date of disability?
   - Update
   - GPI

6. Age when claim began?

New Jersey TDB: Concurrent Coverage

April 14,1997

You may have a TDB claim situation where the employee has TDB coverage through two employers. If you receive a claim on one of these employees, the first step in processing the claim is to determine the last employer for whom the claimant worked prior to the disability. The **last** New Jersey covered employer is liable for the claim. The liable employer may be either a full-time or part-time employer, since liability is not based on the claimant's work schedules.

In the event the claimant worked for both covered employers on the same last day, you must determine if the other employer has State Plan coverage or Private Plan coverage.

1. The weekly benefit amount must be calculated based on the wages earned with both employers in the last eight weeks before the disability began.
2. If the other employer has Private Plan coverage, each plan is responsible for paying a percentage of the total weekly benefit, calculated as follows:
   - Determine the claimant's total weekly benefit.
   - Determine the claimant's income in the last eight weeks for both employers.
   - Determine the percentage of the benefit to be paid by each plan.

New Jersey TDB: Continuation of Salary

July 19,1999
According to the New Jersey TDB law, "No benefits are payable under the State Plan to any person in a weekly amount which together with any remuneration the claimant continues to receive from his employer would exceed his regular weekly wages immediately prior to disability." In other words, if the claimant is still receiving a salary (continuation of salary) from his employer while on disability, the benefits he receives from TDB along with the continuation of salary may not exceed 100% of his pre-disability earnings. Therefore, if the claimant is receiving 100% continuation of salary, he may not receive a TDB benefit.

NOTE: Continuation of salary could be a salary continuation program, accumulated sick leave or vacation.

If an employer has a continuation of salary program in addition to a TDB policy, that employer has two options for handling the continuation of salary:

The TDB policy may offset the continuation of salary.

If the employee is receiving 100% continuation of salary, offset the entire TDB benefit.

If the employee is receiving a percentage of salary that is less than 100% of pre-disability earnings, add the salary continuation amount to the TDB benefit amount. If the total is more than 100% of pre-disability earnings, offset the difference between the total and 100% of pre-disability earnings. For example:

Pre-disability earnings	$500.00 per week
TDB benefit	$334.00
Salary continuation	$300.00

The total of the TDB benefit and the salary continuation is $634.00. Since this amount is greater than 100% of the pre-disability earnings by $134.00 ($634.00 minus $500-00), you will offset $134.00.

1. Employer Reimbursement (the employer signs a Reimbursement Agreement instructing us to pay benefits to the employer for the continuation of salary period).

If you have a claim on a TDB policy and continuation of salary is indicated on the claim form, check Agreement and/or Text Data to determine which option the employer has chosen. The Agreement provisions are:
1. OIB Salary Continuation
2. ER Reimburse

If the option is not coded on Agreement or noted on Text Data, you should contact the employer to confirm which option applies. Request that the employer confirm the option in writing and refer the documentation to Issue Resolution to add a note to Customer Profile. Issue Resolution will provide documentation to the Business Unit to code Agreement and to include the documentation in the contract file.

New Jersey TDB: Claim Denial Requirements

February 12, 1999
The New Jersey State Temporary Disability Benefits are not governed by the federal legislation of ERISA. Therefore,.when processing claims under statutory plans, we must abide by state requirements.

When denying a TDB claim on a statutory plan or division, the following procedures should be followed once the denial decision has been made:

1. Write a draft of the denial letter. Do not include an ERISA paragraph, since these policies are not governed by ERISA. Rather, include the Statutory TDB Appeal paragraph.
2. Refer the claim to your manager for approval.
3. Once approved by your manager, make a telephone call to the claimant advising him/her of the denial.
4. Make any necessary changes to the letter and mail it to the employee with a copy to the employer.
5. Complete the NJ Cessation form, attach a copy of the denial letter and the claim file, and mail to the state of New Jersey, Department of Labor.

Enriched TDB plans/divisions are governed by ERISA. When denying an enriched TDB claim, the following procedures should be followed once the denial decision has been made:

1. Write a draft of the denial letter. It is necessary to include the New Jersey ERISA paragraph.
2. Refer the claim to your manager for approval.
3. Once approved by your manager, make a telephone call to the claimant advising him/her of the denial.
4. Make any necessary changes to the letter and mail it to the employee with a copy to the employer.
5. Complete the NJ Cessation form, attach a copy of the denial letter and the claim file, and mail to the state of New Jersey, Department of Labor.

It is important to note that a policy may have multiple divisions. One or more of these divisions could insure statutory benefits (non-ERISA), while other divisions could insure enriched benefits (ERISA).

New Jersey TDB Claim Denial/Cessation of Benefits

February 18, 1994
We have recently been informed by the State of New Jersey that we need to observe the following procedures when processing New Jersey claims:

1. The New Jersey cessation form must be completed for each claim denial. A copy of our denial letter and a copy of the claim file must be attached to the form.
2. The following paragraph must be added to our denial letter after the ERISA paragraph:

   "You have one year from your date of disability to appeal our claim decision with the State of New Jersey. Your appeal should be sent to:

   State of New Jersey
   Bureau of Private Plan
   CN957
   Trenton, NJ 08625-0957"

The New Jersey cessation form is available under Letters/Forms in Genesis.

New Jersey TDB: Claimants with Legal Representation

March 10, 1997
Previously under the New Jersey Unfair Claims Settlement Practices law, the requirement for written notice of a delay in the claim decision would no longer apply once the claimant filed a lawsuit. Recently a change was made to this section of the law.

The newly adopted amendment states:
"The written notifications required under this subsection shall not continue to apply to that aspect of a claim for which the claimant has become represented by an attorney, as evidenced by a letter of representation."

Therefore, written notice of delayed claim decision (Delay Action letter) is no longer required once the claimant is represented by an attorney. This will help ensure that once a claimant has retained an attorney, all future correspondence will be between the insurance company and the claimant's attorney.

New Jersey TDB: Maximum Benefit

2000 Maximum Benefit

December 29, 1999
The New Jersey Commissioner of Labor has determined that the maximum weekly Temporary Disability Benefit (TDB) will be increased to $401.00 per week for all non-work-related temporary disability claims that begin on or after 1/1/2000.

Also effective 1/1/2000, the claimant must have worked for at least 20 base weeks with earnings of at least $152.00 per week, or in the alternative, have earned at least $9,100.00 in the base year, in order to be eligible for benefits.

If you have any questions or concerns regarding this issue, please do not hesitate to contact a member of the training staff.

1999 Maximum Benefit

October 8, 1998
The New Jersey Commissioner of Labor has determined that the maximum weekly Temporary Disability Benefit (TDB) Will be increased to $381.00 per week for all non-work-related temporary disability claims that begin on or after 1/l/99.

Also effective 1/l/99, the claimant must have worked for at least 20 base weeks with earnings of at least $144.00 per week or, in the alternative, have earned at least $8700.00 in the base year, in order to be eligible for benefits.

1998 Maximum Benefit

December 16, 1997
The New Jersey Commissioner of Labor has determined that the maximum weekly Temporary Disability Benefit (TDB) will be increased to $364.00 per week for all non-work-related temporary disability claims that begin on or after 1/1/98.

Also effective 1/1/98, the claimant must have worked for at least 20 base weeks with earnings of at least $138.00 per week, or in the alternative, have earned at least $8,300.00 in the base year, in order to be eligible for benefits.

If you have any questions or concerns regarding this issue, please do not hesitate to contact a member of the training staff.

1997 Maximum Benefit

October 31, 1996
The New Jersey Commissioner of Labor has determined that the maximum weekly Temporary Disability Benefit (TDB) will be increased to $350.00 per week for all non-work-related temporary disability claims that begin on or after 1/l/97.

Also effective 1/l/97, the claimant must have worked for at least 20 base weeks with earnings of at least $133.00 per week or, in the alternative, have earned at least $8000.00 in the base year, in order to be eligible for benefits.

1996 Maximum Benefit

January 4, 1996
The New Jersey Commissioner of Labor has determined that the maximum weekly Temporary Disability Benefit (TDB) will be increased to $339.00 per week for all non-work-related temporary disability claims that begin on or after 1/1/96.

Also effective 1/1/96, the claimant must have worked for at least 20 base weeks with earnings of at least $128.00 per week, or in the alternative, have earned at least $7,700.00 in the base year, in order to be eligible for benefits.

If you have any questions or concerns regarding this issue, please do not hesitate to contact a member of the training staff.

New Jersey TDB: Return to Part-Time Work

September 9, 1998
In the case of a New Jersey TDB claim where the employee is returning to work part-time, the TDB Private Plan Claims Manual states:

"Occasionally a disabled claimant may return to work on a part-time basis. The policy of the Division of Temporary Disability Insurance regarding this situation is as follows:

The only situation where the claimant may continue collecting temporary disability benefits when returning to work part-time is where the claimant had both a full-time and a part-time employer prior to the disability, is unable to perform the duties of his/her regular full-time employment, but is able to perform totally different duties with his/her part-time employer. Benefits in this situation are paid for days where the claimant has not worked anywhere. Changing any element of this situation (one employer prior to the disability, two part-time employers, returning to the full-time employer, etc.) results in a termination of temporary disability benefits."

In other words, if the claimant had two employers prior to the date of disability (one full-time and one part-time), and can return to his part-time employment while continuing to be disabled for his full-time employment, we can continue to extend benefits for the days the claimant does not perform **any** work. We should pay $1/7^{th}$ of the weekly benefit for each day the claimant does not work.

NJ TDB: Sick/Vacation Pay

November 5, 1992
We had a claim situation where an insured (covered under a TDB policy) was receiving accumulated sick/vacation pay from his employer while receiving TDB benefits from us. We called the state of NJ to verify how this situation should be handled.

The insured cannot receive sick/vacation pay while receiving TDB benefits. If the employer wants to "make up the difference" between pre-disability earnings and the TDB benefit, they may do so. However, the insured cannot make more money on disability than he made pre-disability.

If you run into a situation like this one, call the employer and inform them that the insured cannot receive sick/vacation pay while on disability.

New Jersey TDB: Surgery

Elective Abortion

October 22, 1993
Under the Temporary Disability Benefits (TDB) Law in New Jersey, an elective abortion is considered a covered disability. While the procedure is elective in nature, TDB law only denies cosmetic surgery as elective.

Therefore, on all TDB policies, we should be extending benefits on disabilities that result from elective abortions subject to all other policy provisions. These claims should be managed in the same manner as all other claims.

Tubal Ligation

February 22, 1993

Under the Temporary Disability Benefits (TDB) Law in New Jersey, a tubal ligation is considered a covered disability. While a tubal ligation is elective in nature, TDB law only denies cosmetic surgery as elective.

Therefore, on all TDB policies, we should be extending benefits on disabilities that result from tubal ligations subject to all other policy provisions. These claims should be managed in the same manner as all other claims.

New Jersey TDB: Wage Definition

March 27,1997
Under New Jersey TDB there are two earnings test that must be applied in order to determine if a claimant is eligible for benefits.

For claims with disability dates in 1996, the two tests are:
1. The claimant must have worked at least 20 base weeks with earnings of at least $128.00 per week; OR
2. The claimant must have earned at least $7700.00 in the base year.

For claims with disability dates in 1997, the two tests are:
1. The claimant must have worked at least 20 base weeks with earnings of at least $133.00 per week; OR
2. The claimant must have earned at least $8000.00 in the base year.

"Base week" is defined as:
1. (for 1996): "a calendar week in which the claimant earned $128.00 or more."
2. (for 1997): "a calendar week in which the claimant earned $133.00 or more."

"Base year" is defined as "the 52 week period ending the Saturday before the disability began." For example, a disability began on Friday, March 21, 1997. The base year is Sunday, 3/17/96 through Saturday, 3/15/97.

New Jersey TDB: Waiting Week Rollback

April 24, 1995
Under the TDB law in New Jersey, "No benefits are payable under the State Plan to any person for the first seven consecutive days of each period of disability (the waiting week)." However, if eligible for payment for three consecutive weeks following the waiting week, then benefits are payable retroactively with respect to the waiting week.

Please be advised that there is a new interpretation of this provision due to court order. **The State of New Jersey now administers this provision as a retroactive rollback if the claimant has been totally disabled for 21 days**. In other words, if the claimant is still totally disabled on Day 22 of the claim (begin counting on the disability date), benefits may extended for the waiting week (elimination period).

NOTE: This retroactive rollback applies to TDB policies only. If you have a traditional policy that integrates benefits with TDB, apply the elimination period that applies. If benefits under the traditional plan begin on day one, note the duration of the disability. If the claimant is still totally disabled on Day 22, we will have to adjust the claim for the retroactive payment of the TDB waiting week (elimination period).

New Jersey TDB: Workers' Compensation Liens

Background

Occasionally, claimants with contested workers' compensation claims are paid Temporary Disability Benefits with a lien against a potential, future workers' compensation award.

The State of New Jersey Department of Labor has developed a new form to use when filing a lien against a potential workers' compensation award.

Effective Date

This is effective immediately.

Applicability

This is applicable to all New Jersey Temporary Disability Benefits (TDB) policies.

Guidelines

When filing a lien you must use the Lien Notification form below (see Exhibit 1). This information will be data entered into the NJ COURTS system (Case Organization, Utilization, Reporting and Tracking System) for subsequent processing at the time of case closure.

NOTE: This form has not been added to Genesis. Therefore, it will be necessary for you to save a copy of this form on Word to be printed when needed. Also, remember to place a copy of the completed form in the claim file.

The Division of Workers' Compensation will provide you with a confirmation of the data entered. If the information on the confirmation is not accurate, contact them immediately. They will not be responsible for any error(s) in data capture that have not been identified subsequent to the confirmation.

Questions?

Any questions should be directed to your manager or consultant.

Exhibit 1: Lien Notification Document

Lien issue date _____

Lien Description: Private Plan _____ Self-Insured Employer _____ Welfare Fund _____

Lien Amount $ _____

Lien filer's name, address and telephone number:

_____

Claimant's Name: _____
Social Security #: _____
Claim Petition # (if applicable): _____

Comments:

_____ DS 221 Approved
_____ Claim eligible for (diagnosis)
_____
_____ First or Final Notice of lien, TDB
_____
weekly payments ongoing from (date)
_____
(if final) to (date)
_____

_____ Benefits stopped because
_____
_____ Benefits exhausted
_____ Recovery
_____ Return to Work
_____ Non-pursuit of claim

Please forward to:

Division of Workers' Compensation
Attn: Technical Support Unit
PO Box 381
Trenton, NJ 08625

_____ Date of Entry (for Division use only)

New York DBL: Benefit Duration

February 1, 1993

DBL law states that benefit duration is 26 weeks during a period of 52 consecutive calendar weeks or during any one period of disability. One period of disability may be defined as one continuous period of time the employee is disabled. If the employee returns to work for less than 3 months and becomes totally disabled again for the same or a related condition, it would be continued on the prior claim and considered one period of disability.

If an employee receives benefits for 26 weeks during a 52-week period and becomes totally disabled before the beginning of the next 52-week period, benefits should begin on the first day of the next 52-week period. That date would be one year from the first disability date within the last 52-week period. In other words, look back 52 weeks from the current date of disability. The first date of disability within that 52-week period plus 12 months is the begin date of the next 52-week period

If an employee receives benefits for a part of the 26-week maximum, and becomes totally disabled before the beginning of the next 52-week period, he may receive benefits for the balance of the 26 weeks. Benefits would terminate at the end of the 52-week period, but could begin again at the beginning of the next 52-week period if the employee is still totally disabled.

Claim Example: Joseph Smith became totally disabled on 4/1/92. He returned to work on 7/29/92. We extended 17 weeks of benefits. Joseph becomes totally disabled again on 12/1/92. Since we had already extended 17 weeks of benefits for the 52 week period of 4/1/92 to (but not including) 4/1/93, we can now extend only 9 weeks of benefits for this new claim which would be through 2/8/93. If Joseph is still totally disabled on 4/1/93, he will be entitled to another 17 weeks of benefits for this one period of disability.

New York DBL: Benefit Waiting Period

8/28/91
Questions arise regarding how to determine benefit waiting period on a DBL policy when the first date of total disability is a non-work day.

Benefit waiting period is calculated on **calendar days**. Therefore, if the first date of total disability is a non-work day, the non-work day counts as part of the waiting period.

Example: Saturday and Sunday are the normally scheduled non-work days. The last day worked is Friday, 8/16/91. The employee becomes totally disabled on Saturday 8/17/91. The benefit waiting period is 8/17/91 through 8/23/91.

Although the benefit waiting period may include non-work days, we cannot extend benefits for non-work days. Therefore, in the above example, benefits may not begin until Monday, 8/26/91. The explanation that is input in the MEMO field should read as follows:

"Waiting period 8/17 to 8/23/91; Benefits begin 8/26/91; (5 day work week)"

New York DBL: Check Routing

July 22, 1994
The New York State Disability Benefits Law requires all benefits payable to an employee be mailed directly to the employee. This action is in accordance with the New York State Disability Benefits Law, Section 208-Sub-division 1. The law will only apply to New York employees.

We can no longer route benefit checks 02 (check and EOB copy to the employer). The Plan Team has changed all DBL policy check routings that were 02 to 01 (check to the payee; EOB copy to the employer).

In the instance where the benefit check is payable to the employer because the employer has been extending the employee's salary during the period of disability, the check and EOB copy will be mailed in separate envelopes.

New York DBL: Definition of Employee

February 22, 1993
Effective 1/11/93, spouses are no longer excluded as eligible employees under a DBL plan. This exclusion only applied to unincorporated employers, i.e., sole proprietors, partnerships. These employers may exclude their spouses on a voluntary basis by completing form DB-212.5 (12/92) and returning it to us.

New York DBL: Claim Denial Requirements

February 12, 1999
The New York State Disability Benefits Law is not governed by the federal legislation of ERISA. Therefore, when processing claims under statutory plans, we must abide by state requirements.

When denying a DBL claim on a statutory plan or division, the following procedures should be followed once the denial decision has been made:

1. Write a draft of the denial letter. Do not include a traditional ERISA Appeal paragraph, since these policies are not governed by ERISA. Instead, use the DBU Statutory Plan appeal paragraph. It states: "If you do not agree with our decision, you may have it reviewed. Please refer to the second page of the enclosed DB-451 for instructions."
2. Refer the claim to your manager for approval.
3. Once approved by your manager, make a telephone call to the claimant advising him/her of the denial.
4. Make any necessary changes to the letter.
5. Complete the DB-451, in triplicate, and include with the denial letter.
6. Mail the letter and DB-451 to the claimant. Mail a carbon copy of the letter to the employer.

Enriched DBL plans/divisions are governed by ERISA. When denying an enriched DBL claim, the following procedures should be followed once the denial decision has been made:

1. Write a draft of the denial letter. It is necessary to include an appeal paragraph. If the plan/division is funded out of First UNUM, use the NY appeal paragraph. If the plan/division is funded out of UNUM America, use the Portland appeal paragraph. To determine which UNUM company funds the plan/division, check the Co/Fund field on the MERLIN division (DVB) record. If it is coded 2132, it is a UNUM America plan. If it is coded 2151, it is a First UNUM plan.
2. Refer the claim to your manager for approval.
3. Once approved by your manager, make a telephone call to the claimant advising him/her of the denial.
4. Make any necessary changes to the letter.
5. Complete the DB-451, in triplicate, and include with the denial letter.
6. Mail the letter and DB-451 to the claimant. Mail a carbon copy of the letter to the employer.

NOTE: A policy may have multiple divisions. One or more of these divisions could insure statutory benefits (non-ERISA), while other divisions could insure enriched benefits (ERISA).

New York DBL: Disability Definition

December 10, 1992
When denying a DBL claim because the claimant does not meet the definition of disability, please be sure to quote the DBL disability definition.

Under DBL law, disability is defined as:
Disability during employment, means the inability of an employee, as a result of an injury or sickness not arising out of or in the course of employment, to perform the regular duties of his employment or the duties of any other employment which his employer offers him at regular wages and which his injury or sickness does not prevent him from performing.

Disability during unemployment, means the inability of an employee, as a result of an injury or sickness not arising out of or in the course of employment, to perform the duties of any employment for which he is reasonably qualified by training and experience.

Disability also includes disability caused by or in connection with a pregnancy.

New York DBL: Exempt Employees

December 10, 1992
A question arose regarding whether students who work part-time during the school year are covered under a DBL policy.

According to DBL law, exempt employees (employees who cannot be covered) include "Daytime students in elementary or secondary school, who work part-time during the school year or their regular vacation period."

New York DBL: Maximum Benefit Period

August 7, 1991
DBL law provides a Maximum Benefit Period of 26 weeks for any one period of disability during a period of 52 consecutive weeks. The 52 week period begins on the day disability benefits begin.

Example: Benefits begin on 1/6/91 and are extended for the maximum benefit period of 26 weeks (to 7/7/91). The insured will not be eligible for benefits again until 1/6/92.

We recently ran into a situation where we received a claim on an insured of a take-over group. The prior carrier had extended 26 weeks of benefits within the last 52 consecutive week period for the same condition. We were unaware of this and extended benefits on the claim we had received.

On a DBL policy we cannot extend benefits for more than 26 weeks for any one period of disability during a period of 52 consecutive weeks even if part or all of the 26 weeks were extended by the prior carrier. Therefore, if we receive a claim on an original employee within one year of the policy effective date for a chronic condition (i.e., heart condition), it will be necessary to call the policyholder and ask if the prior carrier had extended benefits in the last 52 weeks.

New York DBL: Prorating Benefits

Prorating Enriched Plans

October 22, 1993
We recently came across a situation where we were providing enriched DBL benefits to a claimant who also has statutory DBL benefits through another employer. We contacted the Workers' Compensation Board to find out how we should pro-rate benefits.

We were advised that with an enriched plan we may not pro-rate our benefit. The enriched plan must pay the entire benefit due. Therefore, the employee will receive the full benefit from both plans. In most cases, the total of the two benefits will total more than the enriched plan maximum benefit.

Prorated Benefits

6/28/91
Recently, we have had several claim situations where our insured (on a DBL policy) was also covered under another DBL policy. Usually in this instance the insured is a full-time employee under one policy and a part-time employee under the other policy. According to DBL law, the insured is entitled to one $170.00/week benefit. Therefore, it is necessary to pro-rate our benefit.

To determine the amount of the pro-rated benefit, follow this procedure:
1. Combine the average weekly wage of both jobs.
2. If the total average weekly wage is $340.00 or under (the $170.00 maximum weekly benefit is 50% of $340.00) each DBL carrier is responsible for its normal benefit (50% of their average weekly wage).

For example:
Employer A wage = $200.00
Employer B wage = $100.00
Total Wage = $300.00
Employer A pays $100.00 (50% of $200.00)
Employer B pays $ 50.00 (50% of $100.00)
Total Benefit = $150.00

If the average weekly wage is over $340.00 each DBL carrier must multiply its average weekly wage by $170.00 and then divide by the total average weekly wage. The resulting amount will be its portion of the benefit.

For example:
Employer A wage = $400.00
Employer B wage = $200.00
Total Wage = $600.00
$680-00 - $600.00 = $113.33

Employer A: $400.00 X $170.00 = $680.00
$680.00-$600.00 = $113.13

Employer B: $200.00 X $170.00 = $340.00
$340.00 - $600.00 = $ 56.67
Total Benefit = $170.00

New York DBL: Q&A

March 2, 1992
The following are some common questions and answers regarding the administration of the DBL plan.

Do DBL claims have to be submitted on DBL claim forms if the policy was written out of a different sales offices?

Yes. However, if they don't submit the claim on a DBL claim form, send the Salary Form to the policyholder for completion.

Is it necessary to send a DB-451 if the employee dies?

Yes. Also, if the claim is work related, it is necessary to send the DB-470 and DB-471.

On the DB-471, do the dates include the waiting period?

No. Use the actual paid dates. The FROM date will be the first date of payment and the TO date will be the through date.

When the employer continues salary during the disability, but doesn't want us to pay them, do we issue the benefits to the employee?

If the employer participates in collective bargaining, issue the benefits to the employee. If the employer doesn't participate in collective bargaining, we will offset the benefit with the amount the employer is paying.

If the employer is making a voluntary contribution, we will issue the check to the employee. In this case, the employer is usually trying to supplement the DBL benefit.

New York DBL: Salary Calculation

Salary Calculation

11/14/91
On a DBL policy, the basic weekly earnings is an average of the last eight (8) full weeks of wages immediately preceding the date of disability. The employer must provide this information on the claim form.

If the employee did not work eight (8) weeks prior to the date of disability, the employer must report wages for the number of weeks worked. We then average by the number of weeks reported, not by eight (8).

Definition of Earnings

8/7/91
DBL Definition of Earnings includes commissions and bonuses.

When calculating the average weekly wage on a DBL claim, it is necessary to include commissions and bonuses if applicable.

New York DBL: Timely Filing

April 19,1993
Under Section 217: Notice and Proof of Claim of the New York DBL law, it states: "Written notice and proof of disability shall be furnished ... within thirty days after commencement of the period of disability."

It also states: that no benefits shall be paid unless the required proof of disability is furnished within twenty-six weeks after commencement of the period of disability.

If you receive a DBL claim that was submitted after 26 weeks from the date of disability, deny benefits on the basis of untimely filing.

New York DBL: Workers' Compensation

Controverted (Disputed)
Workers' Compensation Claims

June 24, 1991
In the state of New York, when a Worker's Compensation claim is controverted (disputed) the Worker's Compensation carrier sends the employee a form C-7. The employee may then forward the C-7 onto us (the DBL carrier) with a copy of the claim, and we may extend benefits. It is not necessary to obtain a signed lien; the C-7 is sufficient.

Complete a form DB-470 for enclosure with the first check issued. The employer, Worker's Compensation carrier and any other parties mentioned on the C-7 must be copied. The information needed for the DB-470 may be obtained from the C-7.

A form DB-471 must be completed and enclosed with the last check issued. Once again, the employer, Worker's Compensation carrier and all other parties mentioned on the C-7 must be copied. The information needed for the DB-471 may be obtained from the C-7.

These procedures must be followed for all controverted Workers Compensation claims when we are the DBL carrier.

NY Workers' Compensation

September 3, 1992
When you have extended benefits on a New York work related claim, it is necessary to complete a form DB-471 once final benefits have been paid.

We were recently informed that the amount input in Box #8 ("Amount of Reimbursement Claimed") will differ depending on when the form is completed. If we are requesting reimbursement for the current year, input the **net benefit.** If we are requesting reimbursement for the prior year, input the **net benefit plus any federal and/or state income tax withheld** (do not include FICA).

California State Disability

January 3, 2000
The following changes to California's State Disability Insurance (SDI) plan are effective on 1/1/2000 for disabilities beginning on or after 1/1/2000:

- The taxable wage limit is $46,327.00 (up from 31,767.00).
- The SDI contribution rate remains the same at 0.5%.
- The maximum yearly premium is $231.64 (up from $158.83).
- The maximum weekly benefit amount is $490.00 (up from 336.00).
- The minimum weekly benefit of $50.00 remains the same.
- If you have any questions or concerns regarding this issue, please direct them to a Sr. DBS or manager.

January 21, 1994
California has a Statutory disability plan referred to as State Disability Insurance (SDI). Recent changes to the California State Disability plan are as follows:

- The maximum benefit has been increased to $336.00 per week. This applies to all new and existing claims regardless of the commencing date of disability.
- Effective 1/1/94, California SDI no longer waives the seven (7) day elimination period it the claimant was hospitalized during the elimination period. SDI plans have a seven (7) day elimination period for claims related to an injury and a seven (7) day elimination period for claims related to an illness. Benefits begin on the eighth (8th) day.
- Offset Workers' Compensation Permanent Disability if the claimant is receiving both WCPD and State Disability Insurance.

July 29, 1994
One of the provisions of California SDI is that they integrate benefits with the employer's salary continuation program. If the employer is extending salary continuation in an amount equal to or greater than the SDI benefit, SDI extends a $0.00 benefit.

In the event the employer also has a traditional STD policy with UnumProvident, it usually provides for integration with the SDI benefit, but seldom provides for integration with salary continuation. If SDI did not extend benefits for a period of time due to a salary continuation offset, we cannot offset SDI for that same period of time since they did not issue a benefit. In other words, we will extend our entire benefit for the period of time the employee was receiving salary continuation taking into consideration the elimination period and all other applicable policy provisions.

California SDI Integration with Workers' Comp

April 19,1993
California's state plan covers work related disabilities. Under this statutory plan, benefits are not extended if the claimant is receiving Workers' Compensation benefits for temporary disability that are equal to or more than the SDI benefit. However, if the Workers' Compensation benefit is less than the SDI benefit, SDI will pay the difference between the two. In other words, SDI integrates benefits with Workers' Compensation. Therefore, if we have a policy that integrates benefits with SDI, we are also integrating with Workers' Compensation.

Hawaii TDI

Hawaii TDI 2000

December 29, 1999
The Hawaii Department of Labor and Industrial Relations announced the following increase for the 2000 statutory disability benefit. Effective 1/1/2000 for all disabilities that begin on or after 1/1/2000:
Maximum Weekly Benefit: $372.00
Maximum Weekly Wage Base: $640.49
The percentage used to calculate the TDI weekly benefit amount will remain at 58%.

If you have any questions or concerns regarding this issue, please contact your manager or Sr. DBS.

Hawaii TDI 1999

January 13, 1999
The Hawaii Department of Labor and Industrial Relations announced the following increase for the 1999 statutory disability benefit. Effective 1/1/99 for all disabilities that begin on or after 1/1/99:
Maximum Weekly Benefit: $365.00
Maximum Weekly Wage Base: $628.05
The percentage used to calculate the TDI weekly benefit amount will remain at 58%.

Hawaii TDI 1997

January 10, 1997
Effective January 1, 1997 the Hawaii TDI Weekly Wage Base was increased to $605.93 and the Maximum Weekly benefit was increased to $352.00. The percentage used to calculate the TDI weekly benefit amount remains at 58%.
This applies to all disabilities beginning on or after January 1, 1997.

Hawaii TDI 1996

January 11, 1996
Effective January 1, 1996 the Hawaii TDI Weekly Wage Base was increased to $599.76 and the Maximum Weekly benefit was increased to $348.00. The percentage used to calculate the TDI weekly benefit amount remains at 58%.
This applies to all disabilities beginning on or after January 1, 1996.

Hawaii TDI 1995

August 8, 1995
Effective January 1, 1995 the Hawaii TDI Weekly Wage Base was increased to $593.94 and the Maximum Weekly Benefit was increased to $345.00. The percentage used to calculate the TDI weekly benefit amount remains at 58%.
This applies to all disabilities beginning on or after January 1, 1995.

Rhode Island TDI

Maximum Benefit 1999

Although we do not provide TDI for Rhode Island employers, we have many plans that integrate with Rhode Island TDI.

The maximum weekly benefit for Rhode Island TDI was increased from $463.00 to $487.00 for the benefit year beginning 7/1/99. A benefit year is the 52-week period beginning with the date a person establishes a new claim. A person is allowed 30 weeks of benefits within a benefit year.

Maximum Benefit 1998

The maximum weekly benefit for Rhode Island TDI was increased from $441.00 to $463.00 for the benefit year beginning 7/1/98. A benefit year is the 52-week period beginning with the date a person establishes a new claim. A person is allowed 30 weeks of benefits within a benefit year.

Maximum Benefit 1996

The maximum weekly benefit for Rhode Island TDI was increased from $403.00 to $428.00 for benefit year beginning 7/l/96. A benefit year is the 52-week period beginning with the date a person establishes a new claim. A person is allowed 30 weeks of benefits within a benefit year.

Rhode Island TDI Exception

Rhode Island TDI (the state mandated disability benefit) pays an additional benefit of $10.00 per week or 7% of the regular weekly benefit for each dependent child under the age of 18 for up to five children.

When a policyholder contracts weekly income benefits with UnumProvident that will integrate benefits with Rhode Island TDI, that policyholder is given the option of integrating the entire TDI benefit (including the dependent child benefit) or of integrating just the regular weekly benefit (not including the dependent child benefit). The contract should be reviewed to verify whether or not the policy integrates with the dependent child benefit.

Weekly Wage Calculations

11/23/94
Since the Short Term Disability benefit is usually a percentage of the employee's weekly wage, it is necessary to have the amount of the weekly wage to calculate the benefit. If the employer reports something on the claim form other than weekly wage (e.g. annual salary), it is necessary to convert that amount into the weekly amount.

Below are the formulas you need to use for the conversion of other reported earnings to the weekly earnings.

Hourly
If earnings are reported as dollars per hour, multiply the hourly wage by the number of hours the employee is scheduled to work each week. This may require a telephone call to the employer for the number of scheduled hours.

Bi-weekly
If earnings are reported as bi-weekly (paid every other week or 26 times per year), the bi-weekly amount must be divided by 2 to determine the weekly wage. Another formula is to multiply the bi-weekly amount by 26 to obtain the annual salary and divide the annual salary by 52 to obtain the weekly wage.

Semi-monthly
If earnings are reported as semi-monthly (paid 24 times a year), the semi-monthly amount must be multiplied by 24 to determine the annual salary. Divide the annual salary by 52 to determine the weekly wage.

Monthly
If earnings are reported as monthly, the dollar amount must be multiplied by twelve (12) to determine an annual salary. The annual salary must be divided by 52 to determine the weekly wage.

Annual
If earnings are reported as salary, divide the annual amount by 52 to determine the weekly wage.

Totally Disabled Dependents/Continuity of Coverage

UNUM policies standardly contain a provision that delays the effective date of coverage for a dependent if that dependent is "totally disabled" on the date the insurance is to become effective.

In situations where there was coverage in force with a previous carrier UNUM will provide **Continuity of Coverage** to all disabled dependents for all Life products. This means that regardless of the dependent's disability status, if the dependent was covered by the prior carrier up to the termination date of the prior carrier's plan, UNUM will provide life insurance in the amount in force with the prior carrier or UNUM amount, whichever is lower, reduced by any payment by the prior carrier.

Outlined below is the process to follow:

1. **Is this:**
   - an eligible dependent (i.e. spouse or dependent child as defined in the policy) and
   - is there clear documentation of dependent coverage election?

   If yes, proceed to next step.
   If no, investigate eligibility further before proceeding.

2. **Does it appear from the cause of death that the dependent may have been disabled on the policy effective date?**

   If not, proceed with the usual claim process.
   If yes, proceed to the next step.

3. **Is there a prior carrier, or is this a new policy with no prior carrier involved?**

   If new/no prior carrier, proceed with the usual process of determining eligibility.
   If prior carrier, proceed to the next step.

4. **Contact Policyholder to obtain documentation/confirmation of prior carrier coverage and amount. Pay amount in force with prior carrier or the UNUM amount, whichever is less, once full eligibility determination has been made, reduced by any amount paid by the prior carrier.**

5. **In claim situations involving:**
   - New case, no prior carrier coverage
   - New hires
   - First time buyers (i.e. late enrollees)
   - Buy-ups

   It will be necessary to investigate the claim further to determine if the dependent was "totally disabled" on the effective date of coverage or a coverage increase. The following approach will be used in this investigation.
   Is the dependent working or otherwise active (i.e. performing usual duties or

activities)?

If yes, cover the dependent.
If no, proceed to next step.

6. **Is/does the dependent**
   - confined to a hospital or similar institution?
   - unable to perform two or more ADLs?
   - cognitively impaired?
   - have a life-threatening condition?
   - unable to attend school outside the home, etc?

   If no, cover the dependent.
   If yes, claim is denied.

Dependent Child Benefit

Background

In the past, for statutory and risk reasons, the Life Insurance amount for **Dependent Children between live birth and 6 months of age** has been limited to $100.00 (some exceptions exist on a case by case basis). In recognition of Customer needs, we have increased the amount of coverage currently provided.

Procedure

Effective immediately, the amount of coverage is increased to $1,000.00 administratively for all eligible children in the aforementioned age group. This pertains to both new and existing policies **except:**

- **AA series New Jersey SITUS policies (Traditional and Flex Business):** New Jersey law limits the statutory maximum benefit to $100.00
- **Policies that do not provide a benefit for the specified age group:** In rare instances employers have a plan design that does not provide a benefit for the specified age group.

Student Status: Disabled Dependent

The following describes how to administer **student status** when an insured dependent becomes disabled and cannot attend school.

If a covered dependent becomes disabled while s/he is a full-time student, then coverage should continue while the dependent remains disabled until he/she reaches the maximum student age limit for coverage. If the policy has a handicapped child benefit, the coverage would then continue beyond the maximum student age limit.

If you have any questions, refer the issue to your mentor and/or manager.

Assignments

A beneficiary request is considered non-standard when the insured designates his/her proceeds to an individual or a company (other than the policyholder) and gives ownership through an Assignment. All of these requests must be completed in triplicate on special forms and acknowledged by the Registrar in UnumProvident to be valid. The three approved copies will be distributed between the insured, the policyholder, and UnumProvident's Life Department.

Collateral Assignment (see Exhibit 1)

The insured, who is the Assignor, wishes to transfer all or some of the benefits of the life insurance certificate to a Collateral Assignee to secure payment of indebtedness.

The Collateral assignment is requested by checking the option "for value received" and "Collateral." The assignee is usually a bank or organization.

Upon the death of the insured, only the outstanding balance of the loan will be paid to the collateral assignee. The remainder of the proceeds will be paid to the designated beneficiary. If the debt has been repaid before the death of the insured, the assignment becomes null and void. It is not necessary to complete a release of assignment form at that time.

Absolute Assignment (see Exhibit 1)

The insured, who is the Assignor, wishes to transfer ownership of all the rights of his/her certificate (such as naming a beneficiary and conversion rights) to another person, called the Absolute Assignee.

Examples: Sally T. Doe, wife
OR
Sally T. Doe, Trustee of the John C. Doe Family Trust u/t/d April 3, 1990

The Absolute Assignment is requested by selecting the options of "For no value, but as a gift" and "Absolute." The assignee is usually the spouse, relative or the Trustee of the Trust.

The Assignee is now the owner and primary beneficiary. The Assignee may designate a contingent beneficiary by using the Request of Change Card. The insured has no control in changing the beneficiary since he assigned the rights of his certificate.

Taxation is the major reason for an assignment to be requested. The assignment may free the Life benefits from federal estate taxation. The insured should be advised to seek assistance from a tax consultant if he has any questions about the tax liability of the benefits.

Acknowledgment of Prior Assignment of Rights to Group Life Insurance (see Exhibit 2)

This form is used when an insured has completed an assignment under a prior insurance policy and wishes to continue that assignment through the current policy with UNUM.

The materials needed to process this assignment are:
1. a copy of the prior assignment under the prior policy.
2. the employee's enrollment card stating 'see prior assignment'
3. a completed acknowledgment form signed by the employee.

If this form is not completed by the employee and acknowledged by the Home Office, no prior assignment

will continue. Benefits will be payable to the beneficiary stated on the enrollment card.

Release of Assignment (see Exhibit 3)

This form may be used by the Assignee to relinquish his or her rights under the certificate back to the insured.

Once the forms have been approved, the insured has the right to designate or assign a new beneficiary.

The Specialist may receive a copy of the enrollment card that has the special request on it. It is up to the specialist to decide which form it should be transferred to.

Assignments: Exhibit 1

UNUM

UNUM Life Insurance Company of America
Portland, Maine 04122-0215

Assignment of Life Insurance Under Group Policy

Master Policy No	Name of Master Policyholder
Social Security No	Name of Insured

The undersigned ☐ for value received ☐ for no value, but as a gift (check one) does hereby assign and set over unto

_____ of _____, _____

(hereinafter called the Assignee), and the successors in interest of the Assignee, all of the rights of the undersigned in and to the life insurance on the life of the Insured as may be provided now or in the future under the above Certificate and Policy or as may be provided by any policy issued by any company in replacement thereof including, but not limited to rights, where exercisable under the policy(s), to convert any and all such insurance to individual life insurance.

This assignment is (mark one):

☐ Absolute, revoking all prior beneficiary designations and naming the Assignee as beneficiary, reserving to the Assignee the right to designate and change the beneficiary.

☐ Collateral, to secure indebtedness owed Assignee, and the right is reserved to the Insured to designate or change the beneficiary.

(If neither of the above boxes is marked, the Assignment shall be treated as collateral.)

The execution of this assignment is a warranty that no proceedings in insolvency or bankruptcy has been instituted by or against the undersigned. It is agreed by the undersigned and the Assignee that the Company assumes no responsibility for the validity, sufficiency or effect of this assignment.

Dated And Signed At _____, this _____ day of _____, 19____

Witness	Insured

Received in triplicate, acknowledged and assented to

Date: _____, 19____

Master Policyholder

Name: _____

By _____

The Company

By

Instructions For Completing This Form:
Please complete 3 copies. All copies should be acknowledged in writing by the Master Policyholder, and forwarded to the Company for its acknowledgment.

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Assignments: Exhibit 2

Acknowledgement of Prior Assignment of Rights To Group Life Insurance

UNUM.

☐ UNUM Life Insurance Company of America
☐ First UNUM Life Insurance Company
(Check one)
(hereinafter designated as the "Company")

I, _____ have previously made an assignment of all my ownership rights to group life insurance on a form provided by _____ dated , in favor of _____

I hereby declare that it was my intent in making that assignment to transfer to the Assignee named therein all of my ownership right, title and interest with regard to any group life insurance (whether contributory or non-contributory) as then provided or to be provided in connection with, or stemming from, my employment by or association with _____ or as to be so provided in the future, regardless of insurance carrier or policy. Those ownership rights were intended to include, by way of illustration and not of limitation, the right to elect or decline coverage; the right to elect or decline dependent coverage; the right to increase or decrease coverage; the right to execute enrollment cards and supply and verify all information requested therein in my name; the right to authorize payroll deductions for contributory coverage; and the right to name or change beneficiaries. Any language contained in that assignment form purporting to limit the assignment to a particular policy or carrier was required by said carrier for its convenience, and did not in any way limit the transfer of all such ownership rights.

If the above-described assignment is held by a court of competent jurisdiction to be ineffective to carry out my intent, this form shall constitute a present assignment to _____ as of this date, of all of my ownership rights with regard to group life insurance (whether contributory or non-contributory) as currently provided in connection with, or stemming from, my employment or association with _____ or as to be so provided in the future, regardless of carrier or policy. These rights are intended to include, by way of illustration and not of limitation, the right to elect or decline coverage; the right to elect or decline dependent coverage; the right to increase or decrease coverage; the right to execute enrollment cards and supply and verify all information requested therein in my name; the right to authorize payroll deductions for contributory coverage; and the right to name or change beneficiaries. This assignment is absolute and irrevocable, and is made as a gift.

The execution of this assignment is warrant that no proceedings in insolvency or bankruptcy has been instituted by or against the undersigned. It is agreed by the undersigned and the Assignee that the Company assumes no responsibility for the validity, sufficiency or effect of this assignment.

Dated and Signed At _____ this _____ day of _____ 19_____

Witness_____ Insured_____

Social Security No._____

Name of Master Policyholder_____

Master Policy No._____

Signed by_____

[illegible]

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Assignments: Exhibit 3

UNUM.

(Complete in Duplicate)

UNUM Life Insurance Company of America, Portland, Maine 04122
(herein after called "Company")

Release of Assignment of Insurance

Date of Assignment _____ Name of Insured _____

Policy No. _____ Name of Assignor _____
(if not the Insured)

Certificate No. _____ Name of Assignee _____
(if group insurance) (the undersigned)

Address of Assignee _____
City or Town

_____
State

FOR VALUE RECEIVED, the undersigned hereby releases, remises and relinquishes unto the above Assignor all right, title and interest of the undersigned in and to the insurance previously assigned to the undersigned by the above described Assignment, meaning and intending hereby to release and discharge absolutely said Assignment and to transfer, reassign and set over unto said Assignor all right, title and interest of the undersigned therein.

IN WITNESS WHEREOF the undersigned has executed this release this _____

day of _____ , 19 _____ , at _____

_____ _____
Witness (Assignee)

Date _____ 19 _____

The Company hereby acknowledges the receipt of a duplicate of the foregoing Release of Assignment.

By _____
Authorized Official

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Catastrophic Reinsurance

What is Catastrophic Reinsurance?

Catastrophic reinsurance covers all aggregate (at least 3 from the same incident) claims over $1,000,000.00. The amount over $1,000,000.00 is reinsured through JP Woods. The information on these claims is forwarded to Life Finance (John Howard).

Why is it important?

Just as Group policyholders pay Unum to assume their Life risk on a case-by-case basis, Unum pays another insurance company (the reinsurer) to assume the risk over a certain amount. If we do not report the liability to the reinsurer, Unum is liable for the risk (which can be significant).

What do you need to do?

You need to be aware of the total number of claims per accident. These should be notable because of the nature of the deaths. Once you determine that there have been three or more claims from on incident and the aggregate total is $1,000,000.00+, the following information must be sent to John Howard:

- Group Policyholder Name
- Policy Number
- Product
- Claimant Face Amount, Interest, and Total Paid
- Copy of Death Certificates
- Copy of the Check(s) or the LRA letter(s) to the Beneficiary

Exhibit 1 is an example of the format/information sent to Finance. John Howard will then submit the information to the reinsurer and notify the appropriate UNUM parties. A copy of the information provided to Finance should also be placed in the claim file(s).

If you have any questions, please refer them to your mentor or manager.

Catastrophic Reinsurance: Exhibit 1

Unum America
Group Life Benefits

Policy Number	Policyholder	Insured	Soc Sec No	Product	Face Amount	Interest	Total Paid
123455	White House	John Jones	123-45-6789	Life/AD&D	$465,556.00	$1,587.00	$470,143.00
123456	White House	Sue Smith	987-65-4321	Life AD&D	$768,556.00	$3,587.00	$772,143.00
123456	White House	Dick Down	654-28-1793	Life/AD&D	$542,222.00	$2,503.00	$544,725.00
123458	White House	Mary Magic	369-85-2147	Life	$225,351.00	$995.00	$226,346.00
					$2,001,685.00	$8,672.00	$2,013,357.00

Death Certificates

Overview

All Life Insurance and Accidental Death claims require certified death certificates. "Certified" refers to the City, raised stamp or seal, colored stamp, or imprint of the City, Town or District where the death occurred, along with the signature of the official who verified the document (i.e., Registrar, City Clerk). Most certificates indicate that they are not valid if the stamp or seal is not visible.

NOTE: Occasionally, death certificates will be submitted that bear the stamp of a Notary Public. These are not acceptable as "certified" death certificates.

Purpose of the death certificate

There are three purposes of the death certificate:

- It documents the fact of death for legal and other uses, such as insurance claims.
- It provides an opinion regarding the cause and manner of death.
- It is used for statistical information for mortality surveillance, epidemiological research, public health planning and allocation of funding for health and safety research projects and programs.

Filing of death certificates

The death certificate is frequently filed in multiple locations, which can include the place of death and the place of residence, but always includes the state Office of Vital Records/Statistics. The state office then sends the information to the National Center for Health Statistics where the underlying cause of death is coded according to rules and algorithms agreed upon by the World Health Organization.

Limitations of death certificate data

Limitations of death certificate data are due to problems with accuracy and completeness. The main reasons cited include:

- Very little formal instruction is given in medical school or postgraduate training.
- Most physicians fill out very few death certificates and therefore never gain experience.
- The responsibility for filling out the death certificate is often delegated to inexperienced interns and residents.

Common mistakes in filling out a death certificate

Common mistakes in filling out a death certificate:

- Reversing the order in Part A.
- Citing terminal mechanisms instead of the underlying cause of death.
- Citing a nonspecific process as the underlying cause of death.
- Losing sight of the underlying cause of death due to a prolonged clinical course or lengthy survival and citing complications rather than underlying cause of death.

Other points

In most instances, the death certificate will state the cause and manner of death, although occasionally some do not have either, such as in Canada. In these instances, the Specialist may need to obtain additional information related to the death from the appropriate sources (i.e.,

Coroner, Police Dept.). In the state of New York, if death is due to natural causes, the death certificate does not provide an exact cause (it will indicate "natural"). If the death is due to other than natural an exact cause and manner will be indicated.

Occasionally, death certificates are issued with either the cause or manner of death as "pending." In this situation, the Specialist may contact the Medical Examiner or Coroner to obtain more details as to the cause and manner of death. It is necessary to inquire as to whether an amended death certificate will be issued and when. If one is to be issued the Specialist should request it from the policyholder or beneficiary but may determine that claim processing can be finalized prior to receipt. This may be done by documenting the file with the cause and manner of death obtained from your phone call with the Medical Examiner or Coroner.

Errors on a death certificate

NOTE: It is the Funeral Home's responsibility for correcting any inaccurate information on the Death Certificate. If you find any discrepancies, you should contact the Funeral Home and advise them of the error.

Copied or Uncertified Death Certificates

Occasionally we are asked to accept copies of death certificates and/or death certificates that have not been state certified. Specialist can make this decision providing it is within his/her dollar limit of authority and the reasoning behind the decision must be documented. We will also return an original certified death certificate when requested. You should annotate the file that the certified death certificate was returned and include a photocopy of the certified death certificate.

Disclaimer

Disclaimer in our business means that the beneficiary refuses to accept, or disclaims, the life insurance proceeds. A beneficiary may do this either in whole or in part. It requires a clear, written statement signed by the beneficiary, addressed to us and received by us before we have disbursed the proceeds. The statement also needs to identify the policy and proceeds in question, and to say that the beneficiary disclaims the proceeds.

A disclaimer has the same effect, to us, as if the beneficiary had pre-deceased the insured. Depending on the policy terms, the amount disclaimed is paid to the contingent beneficiaries, if any, or if there are no contingent beneficiaries named, to the insured's estate or to a relative under facility of payment.

In a disclaimer, the beneficiary cannot direct how the proceeds will be paid, because that would have the same tax effect as if the beneficiary received the proceeds and then disbursed them, and the purpose of a disclaimer from a beneficiary's point of view is to avoid the tax effect of receipt of the proceeds. We **can** disburse proceeds as instructed by a beneficiary, assuming we have clear, written instructions, but that would not be a disclaimer. That would simply be accommodating a beneficiary in the manner of payment.

If a disclaimer is made by a guardian or other fiduciary or person acting under a power of attorney, disclaiming life insurance proceeds on behalf of a named beneficiary (i.e., the named beneficiary is not acting on his or her own to disclaim), then we may require clear evidence of full and proper authority to disclaim on behalf of another.

Facility of Payment

In all of our Group Life contracts, there is a Facility of Payment provision which allows UnumProvident to make decisions regarding who benefits are payable to in the event that there is no designated and/or surviving beneficiary, if the beneficiary has been disqualified or no record of one can be found.

The provision indicates that we would look to pay the Estate first, however, it also states we may choose to pay survivors rather than the estate. **In order to ensure good faith, caution and sound judgment and to minimize the risk of disputes or litigation, the process outlined below is to be strictly adhered to in determining who will receive the benefits:**

Determine if there is an estate or whether one will be established. NOTE: If circumstances of death suggest potential legal actions against the estate, such as a wrongful death suit in the event of a motor vehicle fatality, or if UnumProvident is otherwise aware of creditors or claimants to the estate.

If no estate: Is there a surviving spouse? If so, benefits are payable to spouse.

If no spouse: Are there surviving children? If so, benefits are payable equally to all children (NOTE: If stepchildren or adoptive children are included be sure they meet the policy definition of children prior to considering them for a share of proceeds.) If child is a minor, follow process for minor beneficiaries.

If no children: Are there surviving parents? If so, benefits are payable to both parents, if living

If no parents: Are there siblings? If so, benefits are payable equally to all siblings.

Each claim situation where the decision is made to pay using this provision will require complete documentation of the decision and must include an affidavit from the spouse or an individual representing children, parents or siblings. See Exhibit 1, Exhibit 2, Exhibit 3 and Exhibit 4.

Facility of Payment: Exhibit 1

FACILITY OF PAYMENT AFFIDAVIT

By completion of the following affidavit, I _____ certify that no survivor or other representative of _____ have established or intend to establish an estate in his/her name.

Listed below are all his/her surviving children including addresses, birth dates and Social Security Numbers.

_____
_____
_____
_____
_____

I hereby certify that the information contained in this statement is true to the best of my

knowledge and belief.

_____
Signature

_____
Name (please print)

_____
Relationship to deceased

_____
Address

_____

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, ____

_____
Notary Public

My Commission Expires

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Facility of Payment: Exhibit 2

FACILITY OF PAYMENT AFFIDAVIT

By completion of the following affidavit, I _____ certify that no survivor or other representative of _____ have established or intend to establish an estate in his/her name.

Listed below are the surviving parents including addresses, birth dates and Social Security Numbers.

_____

_____

I hereby certify that the information contained in this statement is true to the best of my knowledge and belief.

_____
Signature of parent

_____
Name (please print)

_____
Address

_____

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, ____

_____
Notary Public

My Commission Expires

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Facility of Payment: Exhibit 3

FACILITY OF PAYMENT AFFIDAVIT

By completion of the following affidavit, I _____ certify that no survivor or other representative of _____ have established or intend to establish an estate in his/her name.

Listed below are all his/her surviving brothers and sisters including addresses, birth dates and Social Security Numbers.

_____
_____
_____
_____
_____

I hereby certify that the information contained in this statement is true to the best of my knowledge and belief.

_____
Signature

_____
Name (please print)

_____
Relationship to deceased

_____
Address

_____

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, ____

_____
Notary Public

My Commission Expires

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Facility of Payment: Exhibit 4

FACILITY OF PAYMENT AFFIDAVIT

By completion of the following affidavit, I _____ certify that no survivor or other representative of _____ have established or intend to establish an estate in his/her name.

I hereby certify that the information contained in this statement is true to the best of my knowledge and belief.

_____
Signature of Spouse

_____
Name (please print)

_____
Address

_____

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, ____

_____
Notary Public

My Commission Expires

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Foreign Death Claims

Any death that occurs outside of the United States and Canada is considered a foreign death. The major concern with deaths outside of the United States is obtaining all the proper documentation to verify the death. Statistics support a much higher incidence of fraud with deaths occurring outside the U.S. and for that reason additional documentation and/or investigation is necessary at the time the claim is presented.

The documentation required can vary from country to country and whether or not the individual is a United States citizen. For that and many other reasons, all foreign death claims are assigned to a specific Life Benefit Specialist. That Specialist secures a wide variety of additional documentation to validate the death while being sensitive to the survivors when asking questions and requesting the appropriate additional information.

Some standard questions to ask upon receipt of a foreign death are:

- Citizenship of the deceased
- Reason for being in the particular country at time of death (i.e., business trip, vacation)
- Location of the remains (i.e., transported to another country for burial, cremated, buried in the particular country of death)
- How were remains identified. If the remains were transported back to the US, obtain the name, address and phone number of the funeral home. Additionally, call the funeral home to verify their services and inquire as to what additional documentation may be available.

Depending on the answers to these questions additional documentation or further investigation may be necessary.

Standard documents to request if not submitted with the claim:

- If US citizen a "Report of Death of an American Citizen Abroad"
- Certified death certificate from the particular country of death
- Embalming certificate
- Permit to export a coffin
- Coroner or physician's report of death

If the death was accidental in addition to the above:

- Police report
- Coroner's or physician's report
- Any and all reports or documents concerning the accident

In addition, in some countries it would be prudent regardless of documents presented, to conduct an independent investigation into the death.

An Excel spreadsheet is also maintained by the LBS to track data related to foreign claims in order to provide data on volumes as well as any other emerging trends associated with foreign claims.

Once the claim is finalized, whether paid or denied, it is necessary to notify the International Business Group. The IBG tracks all foreign claims for experience and trends, if any.

Funeral Home Assignments

At the time funeral arrangements are made, the beneficiary has the option of assigning all or part of the benefits to the funeral home. Funeral homes maintain assignment forms that are completed and submitted with the claim.

The Specialist must determine that the funeral home assignment makes reference to UnumProvident (preferably by name and policy number) and in must cases where the funeral bill is being deducted from the insurance proceeds, must be signed by all named beneficiaries. If these requirements are met and the claim is payable, we will make payment to the funeral home.

If proceeds are less than the assigned amount, we will pay the full amount of proceeds, including interest, to the funeral home.

If proceeds are greater than the assigned amount, the difference is paid to the beneficiaries. In this instance, the interest is calculated on the full amount of the benefit and paid to the beneficiary. To calculate the interest the person releasing the claim must:

- Code the Claimfacts Service Line Amount field to reflect the total amount of proceeds interest is to be calculated from, and press Enter.
- This will calculate the entire amount of interest to be paid. This amount should be indicated in the claim file.
- Change the Service Line Amount to the amount to be released, minus the funeral home charge.
- Press Enter to re-adjudicate (be sure the interest line reflects the amount of interest you noted earlier).
- Release the claim and any additional segments. Be sure that interest is coded appropriately on all segments and that no interest is calculated on the amount paid to the funeral home.

NOTE: When coding the segment made payable to the funeral home, the Specialist should manually code an interest line (with the type of service INL and the amount as $0) to ensure interest is not paid to the funeral home. If the Funeral Home Assignment is received after payment has been made, it would not be honored and we would explain this to the funeral home in writing if required.

Payment to a Trust

An insured employee may name a Trust as beneficiary. This may be done via a beneficiary designation on a regular UnumProvident enrollment form or a change of beneficiary form.

At the time of death, we must determine whether the Trust is still in effect and if the Trustee(s) has/have accepted the duties of Trustee (s) under the Trust Agreement. An Affidavit of Trustee(s) (see Exhibit 1) must be completed & notarized and retained in the claim file. The affidavit verifies this acceptance. Once the completed affidavit is returned, any benefits payable to the Trust can then be released.

Check wording examples:

John Doe, Trustee of the Jane Doe Trust Under Agreement dated March 1, 1987.
NOTE: If this wording is used, the NAA screen on Claimfacts must be completed.

Jane Doe Trust Under Agreement dated March 1, 1987
John Doe, Trustee
NOTE: If this wording is used, the NAA screen does not need to be completed.

Exhibit 1

Affidavit of Trustee

STATE OF _____:

COUNTY OF _____:

_____ (and _____), being first duly cautioned and sworn, depose(s) of (his) (her) (their) own personal knowledge as follows:

1. I am (We are) the Trustee(s) appointed by _____ in his/her Trust Agreement dated _____ (Agreement).
2. The Agreement has not been revoked and is currently in full force and effect.
3. I (We) have accepted my (our) duties as Trustee(s) under the Agreement.

Further Affiant(s) say(s) nothing.

_____

Sworn to and subscribed in my presence this ___ day of _____, 19____.

_____
Notary Public

My Commission Expires:

_____

Reinsurance Claim Procedures

UNUM'S Life and AD&D reinsurer is Reliastar Insurance Company. This reinsurance is for Group Life claims above a $750,000 retention limit, with the exception of three cases with a $500,000 retention limit and one case with a $1,000,000. (Any non-standard retention limits will be shown on PIB). Additionally, Lifestyle AD&D policies have a retention limit of $200,000. There are also reinsurance maximums of $1.75 million of Life and $2.0 million for AD&D for each individual covered as well as $500,000 for Lifestyle Life AD&D. Additionally, there are other reinsurance limits and carriers for the Commercial Life Policies and UNUM'S HIV Product. Please consult the attached sheet for the retention limits and reinsurance carriers associated with those. This memo will address UNUM'S Group Life and AD&D policies and procedures.

UnumProvident reports all reinsurance volumes and premium to Reliastar on a prior quarter basis. Therefore, it is **extremely important** that all claims over the reinsured amount are reported to Finance and Underwriting **immediately**. It is imperative that the specialist does not wait until the end of the claim process, but reports the potential reinsurance claim as soon as it is determined that the benefit amount **may** exceed the reinsurance limit. (It is better to report it early and the benefit end up not being a reinsurance claim than reporting it late.) It is also important that the reinsurance packages are forwarded to Reliastar on a timely basis. Below are the procedures to be followed when a claim (both Life and Waiver) has been identified as being over the retention limits set forth:

1. Benefits will put Underwriting and Finance on notice when a potential reinsurance claim is received. Your respective manager should also be copied on the memo. The notice should include the policy #, Insured's SS#, Date of Death, Face Amount of claim and Cause of Death.
2. Underwriting will verify the reinsurance amount and send a notice of a potential Life or Waiver of Premium claim to Reliastar. Life Customer Care Center will process the claim and determine liability. If UnumProvident is to accept liability for the claim, the claim specialist will a notice of decision to Underwriting and Finance Dept.
3. The Specialist will prepare the reinsurance package **(only for Life claims, not needed for Waiver claims)** to be sent to:

   Karen Rudesill
   Account Manager
   Reliastar Insurance Company
   20 Washington Avenue South
   Minneapolis, MN 55401

   - Package must be sent within 24 hours of the release of the claim.
   - Include any pertinent information such as autopsy reports, police/accident reports on AD&D claims.
   - Send a copy of the completed package to Underwriting and Finance.
   - Cover letter in the package should include mailing instructions for reimbursement check to Finance, Attention of James Paul; claim questions to be directed to the Benefit Examiner.
   - Send a copy of the cover memo to the Attention of Steve Dvorak, Director of Reinsurance at Northwestern National Life.
4. The Customer Care Specialist will follow up within one week to verify receipt by Reliastar. Reliastar's turnaround time is approximately 10 business days from the date of receipt. However, it may take longer for an accident claim.
5. The Finance area will follow up for receipt of reimbursement payments and post the payment to the appropriate account.

Release of Claim

Once all the information pertinent to the claim has been reviewed, the systems have been checked and the LBS has determined UnumProvident's liability, who the beneficiary is and the appropriate amount to be paid, the claim can be prepared for release.

A dollar limit of authority is the dollar amount each LBS has for releasing claims. This amount varies among LBS based on experience.

If the total amount of the claim is under the LBS' limit, he/she can release the payment. If the total amount of the claim is over the LBS' limit, the claim must be referred to the person with the next dollar limit of authority for approval of release of payment.

The next step is to determine how proceeds are to be paid. Most claims over $10,000.00 will be issued via the UnumProvident Security Account (refer to UnumProvident Security Account section for further information). For claims under $10,000.00 as well as for exception policies and claims, payment will be issued in a lump sum check. In most instances, payments are directed to the policyholder for delivery to the beneficiary. On occasion, special requests are made (i.e., delivery to the broker or beneficiary). These requests must be cleared with the policyholder.

The claim can now be processed/released on Claimfacts (see section on Claimfacts for specifics).

Lump sum checks are generated overnight and delivered to Life Benefits for mailing. Checks in excess of $25,000.00 must be countersigned (manual signature) by a designated level of management. It is the responsibility of the BCSR to ensure this signature is acquired, however, the LBS must be aware of this procedure in case questions arise (i.e., a telephone call from a bank receiving a check which was not countersigned).

At the time of the claim release, the LBS must also prepare a letter to accompany the check. The file and letter are referred to the BCSR for mailing with the check and to complete any necessary tax notification forms that may be necessary. The file is then filed with closed claims unless the LBS requires it to be returned.

NOTE: When the claim is being denied, the claim must be referred to the LBS' manager for approval (see Denials/Withdrawals for specific information).

Special Payment Arrangements

A special payment arrangement is any payment of life or AD&D insurance proceeds other than our ordinary payment arrangement, which is: payment to a named beneficiary, who is not suspected of causing the death of the insured, in the full amount of the insurance, in the context of a properly documented death (or accident) of our insured. A special payment arrangement entails special consideration and documentation, and may arise in many different kinds of situations. The claim examiner may consult with the Senior Claim Specialist, SIU, Legal Liaison or our Legal Department to consider and document these situations. The most common situations giving rise to special payment arrangements are:

Competing Beneficiaries
Most special payment arrangements arise in the context of a competing beneficiaries situation. If the competition ends up in court, then the usual resolution will be an "Interpleader" of the proceeds to the court, and proper documentation will be the responsibility of our Legal Department. If the competition is resolved without court action, then clear documentation of the resolution is the responsibility of the claim examiner.

Suspected Beneficiary Involvement
Generally speaking, a beneficiary who intentionally kills the insured is disqualified by the laws of all states from receiving life insurance benefits. Most states have statutes specifically dealing with this situation, but a few states have only their common law. Any homicide or suspicious death should be investigated by us for the possibility of beneficiary involvement, or we should await the outcome of any investigation being conducted by the proper authorities. If we determine that the beneficiary is disqualified (if, for example the beneficiary is convicted), then we should follow the statutory or common law prescription of the applicable state and also the terms of the policy in paying the proceeds. This usually means paying the next contingent beneficiary, if there is one, or the estate of the insured. If we have good reason to suspect that the beneficiary was involved in the death of the insured, but no investigation is being conducted and no charge has been made against the beneficiary by proper authorities, then we may decide to pay the beneficiary, but in this case we should pay only with a Reimbursement Agreement, in which the beneficiary agrees to reimburse us if the beneficiary should later be convicted of the intentional killing of the insured.

Disappearance
Generally speaking, we should not pay any life insurance claim in the case of a disappearance (i.e. no dead body), unless there has been a court declaration of death that we find credible. If we do not consider a court declaration of death credible, and yet may **have to pay** the beneficiary in accordance with the court order, or in certain situations where we may determine without a court declaration that our risk is minimal and we **wish to pay** the beneficiary, we should pay only with a Reimbursement Agreement, in which the beneficiary agrees to reimburse us if the insured later turns out to be alive.

Settlement
In some instances where liability is questionable, we may determine that settlement is the best course of action. In this case we should pay only with a Settlement Agreement, in which the beneficiary agrees to accept a reduced payment as payment in full, and release the company.

Suicide Exclusion

Effective with the CXC policy series a 24-month suicide exclusion was introduced for all contributory amounts of coverage as well as all coverage requiring Evidence of Insurability. In a claim situation involving suicide, the 24-month period is calculated using the effective date of coverage with UNUM.

The following describes how to apply the provision in cases involving take over of coverage from another carrier as well as cases involving Discontinuance and Replacement Laws.

- In non-D&R claim situations the 24-month period will begin with the initial effective date of coverage with either the prior carrier, UNUM or a combination of both totaling 24 months.
  - i.e., insured's effective date of coverage with prior carrier is 1/1/97 and UNUM effective date is 1/1/98. Insured dies of suicide 10/1/98 claim would be denied as death is within 24 months of the 1/1/97 coverage effective date.
  - i.e., insured's effective date of coverage with prior carrier is 1/1/96 and UNUM effective date is 1/1/98. Insured dies of suicide 10/1/98 claim would be paid as death is more than 24 months from the 1/1/96 coverage effective date.
- In D&R states when there is no suicide exclusion, or a shorter one, in the prior carrier's policy the claim will be paid.
- In D& R states when the prior carrier's policy has a similar exclusion, combine the number of months of coverage from the prior carrier and UNUM as discussed in the non D&R states outlined above.

The suicide exclusion will continue to apply to:

- all new entrants
- any increases in coverage with UNUM regardless of prior carrier's contract or applicable D&R legislation.

Minor Beneficiaries

If the named beneficiary is a minor, the proceeds may not be released to him/her until he/she reaches the age of majority. The following listing (see Exhibit 1) indicates the legal age of majority in each state. Use the state of residence of the beneficiary for determination.

Since a minor may disaffirm a contract when he/she reaches the age of majority, it is possible for an insurer to be liable for a double payment if insurance proceeds are paid to a minor and the minor disaffirms the contract (payment) after reaching the age of majority.

If there is a court appointed legal guardian of the minor's estate, the proceeds may be released to such guardian on behalf of the minor. A natural guardian (parent) or legal guardian of the child is not sufficient. A natural guardian or legal guardian of the child typically only controls the care and custody of the child and not the child's property (see below for exception). A copy of the court document naming the legal guardian of the minor's estate must be obtained for the file. Payment is then made in the following manner:

Example: James Smith, Legal guardian of the Estate of Pamela Smith, minor.

In some states, a small benefit amount may be released to the minor's parent, a person with whom the minor resides, an adult member of the minor's family, or certain others. Refer to the **Uniform Transfers to Minors Act and Release of Proceeds to Parent of a Minor Beneficiary** procedures. These provisions must always be reviewed prior to pursuing guardianship.

If a legal guardian of the minor's estate is not appointed, and the **Uniform Transfers to Minors Act or Release of Proceeds to Parent of a Minor Beneficiary** do not apply, refer to the procedures for **Minor Supplemental Contracts.**

Minor Beneficiaries: Exhibit 1

State	Proceeds of Policy Direct to Minor		Comments
	Single	Married	
Alabama	19	19	26-1-1
Alaska	18	18	25-20-010
Arizona	18	18	1-215
	(Community Property State)		
Arkansas	18	18	57.103
California	18	18	S10112
	(Community Property State)		
Colorado	18	18 (age 21 if life insurance is given under Uniform Gift to Minors Act)	2-4-401 [6]
Connecticut	18	18	42-2
Delaware	18	18	1-302
District of Columbia	18	18	DC Law 1-75
Florida	18	any age	May pay $3,000 per year to one 16 or over. 627.0123 1.01 [14]
Georgia	18	any age	74-104, 104.1
Hawaii	18	any age	577-5
Idaho	18	any age	32-101
Illinois	18	18	S43-131
Indiana	18	18	S27-1-12-15
Iowa	18	any age	599.11
Jamaica	18		
Kansas	18	16	38-101
Kentucky	18	18	KRS 2.015
Louisiana	18	18	C.C. 38, am'd. Act 91 of 1974
Maine	18	18	T. 18-A S1-201
Maryland	18	18	Art. 1, S24
Massachusetts	18	18	C. 4, S7
Michigan	18	18	S500.2206
Minnesota	18	18	645.451
Mississippi	21	21	93-19-1
Missouri	18	18	431.055
Montana	18	any age	May pay $3,000 per year to one who has attained age 16. 33-15-502
Nebraska	19	any age	May pay up to $3,000 per year to one age 18.

Nevada	18	18	129.010
New Hampshire	18	18	C. 597 S14
New Jersey	18	18	May pay amount not including $2,000 per year to minor not less than 15, if no guardian. May pay amount not exceeding $5,000 per year to minor between 15 and 18, if no guardian.
New Mexico	18	18	28-6-1
	(Community Property State)		
New York	18	18	L. 1974, c.920, S8.
North Carolina	18	any age	48A-1&2
North Dakota	18	18	14-10-0 14-9-17
Ohio	18	18	3109.01 & 3403.01
Oklahoma	18	18	May pay $2,000 per year if over 16. S3627
Oregon	18	any age	109.510; 109/520
Pennsylvania	18	18	1* 1991 20* 102.5302
Puerto Rico	21	21	§ 971 and Civil Code, 1930, §247
Rhode Island	18	18	15-12-1
South Carolina	18	18	15-75-30
South Dakota	18	18	26-1-1
Tennessee	18	18	1-313
Texas	18	18	Fam C. S31.04
	(Community Property State)		
Utah	18	any age	T 15, c.2
Vermont	18	any age	1-173
Virginia	18	18	1,13-42
Washington	18	any age if spouse is 18, otherwise 18.	48.17.020
West Virginia	18	18	c.49, art.7,S27
Wisconsin	18	18	990.01(3)
Wyoming	19	19	14-1-101

CANADA

Ontario	18	18	18	
New Brunswick	19	19	19	
Nova Scotia	19	19	19	
Quebec	18	18	18	
Yukon	19	19	19	

Minor Supplemental Contracts

When a designated beneficiary is a minor and legal financial guardianship has not been obtained, the funds for the minor beneficiary will be transferred into a UNUM Security Account (LRA) once the claim has been reviewed and approved for eligibility/liability. We will no longer delay payment of the proceeds while offering the family the option of either obtaining guardianship or holding the proceeds in a UnumProvident Security Account. The following steps must be taken to establish a minor supplemental contract:

The ACCS/CCS will complete a Minor Supplemental Contract coversheet (see Exhibit 1).

1. The ACCS/CCS will obtain a Supplemental Contract number from the Supplemental Contract Log Book and complete the appropriate information required on the form (see Exhibit 2)
2. The ACCS/CCS will put a note in the memo field of the LP screen on all claim segments for each minor beneficiary indicating the following: "Transfer to SC#_____ - file in Supplemental Contract Drawer".
3. The ACCS/CCS will add a Patient Note indicating the following: "Claim # _____ filed in Supplemental Contract drawer under (full name of minor) - see seg # __".
4. The ACCS/CCS will release the claim into a UNUM Security Account (see Exhibit 3), place the Minor Supplemental Contract coversheet on top of the claim file.
5. The ACCS/CCS will generate a letter addressed to the person appointed on behalf of the minor (see Exhibit 4) advising that UNUM is holding the funds until proof of guardianship is received or until the minor attains the age of majority (see Exhibit 1 in the "Minor Beneficiaries" document in this chapter).
6. The Intake area will prepare a Record Card (see Exhibit 5) and give it to the Benefit Customer Service Representative (BCSR) for filing and maintenance.

Note: Steps #5 & #6 should be done by the ACCS/CCS within two days of release of the Supplemental Contract into a UNUM Security Account.

The ACCS/CCS puts the claim file in a Supplemental Contract folder, indicating the name of the minor and the supplemental contract number on the outside, and places the folder to be filed with the Minor Supplemental Contracts on the shelves.

Exhibit 1

MINOR SUPPLEMENTAL CONTRACT

CONTRACT #_____ AMOUNT $_____

POLICY #_____ CLAIM #_____

DATE OF BIRTH_____ SS#_____

NAME OF MINOR_____

ADDRESS LETTER TO_____

ADDRESS _____

_____

BENEFICIARY STATEMENT IN FILE? YES_____ NO_____
IF NO, REQUEST ONE.

LBS_____ DATE RELEASED_____

WFS_____ DATE_____

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Exhibit 2

SUPPLEMENTAL CONTRACTS

NAME	CLAIM #	POLICY #	$ AMOUNT	DATE OF TRANSFER	CONTRACT #	TYPE OF CONTRACT

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Exhibit 3

UNUM.

Effective Date:_____

Company Name:_____ UNUM

Subsidiary Number:_____ 81 _____ 83 _____

Opening Account Balance:$_____

Account Name (Name of Minor):_____

Account Address:_____

Relation to Decedent:

sps	chd	prt	sbg	mnr	oth	gcd
402	403	404	405	406	407	408

Comment Line 1:_____
policy # - div./insured 1st M last

Comment Line 2:_____
claim # all segments

Social Security Number (SS# of Minor, if available)_____

Birth Date:_____

CTF Mail Code (Send to:_____

Transmittal Date:_____ Sent by:_____

Note: This item should be included on the Daily Transmittal Control Sheet as a Credit entry.

MINOR - LEGAL HOLD

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Exhibit 4

March 14, 2000

John Smith
First Street
Somewhere, Earth 12345

RE: Jane Smith, Insured
Claim #:
Policy #:
Supplemental Contract #:

Dear Mr. Smith:

This letter will confirm that UNUM is currently holding proceeds payable to Mary Smith in the amount of $25,000.00. These proceeds will be held until Mary reaches age 18 or until UNUM receives documentation of appointment of a financial guardian for her.

Please complete the enclosed W-9 Form on her behalf and return it to UNUM. A postage paid self addressed stamped envelope is provided for your convenience.

Please notify us promptly of any address changes. If you write or call, always refer to the Supplemental Contract Number listed above.

Please do not hesitate to contact us should you have any questions.

Sincerely,

Name
Life Benefit Specialist

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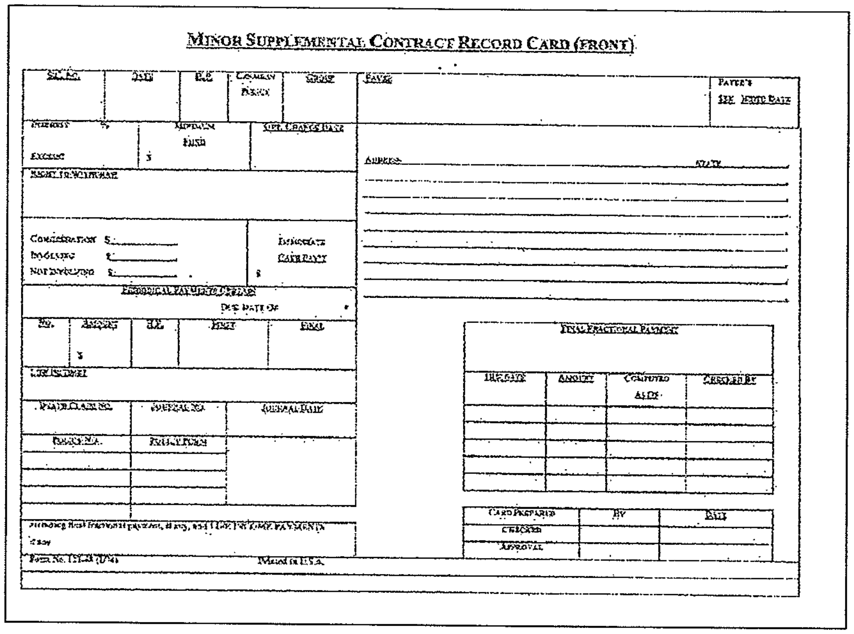
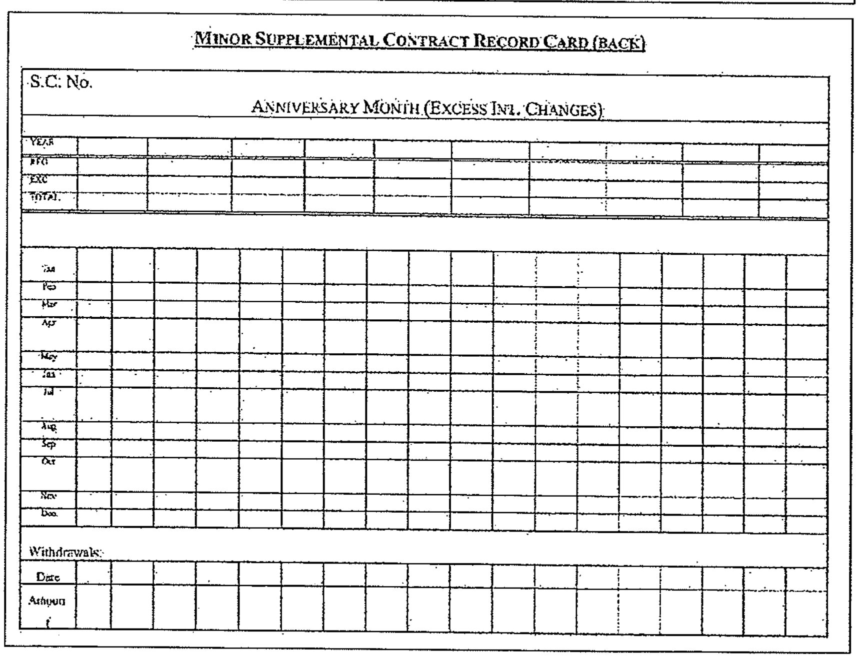
Exhibit 5


MINOR SUPPLEMENTAL CONTRACT RECORD CARD (FRONT)


MINOR SUPPLEMENTAL CONTRACT RECORD CARD (BACK)

S.C. No.

ANNIVERSARY MONTH (EXCESS INT. CHANGES)

YEAR

EXC

TOTAL

Withdrawals:

Date

Amount

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Release of Proceeds to Parent of a Minor Beneficiary

Some states allow the payment of policy proceeds under a certain amount to a minor's parent, the person with whom the minor resides, a minor's spouse, the minor, if married, etc. without the insurance company risking a double payment. Typically, this allowance is found under the Probate Statutes. In order for this payment to be valid and binding on the minor, some of these statutes provide that a signed, notarized statement must be obtained from the person to whom the money is paid. It may be prudent to obtain such a statement even in those jurisdictions not requiring one. See the final page of this article for the sample California notarized statement.

Alabama allows for the payment of insurance proceeds not exceeding $5,000 if paid in a single payment, or $3,000 a year if paid in a series of payments (not to exceed $25,000 during the minor's minority) to any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or the judge of the Probate Court. Although a notarized statement is not required, a notice of such payment must be filed with the Probate Judge. Insurance companies who pay according to the above are not responsible for the proper application of the funds. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. Code 1975, §§ 26-2A-6.

Alaska allows for the payment of insurance proceeds not exceeding $5,000 a year to the minor if he/she is 18 years old or is married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. A notarized statement is not required, and insurance companies who pay according to the above are not responsible for the proper application of the funds. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. § 13.26.015.

Arizona allows for the payment of insurance proceeds not exceeding $5,000 per year to the minor if married, any person having the care and custody of the minor with whom the minor resides, the guardian of the minor or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. A notarized statement is not required, and insurance companies who pay in accordance with the above are not responsible for the proper application of the funds. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. A.R.S. § 14-5103.

Arkansas allows for the payment of insurance proceeds not exceeding $5,000 per annum to the minor if he/she is 18 years old or is married, any person having the care and custody of the minor with whom the minor resides, a guardian of the person of the minor, or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. BUT, any amount paid in excess of $1,000 per annum must also be approved by the Probate Court. Insurance companies who pay according to the above are not responsible for the proper application of the funds, and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a guardian has been appointed or that proceedings are pending. A.C.A. § 9-26-102.

California allows for the payment of insurance proceeds not exceeding $5,000 to the parent of the minor entitled to the custody of the minor if no guardian has been appointed for the minor. In order to pay under this option, however, the parent must give the insurance company written assurance, verified by oath, that the estate of the minor, including the money to be paid to the parent, does not exceed $5,000. Use the form found on the final page of this article for releasing proceeds according to the above. West's Ann. Cal. Prob. Code, § 3401.

Colorado allows for the payment of insurance proceeds not exceeding $1,000 per annum to the minor if married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor, or a financial institution incident to a deposit in a federally insured savings account in the sole name and giving notice of the deposit to the minor. Up to $5,000 may be payable if the insurance company obtains an order from the Probate Court authorizing the payment. Insurance companies who pay according to the above are not responsible for the proper application of the funds, and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. West's C.R.S.A. § 15-14-103.

Connecticut allows for the payment of insurance proceeds not exceeding $5,000 to a parent, guardian of the minor or spouse of the minor. In order for this payment to be valid and binding on the minor, however, a release must be signed by both parents or the parent who has legal custody of the minor or the guardian or the spouse. Connecticut Probate Statutes, § 45-49.

Hawaii allows for the payment of insurance proceeds not exceeding $1,000 to the minor if married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. Insurance companies who pay according to the above are not responsible for the proper application of the funds, and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a guardian has been appointed or that proceedings are pending. HRS § 560:5-103.

Idaho allows for the payment of insurance proceeds not exceeding $10,000 per year to a minor if 18 years old or married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. Insurance companies who pay according to the above are not responsible for the proper application of the funds, and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. I.C. § 15-5-103.

Iowa allows for the payment of insurance proceeds not exceeding $4,000 to a parent or other person entitled to the custody of the minor. A written statement verified by oath must be received from the person to whom the money is paid stating, "(All) money or property of the minor does not exceed in the aggregate four thousand dollars." Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. I.C.A. § 633.574

Maine allows for the payment of insurance proceeds not exceeding $5,000 to the minor if married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. Insurance companies who pay according to the above are not responsible for the proper application of the funds, and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. 18-A M.R.S.A. § 5-103.

Michigan allows for the payment of insurance proceeds not exceeding $5,000 per year to a minor if married, a parent or person having the care and custody of the minor under court order and with whom the minor resides or a guardian of the minor. Insurance companies who pay according to the above are not responsible for the proper application of the funds and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. Michigan Probate Statutes, § 700.403.

Minnesota allows for the payment of insurance proceeds not exceeding $5,000 per year to a minor if 16 years old or married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. Insurance companies who pay according to the above are not responsible for the proper application of the funds and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. M.S.A. § 525.6196.

Nebraska allows for the payment of insurance proceeds not exceeding $10,000 per year to any person having the care and custody of the minor with whom the minor resides. Article 26 § 30-2603.

New Jersey allows for the payment of insurance proceeds not exceeding $5,000 to the minor if married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or a financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. If other than a financial institution or a married minor is paid the proceeds, the insurance company must obtain an Affidavit acknowledging receipt of the money, the status of the person in relation to the minor, and the purpose for which the money is to be used. The Affidavit must be filed in the office of the surrogate of the county in which the minor resides. Insurance companies who pay according to the above are not responsible for the proper application of the funds. Note: Insurance companies may not pay under this statute if they have actual notice that a guardian has been appointed or that proceedings are pending. N.J.S.A. § 3B:12-6.

New Mexico allows for the payment of insurance proceeds not exceeding $5,000 per year to a minor if married, any person having the care and custody of the minor with whom the minor resides, a guardian of the minor or a financial institution for deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor. Insurance companies who pay according to the above are not responsible for the proper application of the funds And a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been

appointed or that proceedings are pending. NMSA 1978, § 45-5-103.

Oregon allows A person under a duty to pay or deliver money or personal property to a minor to pay or deliver the money or property, in amounts not exceeding $10,000 per year to:

- A person having the care and custody of the minor with whom the minor resides;
- A guardian of the minor; or
- A financial institution incident to a deposit in a federally insured savings account in the sole name of the minor and giving notice of the deposit to the minor.

This does not apply if the person making payment or delivery has actual knowledge that a conservator has been appointed or proceedings for appointment of a conservator of the estate of the minor are pending. Persons who pay or deliver money or personal property under this section are not responsible for the proper application of the money or property. Such proceeds are to be released pursuant to O.R.S. § 126.700

Texas allows for the payment of insurance proceeds to the parents of a minor having the care and custody of the minor without requiring a court appointed guardian. Such proceeds are to be released pursuant to § 12.04 (4) (8) of the Texas Family Code

Utah allows for the payment of insurance proceeds not exceeding $5,000 per year to a minor if married, any person having the care and custody of the minor with whom the minor resides or a guardian of the minor. Insurance companies who pay according to the above are not responsible for the proper application of the funds and a notarized statement is not required. Note: Insurance companies may not pay under this statute if they have actual notice that a conservator has been appointed or that proceedings are pending. U.C.A. 1953, § 75-5-102.

If you have any questions regarding the above or any state not listed, you should contact your legal department for advice.

Uniform Transfers to Minors Act

The Uniform Transfers to Minors Act (UTMA) allows the payment of policy proceeds to an adult member of the minor's family or to a trust company without the appointment of a guardian for the estate of a minor and without a specific beneficiary designation under the Uniform Transfers to Minors Act. An "adult" means an individual who has attained the age of 21 years (in some states the age is 18). A "member of the minor's family" means the minor's parent, stepparent, spouse, grandparent, brother, sister, uncle or aunt whether of the whole of half blood or by adoption. Many states have enacted this portion of the UTMA.

Where applicable, the amount which may be released pursuant to the Uniform Transfers to Minors Act varies by state. See Uniform Transfers to Minors Act by State (see Exhibit 1) to determine the sum that may be released in the particular state in question.

Proceeds cannot be made payable to more than one minor or more than one custodian in one payment. What this means is that if two minors are named as beneficiary, two checks must be prepared. The entire proceeds cannot be made payable to <Name of Custodian>, as custodian for child A **and** child B. Additionally, a mother and a father, a grandmother or grandfather, a sister and brother, etc. cannot be named as custodians. One must be selected. This person may be custodian for one or more minors, however.

Example
An insurance company **may** pay $5,000 to Mother, as custodian for Child A and $5,000 to Mother, as custodian for Child B (two checks).

An insurance company **may not** pay $10,000 to Mother, as custodian for Child A **and** Child B.

An insurance company **may not** pay $5,000 to Mother **and** Father, as custodians to Child A and $5,000 to Mother **and** Father, as custodians for Child B.

NOTE: The amount to consider when paying a benefit under the UTMA statute is the amount payable per minor beneficiary, not the amount of the claim; i.e., if the claim is $20,000 and there are two minor beneficiaries, the UTMA for the particular state is $10,000, payment under the UTMA statute would be allowable as the amount per minor would be $10,000.

When releasing proceeds under this Act, use the Transfer Form (see Exhibit 2).

Uniform Transfers to Minors Act: Exhibit 1

Alabama has adopted the Uniform Transfers to Minors Act, Code 1975, §§ 35-5A-1 to 35-5A-24, Property Statutes Section. The amount which may be released pursuant to this Act in Alabama is $10,000.

Alaska has adopted the Uniform Transfers to Minors Act, AS13.46.010 to 13.46..999. The amount which may be released pursuant to this Act in Alaska is $5,000.00.

Arizona has adopted the Uniform Transfers to Minors Act, A.R.S. §§ 14-7651 to 14-7671, Decedents' Estates Statutes Section. The amount which may be released pursuant to this Act in Arizona is $10,000.

Arkansas has adopted the Uniform Transfers to Minors Act, A.C.A. §§ 9-26-201 to 9-26-227,

	Family Law Statutes Section. The amount which may be released pursuant to this Act in Arkansas is $10,000.
California	has adopted the Uniform Transfers to Minors Act, West's Ann. Cal. Prob. Code, §§ 3900 to 3925, Probate Statutes Section. The amount which may be released pursuant to this Act in California is $10,000.
Colorado	has adopted the Uniform Transfers to Minors Act, West's C.R.S.A. §§ 11-50-101 to 11-50-126, Financial Institutions Statutes Section. The amount which may be released pursuant to this Act in Colorado is $10,000.
Connecticut	has adopted the Uniform Transfers to Minors Act, C.G.S.A. §§ 45a-557 to 45a-560b. The amount which may be released pursuant to this Act in Connecticut is $5,000.
District Of Columbia	has adopted the Uniform Transfers to Minors Act, D.C. Code 1981, §§ 21-301 to 21-324. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in the District of Columbia is $10,000.
Florida	has adopted the Uniform Transfers to Minors Act, West's F.S.A §§ 710.101 to 710.126, Real & Personal Property Statutes Section. The amount which may be released pursuant to this Act in Florida is $10,000.
Georgia	The GA UTMA (in Code of GA 44-5-117) permits the disbursement of <u>any</u> amount of life insurance proceeds owing to a minor to be disbursed to an adult member of the minor's family or to a trust company, but only if the disbursement is approved by a court appointed guardian <u>and</u> specifically authorized by a court (i.e. there is no limit below which it is safe to disburse without a court order!). A separate GA statute (Code of GA 29-4-2) provides that either parent of the minor is the natural guardian of the minor (or the parent having custody of the minor is the only natural guardian if the parents are legally separated or divorced), and that such a natural guardian may demand and receive property of the minor in the amount of $5000 or less without any court approval, but any amount in excess of $5000 requires court approval. So in sum: It's OK to give a parent up to $5000 for the benefit of a minor, but more than $5000 for a parent or any amount for anybody else needs a court order.
Hawaii	has adopted the Uniform Transfers to Minors Act, HRS §§ 553A-1 to 553A-24. The amount which may be released pursuant to this Act in Hawaii is $10,000.
Idaho	has adopted the Uniform Transfers to Minors Act, I.C. §§ 68-801 to 68-825, Trusts & Fiduciaries Statutes Section. The amount which may be released pursuant to this Act in Idaho is $10,000
Illinois	has adopted the Uniform Transfers to Minors Act, S.H.A. 760 ILCS 20/1 to 20/24. The amount which may be released pursuant to this Act in Illinois is $50,000.
Indiana	has adopted the Uniform Transfers to Minors Act, West's A.I.C.30-2-8.5-1 to 30-2-8.5-39, Trusts and Fiduciaries Statutes Section. The amount which may be released pursuant to this Act in Indiana is $10,000.
Iowa	has adopted the Uniform Transfers to Minors Act, I.C.A. §§ 565B.1 to 565B.25, Real Property Statutes Section. The amount which may be released pursuant to this Act in Iowa is $10,000.

Kansas	has adopted the Uniform Transfers to Minors Act, K.S.A. 38-1701 to 38-1726, Minors/Infants Statutes Section. The amount which may be released pursuant to this Act in Kansas is $10,000.
Kentucky	has adopted the Uniform Transfers to Minors Act, KRS 385.012 to 385.252, Property Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in Kentucky is $10,000.
Louisiana	has adopted the Uniform Transfers to Minors Act, LSA-R.S. 9:751 to 9:773, Civil Code Ancillaries Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in Louisiana is $10,000.
Maine	has adopted the Uniform Transfers to Minors Act, 33 M.R.S.A. §§ 1651 to 1674, Property Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in Maine is $10,000.
Maryland	has adopted the Uniform Transfers to Minors Act, Code, Estates and Trusts, §§ 13-301 to 13-324. The amount which may be released pursuant to this Act in Maryland is $10,000.
Massachusetts	has adopted the Uniform Transfers to Minors Act, M.G.L.A. c. 201A, §§ 1 to 24, Guardians and Conservators Statutes Section. The amount which may be released pursuant to this Act in Massachusetts is $10,000.
Minnesota	has adopted the Uniform Transfers to Minors Act, M.S.A. §§ 527.21 to 527.44, Probate Statutes Section. The amount which may be released pursuant to this Act in Massachusetts is $10,000.
Mississippi	has adopted the Uniform Transfers to Minors Act, Code 1972, §§. The amount which may be released pursuant to this Act in Mississippi is $10,000.
Missouri	has adopted the Uniform Transfers to Minors Act, V.A.M.S. §§ 404.005 to 404.094, Trade and Commerce Statutes Section. The amount which may be released pursuant to this Act in Missouri is $10,000.
Montana	has adopted the Uniform Transfers to Minors Act, MCA 72-26-501 to 72-26-803, Estates, Trusts and Fiduciary Relationships Statutes Section. The amount which may be released pursuant to this Act in Montana is $10,000.
Nebraska	has adopted the Uniform Transfers to Minors Act R.R.S. 1943, §§ 43-2701 to 43-2724. The amount which may be released pursuant to this Act in Nebraska is $10,000.
Nevada	has adopted the Uniform Transfers to Minors Act, N.R.S. 167.010 to 167.100, Guardianships, Conservatorships, Trusts Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in Nevada is $10,000.
New Hampshire	has adopted the Uniform Transfers to Minors Act, RSA 463-A:1 to 463-A:26, Guardians and Conservators Statutes Section. The amount which may be released pursuant to this Act in New Hampshire is $10,000.

New Jersey	has adopted the Uniform Transfers to Minors Act, N.J.S.A. 46:38A-1 to 46:38A-57, Personal Property Statutes Section. The amount which may be released pursuant to this Act in New Jersey is $10,000.
New Mexico	has adopted the Uniform Transfers to Minors Act, NMSA 1978, §§ 46-7-11 to 46-7-34, Other Probate Matters Statutes Section. The amount which may be released pursuant to this Act in New Mexico is $10,000.
New York	has adopted the Uniform Transfer to Minors Act, McKinney's EPTL, 7-6.1 to 7-6.25. The amount which may be released pursuant to this Act in New York is $50,000.00.
North Carolina	has adopted the Uniform Transfers to Minors Act, G.S. §§ 33A-1 to 33A-24. The amount which may be released pursuant to this Act in North Carolina is $10,000.
North Dakota	has adopted the Uniform Transfers to Minors Act, NDCC 47-24.1-01 to 47-24.1-22, Property Statutes Section. The amount which may be released pursuant to this Act in North Dakota is $10,000.
Ohio	has adopted the Uniform Transfers to Minors Act, Section 1339.31. An adult means any individual who has attained the age of 18. The amount which may be released pursuant to this Act in Ohio is $10,000.
Oklahoma	has adopted the Uniform Transfers to Minors Act, 58 Okl.St.Ann. §§ 1201 to 1225, Probate Procedure Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in Oklahoma is $10,000.
Oregon	has adopted the Uniform Transfers to Minors Act, ORS 126.805 to 126.886, Guardians, Conservators, Power of Attorney, Trusts Statutes Section. The amount which may be released pursuant to this Act in Oregon is $5,000.
Pennsylvania	has adopted the Uniform Transfers to Minors Act, 20 Pa.C.S.A., §§ 5301 to 5320. The amount which may be released pursuant to this Act in Pennsylvania is $10,000.
Rhode Island	has adopted the Uniform Transfers to Minors Act, Gen. Laws 1956, §§ 18-7-1 to 18-7-26, Fiduciaries Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in Rhode Island is $10,000.
South Dakota	has adopted the Uniform Transfers to Minors Act, SDCL 55-10A-1 to 55-10A-26, Fiduciaries and Trusts Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in South Dakota is $10,000.
Tennessee	has adopted the Uniform Transfers to Minors Act, West's Tenn. Code §§ 35-7-201 to 35-7-226. The amount which may be released pursuant to this Act in Tennessee is $25,000.
Texas	has adopted the Uniform Transfers to Minors Act, V.T.C.A. Property Code, §§ 141.001 to 141.024. The amount which may be released pursuant to this Act in Texas is $10,000.
Utah	has adopted the Uniform Transfers to Minors Act, U.C.A. 1953, 75-5a-101 to 75-5a-

123. The amount which may be released pursuant to this Act in Utah is $10,000.

Virginia has adopted the Uniform Transfers to Minors Act, Code 1950, §§ 31-37 to 31-59, Guardian and Ward Statutes Section. An adult under this statute means an individual who has attained the age of 18 years. The amount which may be released pursuant to this Act in Virginia is $10.000.

Washington has adopted the Uniform Transfers to Minors Act, West's RCWA 11.114.010 to 11.114.904. The amount which may be released pursuant to this Act in Washington is $30,000.

West Virginia has adopted the Uniform Transfers to Minors Act, Code, 36-7-1 to 36-7-24, Estates in Property Statutes Section. The amount which may be released pursuant to this Act in West Virginia is $10,000.

Wisconsin has adopted the Uniform Transfers to Minors Act, W.S.A. 880.61 to 880.72, Guardians and Wards Statutes Section. The amount which may be released pursuant to this Act in Wisconsin is $10,000.

Wyoming has adopted the Uniform Transfers to Minors Act, W.S. 1977, §§ 34-13-114 to 34-13-137, Property, Conveyances and Security Transactions Statutes Section. The amount which may be released pursuant to this Act in Wyoming is $10,000.

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Uniform Transfer to Minors Act: Exhibit 2

TRANSFER UNDER THE (state) UNIFORM TRANSFERS TO MINORS ACT

(Name of Insurance Co.) hereby transfers to (Name of Custodian), as custodian for (Name of Minor) under the (state) Uniform Transfers to Minors Act, the following:

$_____ in proceeds plus any applicable interest payable to _____ (Name of Minor) under Life Insurance Policy No. _____ issued to (Policyholder) by (Name of Insurance Company).

Dated: _____ (Name of Insurance Company)

By (Name of Life Benefit Specialist)
Its Life Benefit Specialist

(Name of Custodian) will accept receipt of the property described above as custodian for the minor named under the (State) Uniform Transfers to Minors Act.

Dated:_____ (Signature of Custodian)
(Name of Custodian)

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Accelerated Benefit

Product Features
This benefit is intended to increase the flexibility and usefulness of the life insurance in the event of a substantial change in the claimant's health.

This product was introduced in February of 1991as an enhancement to the Life Portfolio.

Designed to pay a benefit if the life expectancy of the claimant is 12 months or less. (Claimant can be the insured or dependent spouse/child, provided he/she is otherwise eligible for coverage.)

Claimant can apply for:

- Up to 50% of the death benefit to a maximum of $50,000.00 for AA Series.
- The CXC Series now has numerous choices for an insured to choose depending on the provisions stated within the specific contract. **Be sure to order the contract on the policy you are working on for verification of the maximum**.
- In all cases, the benefit is payable only once in a lifetime.

Employer sponsored option. Prior to 4/1/92, this benefit was available as a Rider to all existing life cases and to new life cases.

Effective 4/1/92, automatically added to all new cases with no rate increase for cases under 250 lives. For cases over 250 lives, the benefit will remain an option at the employer level

Pre-existing exclusion for both Lifestyle and Supplemental Life with Choices will apply if application for Accelerated Benefit is made within 2 years of the effective date of initial or increased coverage.

There is no recovery of the proceeds if the claimant lives longer than 12 months.

If the insured has been approved for Extension of Employee Insurance (Waiver of Premium), the waiver amount is reduced by the "Accelerated Benefit" amount once payment is made.

All reductions and termination provisions in effect will apply to the remaining Life Insurance amount.

No interest is paid on the Accelerated Benefit claim.

An "Accelerated Benefit Claim" form #1107-91 (5/95) must be completed.

The Accelerated Benefit claim is logged as 50% of the death benefit (unless the insured is claiming less than 50%), to a maximum allowed by the contract. Refer to the contract for the maximum that applies to the policy you are working on. The appropriated type of service code is input along with a note in the memo field indicating "Accelerated Benefit claim."

- LBR: Traditional & Lifestyle
- LBE: Excess Life
- LBS: Supplemental Life
- DLB: Dependent Life

Date: the date of disability would be the date indicated on the claim form. If insured is still

working, use the current date.

The LBS releases the claim in a lump sum check.

Eligibility for insurance is determined in the same manner as a regular life claim.

For Lifestyle and Supplemental Life with Choices, the LBS must determine if the pre-existing provision applies. If so, a complete review must be completed by requiring additional medical records from the physician(s) and or hospital(s) as needed.

Our in-house staff will assist with the review of the medical information provided and make recommendations. They must evaluate the physician's prognosis that the insured has a life expectancy of 12 months or less.

If it is determined that an accelerated benefit is payable, a **Disclosure Statement for Accelerated Benefits** must be sent to the insured. Currently, 15 states require specific disclosure statements. We have a **generic** disclosure statement for use in those states that don't have specific requirements.

If there is an irrevocable beneficiary designation on file or an absolute assignment, it will be necessary for the assignee to apply for the Accelerated Benefit on behalf of the insured. In this instance, the beneficiary or assignee must sign both the claim form and the Disclosure Statement.

If the total Life benefit exceeds the LBS dollar limit of authority, the claim must be referred to a Supervisor for review and release.

If the insured dies before the Accelerated Benefit is released, the entire claim should now be handled as a death claim.

If it is determined that the claim is to be denied, a denial letter is sent to the claimant explaining the reason for the denial. Claimfacts would need to be coded accordingly and the file is closed.

Community Property

There are nine Community Property states that have specific laws regarding property (including Life Insurance) acquired by husband and/or wife during their marriage. Occasionally these laws may have the effect of altering an entitlement to insurance proceeds i.e., if the insured's residence at the time of death is in a Community Property state and the named beneficiary is other than the spouse. During the processing of a claim, it is important to check whether community property laws pertain. The nine Community Property states are:

- Arizona
- California
- Idaho
- Louisiana
- Nevada
- New Mexico
- Texas
- Washington
- Wisconsin

Furthermore, four Non-Community Property states have laws providing for the disposition of community property brought from Community Property states by people who are residents of those four states at the time of their divorce or death. These states are:

- Kentucky
- Michigan
- North Carolina
- Oregon

If any questions concerning community property arise, direct all your inquiries to your manager, our legal liaison or directly to the Legal Department for advice.

State Legislation Concerning Divorce Decrees

During the adjudication of a Life claim, the LBS may encounter a situation where the designated beneficiary is an ex-spouse. When this situation arises, the divorce decree becomes an important document, as does the specific legislation of the state that granted the divorce, for the LBS to obtain and review.

Certain states have enacted legislation that disqualifies the Ex-Spouse as Beneficiary unless a new designation is made after the divorce. When processing a claim that fits into the above criteria, the LBS must refer to the specific state legislation in our Legal Reference File. The following states are those which have specific laws, codes and/or provisions:

- Alaska
- Colorado
- Michigan*
- Montana
- New Mexico
- North Dakota
- Oklahoma
- Pennsylvania
- South Dakota
- Texas*
- Utah
- Washington

* Both Michigan and Texas statutes provide for re-designation in the divorce decree itself.

The LBS should always verify if the designation is made irrevocable and get a copy of the divorce decree to check if there are any applicable provisions of the decree and also verify the dates. When processing claims from other states, the LBS should review the decree and any facts that are asserted by a non-beneficiary making a claim for proceeds.

Escheated Funds

Occasionally, a life claim is submitted for processing and, although proceeds are payable, UnumProvident has no one to pay them to. This may occur when the insured does not designate a beneficiary, UnumProvident cannot locate the named beneficiary, there is no surviving named beneficiary, there is no estate and/or there are no surviving relatives to pay under the Facility of Payment provision.

The Specialist must make every attempt to locate the named beneficiary or determine that none exists. Once all avenues have been exhausted and the file has been appropriately documented, the proceeds can be considered unclaimed funds.

All states have laws that require businesses holding unclaimed funds to turn those funds over to the Treasurer in the state of residence of the decedent. This is known as escheatment. The states also have time limits under which these funds must be turned over and businesses are subject to penalty if they fail to comply.

Once it is determined that an escheatment exists, CLAIMFACTS must be coded as follows:

- FLUP (followup date) = 12/31/2010
- HOLD CODE
  - If a **non-waiver claim**, **HM** in the first field
  - If a waiver claim, **WP** in field **1**, **HM** in field ***2***
- Beneficiary = 000000010LB (escheatment internal transfer)
- Status = 3 and DATE = (current date)
- Memo = "Funds Escheated"
- Press PF3 to repend the claim (claim will remain as pended)

No life benefit check is processed as the money is transferred to Corporate Finance via an internal transfer. The Plan Team must be notified of the escheatment in order to process these funds.

Massachusetts Insurance Claim Payment Intercept Procedures

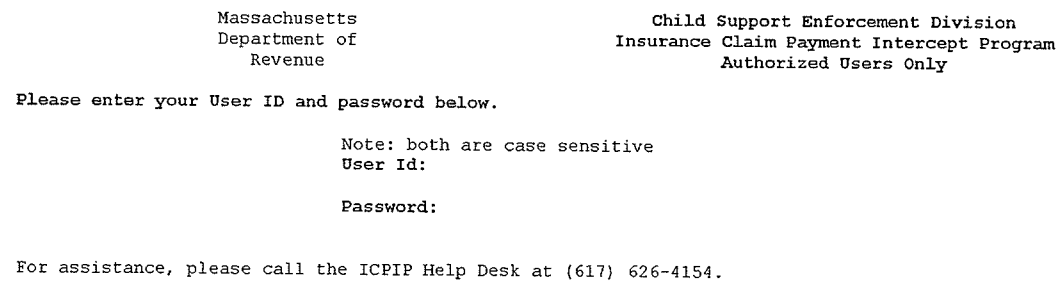
In 1988, the governor of Massachusetts signed legislation that allows the Massachusetts. Department of Revenue to intercept life insurance benefits that are payable to people who owe back child support. This procedure outlines how UNUM's Group Life benefits area will comply with the legislation.

These procedures only apply to life insurance benefits payable in an amount of $500 and over (AD&D, dismemberment and seatbelt/airbag benefits are excluded). Also, these procedures only apply if:

- the **beneficiary** resides in Massachusetts,
- the **insured resided** in Massachusetts **at the time of death**, or
- if the **policyholder is located** in Massachusetts.

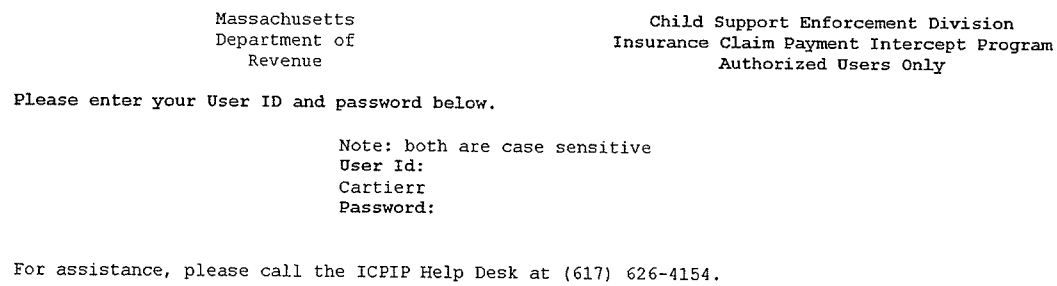
Step 1.

If the above requirements are met, then the first step is to log on to the Mass. Department of Revenue site on the Internet to perform a search to determine if the beneficiary owes child support. The site can be located at https://www.cse.state.ma.us/enf/owa/icpip.login. NOTE: You may want to save this site in your "Favorites" folder.



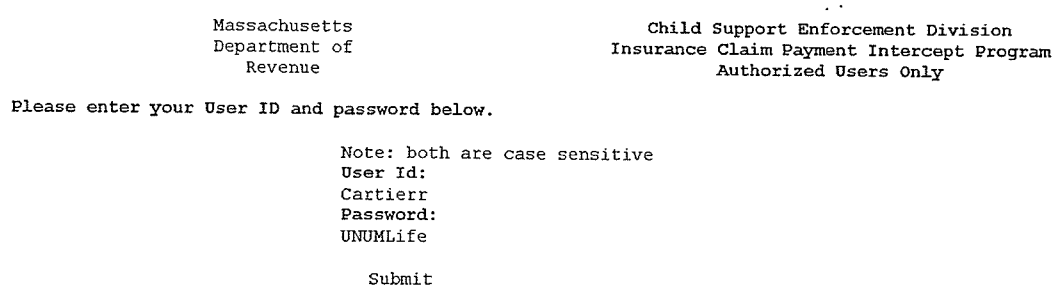
Step 2.

Type in a user ID. "Cartierr" is an example of a user ID. If you don't have your own personal user ID, simply use any user ID as contained on the user ID list (see **Exhibit 1**).



Step 3.

Type in a password. The password for the majority of all user IDs is "UNUMLife." Click on <Submit>.



For assistance, please call the ICPIP Help Desk at (617) 626-4154.

Step 4.

Click on <Proceed to Main Menu>.

Massachusetts
Department of
Revenue

Child Support Enforcement Division
Insurance Claim Payment Intercept Program
Authorized Users Only

Your User ID and password have been validated.
Click the button below to proceed:

Proceed to Main Menu

Help

For assistance, please call the ICPIP Help Desk at (617) 626-4154.

Step 5.

Click on <Single SSN Query>.

Massachusetts
Department of
Revenue

Child Support Enforcement Division
Insurance Claim Payment Intercept Program
Authorized Users Only

Please choose the type of query below:

Single SSN Query

Batch SSN Query

Help

For assistance, please call the ICPIP Help Desk at (617) 626-4154.

Step 6.

Type in the Social Security number of the beneficiary you wish to search.

Massachusetts
Department of
Revenue

Child Support Enforcement Division
Insurance Claim Payment Intercept Program
Authorized Users Only

Please enter a single SSN below:

Note: the SSN must be entered in one of the following formats:
101010101, 101 01 0101, 101-01-0101

987-65-4321

Submit

Main Menu Help

Step 7.

Click on <Submit>.

Massachusetts
Department of
Revenue

Child Support Enforcement Division
Insurance Claim Payment Intercept Program
Authorized Users Only

Please enter a single SSN below:

Note: the SSN must be entered in one of the following formats:
101010101, 101 01 0101, 101-01-0101

987-65-4321

Submit

Main Menu Help

Step 8.

A query results screen will appear indicating whether or not a "match" was found. If the Social Security number you entered did not match a number on the Massachusetts Department of Revenue database, a screen will appear indicating that no matches were found. Print the screen and put a copy in the claim file. If a match was found, print the screen showing the amount of child support obligation or lien and put a copy in the claim file.

Massachusetts
Department of
Revenue

Child Support Enforcement Division
Insurance Claim Payment Intercept Program
Authorized Users Only

Query results:

987-65-4321 - No Match

New Query

Main Menu Help

Step 9.

If a match was found and the claim file indicates that the beneficiary is not being represented by an attorney, do the following:

a. Make a check payable in the amount of the lien (or the amount of the benefit if the amount of the lien is more than the benefit) to:
   DOR/CSE
   P.O. Box 9149
   Boston, MA 02202-9149
   Make sure the beneficiary's name, Social Security number and the term "Code 33" are on the check.
b. Enclose a completed DOR remittance form with the check (Exhibit 2). Keep a copy of the check and a copy of the remittance form for the claim file.
c. Pay the remainder of the benefit (if any) to the beneficiary. A letter should be sent to the beneficiary explaining that a portion of the benefit was paid to the Mass. Department of Revenue (See Exhibit 3 for appropriate wording). Also send a copy of the notice of lien that was printed off the Internet.

Step 10.

If a match was found and the claim file indicates that the beneficiary is being represented by an attorney, do the following:

a. Make a check payable in the amount of the benefit and send the check to the beneficiary's attorney. The check should be made payable to the beneficiary's attorney (e.g. "John Smith as attorney for John Jones"). Complete and send a form memorandum (top portion only) to the attorney (Exhibit 4). Also send the attorney a copy of the notice of lien that was printed off the Internet.
b. Make copies of the check, the form memorandum and the notice of lien and send them to:
   Insurance Claim Payment Intercept Program
   Department of Revenue
   Child Support Enforcement Division
   P.O. Box 9491
   Boston, MA 02205-9491

Michigan Dignified Death Act

Michigan's Dignified Death Act clearly defines a person's right to receive, continue or discontinue medical treatment. The act prohibits insurance companies from **invoking a Suicide or Intentional Death Exemption or Exclusion under his/her existing coverage.**

Based on this, **if the insured dies while exercising his/her rights as outlined by the act**, a claim for benefits cannot be denied based on suicide or self inflicted injury. If a Michigan claim situation arises and suicide or self inflicted injury is questionable, please consult the Senior Specialist, Manager or Director for specific guidance.

Uniform Simultaneous Death Act

Sometimes in claim situations it becomes necessary to determine if the beneficiary outlived the insured. This may be as simple as noting times of pronouncement of death on the respective death certificates. However, if the deaths were the result of a natural disaster or major accident, the times of pronouncement may be identical. For this reason many states have adopted a "Uniform Simultaneous Death Act."

Simply stated, this is legislation that dictates how to determine the rightful beneficiary in cases where death was simultaneous or otherwise unable to be determined. This act clearly states, "for purposes of a provision of a governing instrument that relates to an individual surviving an event, including the death of another individual, an individual who is not established by clear and convincing evidence to have survived the event by 120 hours is deemed to have predeceased the event."

If it cannot be determined whether the beneficiary outlived the insured based on the death certificates in states which have adopted this act, then unless the beneficiary outlived the insured for 120 hours it is considered the beneficiary pre-deceased the insured and benefits would be payable to a contingent beneficiary. If no contingent was named, then the proceeds would be paid to the insured's estate.

The following states have adopted the Uniform Simultaneous Death Act or some form thereof:

- Alaska
- Arizona
- Colorado
- Hawaii
- Kansas
- Kentucky
- Montana
- New Mexico
- North Dakota
- South Dakota
- Virginia

If claims are received involving a state other than those discussed above, the particular state's legislation will need to be researched for similar provisions.

1099 Interest

A Life Insurance claim begins to earn interest upon receipt. Interest reporting to the IRS depends upon the source of the interest. Since our Life policies do not specifically state that interest will be paid on a death claim, the threshold for reporting interest to the IRS is $600.00 for the majority of states. Currently, nine states are exceptions to the rule. The following is a list of those states and their specific reporting threshold:

Arkansas	$100.00
California	$10.00
Hawaii	$10.00
Indiana	$10.00
Minnesota	$10.00
Montana	$10.00
N. Carolina	$100.00
S. Carolina	$200.00
Tennessee	$25.00

The State Street Bank account is a money market checking account. The interest paid on any death benefit deposited into a State Street account is subject to reporting for any amount over $10.00.

It is possible that some beneficiaries will contact you and ask why they have received two separate 1099 Forms from UNUM. Once a claim is paid into a State Street account, it contains some interest from before the account was opened. Upon opening of the account, it begins to earn more interest, thus the reason for two 1099 Forms.

Both 1099 Forms will say UNUM, but you can identify who issued the 1099 Form by the account number listed:

- 07: Identifies 1099 Forms issued by UNUM for interest paid before the State Street account was opened.
- RAA-8100: Identifies 1099 Forms issued by State Street Bank.

If a 1099 issued by State Street Bank needs to be reissued, the call should be referred directly to State Street Back.

Questions concerning 1099 Forms generated by Commercial Life may come in from insureds. If the questions cannot be answered in-house, contact one of the following points of contact at Commercial Life for information/assistance.

Donna Conticchio	908-562-2504
Janet Warley	908-562-2508
Melanie Lisicky	908-562-2502

Form 712

A Form 712 is an IRS form that must be filed with the Federal Estate Tax Return. It reports proceeds received from an insurance policy (see Exhibit 1).

The 712 may be requested during our claim review but cannot be issued until the proceeds are actually paid. The CPS is responsible for completing these forms.

The following fields must be completed for all Form 712s:
1. Decedent's first name and middle initial
2. Decedent's last name
3. Decedent's social security number
4. Date of death
5. Name and address of insurance company
6. Type of policy (Group, in our case)
7. Policy number
8. Date issued: insured's effective date of insurance
9. Name of beneficiaries
10. Face amount of policy: face value of policy at time of death (interest is not included)
11. Amount of proceeds if payable in one sum; same as #15

In addition, the Signature of a Life Benefits Registrar, Title (Registrar) and Date of Certification fields must be completed.

If there is an absolute assignment on file, the following fields must also be completed on the Form 712:
1. Owner's name - name of the group Policyholder
2. Assignor's name - name of the person assigning (usually the insured)
3. Date assigned - date the assignment form was signed.

The 712 is completed with two copies. The original is sent to the person requesting it and one copy is retained in the claim file.

Exhibit 1

Form 712
(Rev. August 1994)
Department of the Treasury
Internal Revenue Service

Life Insurance Statement

OMB No. 1545-0022

Part I Decedent - Insured (To Be Filed by the Executor With United States Estate Tax Return, Form 706 or Form 706-NA)

1 Decedent's first name and middle initial	2 Decedent's last name	3 Decedent's social security number (if known)	4 Date of death
			/ /

5 Name and address of insurance company	UNUM LIFE INSURANCE COMPANY OF AMERICA 2211 CONGRESS STREET PORTLAND ME 04122
6 Type of policy LIFE	7 Policy number

8 Owner's name, if decedent is not owner	9 Date issued	10 Assignee's name. Attach copy of assignment	11 Date assigned
	/ /		/ /

12 Value of the policy at the time of assignment	13 Amount of premium (see instructions)	14 Name of beneficiaries

15	Face amount of policy	$
16	Indemnity benefits	$
17	Additional insurance	$
18	Other benefits	$
19	Principal of any indebtedness to the company that is deductible in determining net proceeds	$
20	Interest on indebtedness (line 19) accrued to date of death	$
21	Amount of accumulated dividends	$
22	Amount of post-mortem dividends	$
23	Amount of returned premium	$
24	Amount of proceeds if payable in one sum	$
25	Value of proceeds as of date of death if not payable in one sum)	$
26	Policy provisions concerning deferred payment or installments. Note: If other than lump-sum settlement is authorized for a surviving spouse, attach a copy of the insurance policy.	
27	Amount of installments	$
28	Date of birth, sex, and name of any person the duration of whose life may measure the number of payments	
29	Amount applied by the insurance company as a single premium representing the purchase of installment benefits	$
30	Basis (mortality table and rate of interest) used by insurer in valuing installment benefits	
31	Was the insured the annuitant or beneficiary of any annuity contract issued by the company?	☐ Yes ☐ No
32	Names of companies with which decedent carried other policies and amount of such policies if this information is disclosed by your records	

The undersigned officer of the above-named assurance company hereby certifies that this statement has been made in the proper information.

Signature ➔ Title ➔ REGISTRAR Date of Certification ➔

Instructions

Paperwork Reduction Act Notice. - We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to give us the information. We need it to ensure that you are complying with these laws and to allow us to figure and collect the right amount of tax.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Form	Recordkeeping	Preparing the form
712	(If Not Required)	10 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to both the IRS and the Office of Management and Budget at the addresses listed in the instructions for the tax return with which this form is filed. DO NOT send the tax form to either of these offices. Instead, return it to the executor or representative who requested it.

Statement of insurer. - This statement must be made, on behalf of the insurance company that issued the policy, by an officer of the company having access to the records of the company. For purposes of this statement, a facsimile signature may be used in lieu of a manual signature and, if used, shall be binding as a manual signature. A facsimile signature may be used in lieu of a manual signature and it used, shall be binding as a manual signature.

Separate statements. - File a separate Form 712 for each policy.

Line 13. - Report on line 13 the annual premium, not the cumulative premium to date of death. If death occurred after the end of the premium period, report the last annual premium.

ISA

STF FED1457

Part II Living Insured
(File With United States Gift Tax Return, Form 709, May Be Filed With United States Estate Tax Return, Form 706 or Form 706-NA, Where Decedent Owned Insurance on Life of Another)

SECTION A - General Information

33 First name and middle initial of donor (or decedent)	34 Last name	35 Social security number

36 Date of gift for which valuation data submitted ➡
37 Date of decedent's death for which valuation data submitted ➡

SECTION B - Policy Information

38 Name of insured	39 Sex	40 Date of birth

41 Name and address of insurance company	

42 Type of policy	43 Policy number	44 Face amount	45 Issue date

46 Gross premium	47 Frequency of payment

48 Assignee's name	49 Date assigned

50 If irrevocable designation of beneficiary made, name of	51 Sex	52 Date of birth, if known	53 Date designated

54 If other than simple designation, quote in full. (Attach additional sheets if necessary.)

55 If policy is not paid up:

a	Interpolated terminal reserve on date of death, assignment, or irrevocable designation of beneficiary	
b	Add proportion of gross premium paid beyond date of death, assignment, or irrevocable designation of beneficiary	
c	Add adjustment on account of dividends to credit of policy	
d	Total (add lines a, b, and c)	
e	Outstanding indebtedness against policy	
f	Net total value of the policy (for gift or estate tax purposes) (subtract line e from line d)	

56 If policy is either paid up or a single premium:

a	Total cost, on date of death, assignment, or irrevocable designation of beneficiary, of a single-premium policy on life of insured at attained age, for original face amount plus any additional paid-up insurance (additional face amount $_____): (If a single-premium policy for the total face amount would not have been issued on the life of the insured as of the date specified, nevertheless, assume that such a policy could then have been purchased by the insured and state the cost thereof, using for such purpose the same formula and basis employed, on the date specified, by the company in calculating single premiums.)	
b	Adjustment on account of dividends to credit of policy	
c	Total (add lines 56a and 56b)	
d	Outstanding indebtedness against policy	
e	Net total value of policy (for gift or estate tax purposes) (subtract line 56d from line 56c)	

The undersigned officer of the above-named insurance company hereby certifies that the statements set forth true and correct information.

Signature ➡ Title ➡ REGISTRAR Date of Certification ➡

Notice And Consent

Due to the variances of state regulations regarding inheritance and Estate Taxes, each state has different requirements as to what insurance companies are obliged to do prior to or concurrent with releasing the proceeds of life insurance benefits. The usual requirement is Notification or Consent and sometimes both.

In the case of Notification, UNUM simply prepares a written Notice on a provided State form. In absence of such form, the CPS types a form containing the pertinent information (i.e., name of deceased, amount payable). The specialist must indicate on the coversheet that Notice is necessary and the state. The CPS will then complete the form and return the file to the Specialist if required, otherwise claim will be filed.

When consent is required, the beneficiary or representative of the Estate makes application to the state for their consent to release the proceeds. The CPS has a listing of the addresses for the various counties in New York. In the State of New York, it is the responsibility of the Specialist to appropriately notify the beneficiary of the consent requirement. A specific form (ET99) is required from New York in order for proceeds greater that $50,000 be released. The entire value of the benefit payable must be reported regardless of the number of beneficiaries named.

Some states require notice or consent only if benefits are payable to the Estate. If benefits are payable to a Trust, that is not considered an Estate, therefore, no Notice or consent would be necessary.

Refer to the Notice and consent Requirements list for specific requirements.

NOTE: Notice and Consent requirements are determined by the state (residence) of the decedent.

Notice and Consent Requirements

State	Comments	Notice Required	Consent Required
Alabama		No	No
Alaska		No	No
Arizona		No	No
Arkansas		No	No
California		No	No
Canada	Except in Province of Quebec. NOTE: Check each Quebec claim individually.	No	No
Colorado		No	No
Connecticut		No	No
Delaware		No	No
District of Columbia	Unless named beneficiary predeceased the insured.	No	No
	If amount payable is $300 or more payable to representative of insured's estate other than the D.C. Court having probate jurisdiction.	Yes	Yes
Florida		No	No
Georgia		No	No
Hawaii	If payable to a named beneficiary	No	No

Idaho		No	No
Illinois		No	No
Indiana	If proceeds are payable to the named beneficiary.	No	No
	Notice within 10 days after life insurance proceeds paid to a resident decedent's estate.	Yes	No
	Annuities, supplemental contracts and pension plans	Yes	Yes
Iowa		No	No
Kansas		No	No
Kentucky	If proceeds are payable to a designated beneficiary.	No	No
	If proceeds are payable to estate. Same is true for annuities, supplemental contracts, pension plans.	Yes	No
Louisiana	If proceeds are payable to estate. Also for annuities.	Yes	No
	For payments under pension or retirement plans.	No	No
Maine		No	No
Maryland		No	No
Massachusetts		No	No
Michigan	Notice on all payments to estate	Yes	No
Minnesota		No	No
Mississippi		No	No
Missouri	If amount is payable to named beneficiary other than insured's estate.	No	No
Montana	No notice or consent requirement if proceeds are payable to a spouse or lineal decedent.	Yes	Yes
	If beneficiary is other than above and amount is $10K or more.	Yes	No
	If beneficiary is other than above and amount is $50K or more.	No	Yes
Nebraska		No	No
Nevada		No	No
New Hampshire	If payable to a named beneficiary or payable to a resident, executor or administrator	No	No
	If payable to an estate which has a non-resident executor or administrator.	Yes	Yes
	If an annuity. Also applies in some instances to Supplemental contracts.	Yes	yes
New Jersey	If payable to estate	Yes	No
	Required on all annuities, pension plans and supplemental contracts unless the payment under a supplemental contract represents a continuation of payments under an insurance policy on the life of a prior decedent.	Yes	No
New Mexico		No	No
New York	No notice or consent required if beneficiary is spouse	No	No
NOTE: These requirements	If beneficiary is other than spouse and dollar amount is>$30,000	Yes	No
DO NOT apply if the policy	If over $50,000 and other than spouse, consent is required.	No	Yes

benefits have been assigned through the processing of an absolute assignment.	If annuity or supplemental contract amount is <$10,000	Yes	No
	If annuity or Supplemental contract is > $10,000	Yes	No
	If pension plan is <$50,000	Yes	No
	If Pension plan is >$50,000	No	Yes
North Carolina	If amount is more than $25,000 under any single policy payable to children, grandchildren, of parents of the decedent	Yes	No
	No requirements on payments to spouse	No	No
	All other amounts payable to any other named beneficiary including decedent's estate	Yes	No
	Annuities and pension plans	No	Yes
North Dakota		NO	NO
Ohio	Amount is over $25,000 (to estate only)	No	Yes
	Also applies to annuities, supplemental contracts and pension plans unless pension plan is payable to a beneficiary other than the estate of the insured's	Yes	Yes
Oklahoma	If amount payable exceeds $2,500 and is payable to a named beneficiary or estate.	Yes	No
	Annuities of any amount	No	Yes
Oregon		No	No
Pennsylvania		No	No
Puerto Rico	If amount payable in excess of $5,000 or 40% of total value	No	No
	If amount payable is $5,000 or less, or 40% of total value of the policy or less may be paid provided notice is made within 30 days of payment	Yes	No
Rhode Island	If amount payable exceeds $5,000	Yes	No
South Carolina		No	No
South Dakota	If amount is payable to estate	Yes	No
Tennessee	Notice required within 10 days of proof	Yes	No
Texas		No	No
Utah		No	No
Vermont		No	No
Virginia		No	No
Washington	If company has been notified of a tax lien against the proceeds	No	Yes
West Virginia		No	No
Wisconsin		No	No
Wyoming		No	No

Ambulating and Mobility ADLs

The states of Texas and California require a seventh ADL involving movement. California's seventh ADL is called "ambulating"; Texas's seventh ADL is called "mobility."

California's "ambulating" refers to the ability to **walk** from place to place. The contractual definition of ambulating discusses that an individual is deemed "independent" if he/she can walk independently indoors or outdoors. To lose the ambulating ADL, an individual must be unable to walk independently indoors and outdoors.

Texas's "mobility" refers to the ability to **move** from place to place. The term "move" would therefore include wheelchair movement. The contractual definition of mobility discusses that an individual is deemed independent only if he/she can move independently indoors and outdoors. To "lose" the mobility ADL, he/she must be unable to move independently indoors, **or** be unable to move independently outdoors.

Please note that the above refers to ILTC contracts. The ambulating ADL was not in earlier California GLTC contracts, and early Texas GLTC contracts used an "indoors or outdoors" definition. GLTC 1995 contracts have been proposed to Texas and California and are awaiting approval. The California ambulating ADL and the Texas mobility ADL contract provisions are to read like their ILTC counterparts.

Addendum: The GLTC 1995 contract for the state of Kansas also includes mobility as a seventh ADL.

Christian Scientists

Claims generated from policies or coverages effective prior to 1/1/96
If a Christian Scientist(s) claimant alleges 2 ADL loss or cognitive impairment without obtaining medical treatment, the Analyst will:
1. obtain whatever information is available from caregivers, CS Practitioners, and CS facilities
2. consider obtaining an Assessment
3. consider utilizing a Field Representative

If a CS claimant has obtained medical treatment, those records should be obtained. The CS claimant would not be required to continue medical treatment. However, it would be expected that s/he will continue to work with a CS Practitioner towards healing.

CS Nurses are considered to be acceptable providers of PHC services, regardless of whether they belong to an agency or not.

Claims generated from policies or coverages effective 1/1/96 or later
Medical verification of disability is required, consistent with claims documentation expectations for all other LTC business.

Re: PHC, contract definitions and documentation apply.

Facilities/Sanatoriums
We consider all facilities accredited by the Mother Church as acceptable nursing home facilities. The Mother Church has recently assigned the authority to accredit sanatoriums to an affiliated agency. Listings of accredited sanatoriums can be found in the LTC Customer Care Center.

To: Individual Sales Reps & Managers
From: Guy W. Bertsch
Re: Christian Scientist Business
Date: January 19, 1997

Underwriting
Effective 1/1/96, all applicants were required to meet the same standard underwriting requirements, as prescribed in our underwriting manual. Depending on age this may include the use of APS, paramed exams, or face to face assessments. This marked a change for CS, who prior to 1/1/96 had received modified underwriting.

Action Required: Reinforce with producers and applicants that our underwriting process utilizes various tools (i.e. APS, assessments, etc) and we will not waive them for any person or group. For CS, who may have little or no documented medical history, UnumProvident will most likely require a paramed exam as part of the underwriting process.

Policy
Effective 1/1/96: CS administrative agreements are no longer included in policies. All insureds receive the same policy wording and no administrative agreements or letters pertaining to CS are issued.

Prior to 1/1/96: We had included an administrative agreement that stated we would recognize CS accredited facilities as meeting the policy definition of "facility." This agreement did not waive our right to adjudicate claims using our standard tools and processes. However, feedback from producers indicated that this administrative agreement caused confusion and thus we discontinued issuing it as of 1/1/96.

Action Required: Explain to producers that we no longer issue a CS administrative agreement. Any inforce insureds that have previously been issued a CS administrative agreement will keep it and it will apply at point of claim.

Claim Adjudication
We have has always maintained a single claim adjudication process for all LTC insureds. This process may include the use of assessments, APS, independent medical exams (IMEs), family member input, and caregiver records. We reserve the right to use any of these tools to adjudicate the claim of any insured.

Action Required: Explain to producers and applicants how our claims process works and what tools we use. Also reinforce that the claims process may require medical exams and tests. This is critical for CS to understand, since they may not

consent to medical exams or tests. Without a complete evaluation of the claimant we may not be able to determine if the claimant is disabled and thus would be unable to pay a claim. Furthermore, since CS administrative agreements are no longer being issued, all facilities and home care services will have to meet the definitions contained in the policy. Simply being an accredited CS facility or practitioner is not sufficient.

PLEASE NOTE: This communication is simply a reiteration of our standard practices. No changes have been made since 1/1/96.

Claim Form Signatures

Unlike other disability product lines, UNUM Long Term Care often receives initial claim forms signed by someone other than the claimant. These situations occur most often because of the unavailability/incapacitation of the claimant and/or the familiarity/relationship of the signee with the claimant and the needs of the claimant.

Processing claims without determining the authority of the signee, if different than the claimant, can create several problems:

- inability in determining the actual intent of the claimant in filing a claim
- protection of the privacy/confidentiality of the claimant
- lack of clarity regarding contacts for the claim
- delay or inability in obtaining medical records due to the authorization not being signed by the claimant/patient.

There is language on the claim form and in notice acknowledgment letters requesting that Power of Attorney* papers be included with the claim form if the signee has Power of Attorney. Should a claim form be received that is not signed by the claimant, and no POA papers are included with the claim form, the Benefits Analyst should:

- immediately investigate whether or not the claimant was aware of and intended to file the claim.
- determine whether a POA has been assigned. If so, obtain the POA papers. If not, obtain an authorization signed by the claimant.

See also the discussion on Power of Attorney in Chapter 2.

Cognitive Impairment

Cognitive Impairment means that you have suffered a deterioration or loss in your intellectual capacity which requires another person's continual supervision and/or verbal cueing to protect the insured or others from harm. For example, if the insured is left alone, s/he may forget and leave the stove on, may wander from his/her house and not be able to find his/her way home. Cognitive Impairment can be a trigger for benefits.

Verbal cueing may be needed in order to complete or remember to complete a task. The individual providing the verbal cues should be in the presence of the claimant when providing the verbal cues.

Cognitive Impairment is generally measured by standardized tests which reliably indicate an impairment of:
1. short or long term memory;
2. orientation as to person, place or time; and
3. deductive or abstract reasoning.

In the absence of these tests, sometimes inferences can be made by the Claim Consultant and our medical staff based on the claimant's age and examples of behavior provided by the claimant's caregivers or doctor. The Customer Care Specialist could request a LifePlan assessment, which includes a section dedicated to cognitive loss. Or the specialist may request daily records from the caregivers or a cognitive letter to be filled out by the claimant's physician. Many physicians will also request other types of tests such as EEG' s, X-rays, and MRIs to rule out other possibilities and therefore diagnose a cognitive condition by process of elimination.

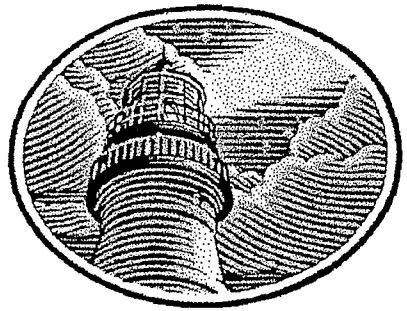
Cognitive losses can result from Alzheimer's disease or similar forms of **physical changes** to the brain. Most of our Long Term Care contracts contain a psychiatric exclusion which excludes payments of benefits for psychiatric or psychological illnesses such as depression or schizophrenia. The contract should be consulted for these exclusions.

GLTC State-Specific Requirements and Variations: 9/8/98

State	NQ	Q	Fraud Reporting
Alabama		1/7/97	No
Alaska		6/20/97	Required
Arizona	6/6 Limitation	3/24/97 Same	Required
Arkansas		4/2/97	Permitted
California			Permitted
Colorado	Plans called "basic" and "standard" have accumulative EPs and waiver for FAC benefits only for 90 days	4/26/97 Same 21 day bed reservation per policy year (NOT annual)	Permitted
Connecticut		8/27/97	Permitted
Delaware	85% ALF	2/4/97 Same	Required
District of Columbia		1/31/97	No
Florida		10/14/97	Permitted
Georgia		7/10/97 Claim determination w/i 15 days of proof or 18% interest due	Permitted
Hawaii		3/20/97	No
Idaho	Pre-ex exclusion is called "limitation"	8/29/97 Same	Permitted
Illinois	DOI language in status letters and denial letters	1/6/97 Same	No
Indiana		12/2/97	Permitted
Iowa		1/29/97	No
Kansas	7th ADL/mobility	3/28/97 6 ADLs only 100% ALF	Permitted
Kentucky		1/16/97	Required
Louisiana		9/23/97	Required
Maine		12/10/96	Permitted
Maryland		10/16/97 100% ALF Pre-ex limitation No rehab/alternate care provision	Permitted
Massachusetts	No psych exclusion	1/1/97 · Same	Permitted
Michigan	Pre-ex limitation		No
Minnesota	3/6 pre-ex limitation Bed reservation=30 days per hospitalization May be different benefit triggers		Permitted
Mississippi		1/3/97 Claim determination w/i 45 days of proof or 1.5% interest per month due	No

State	NQ	Q	Fraud Reporting
Missouri	ALF called "Residential Care Facility II"	1/16/97 Same	Permitted
Montana		1/10/97	Required
Nebraska		1/21/97	Permitted
Nevada		1/30/97	Required
New Hampshire		7/1/97	Permitted
New Jersey		4/29/97	Permitted
New Mexico	State can recover benefits from UNUM if insured also receives Medicaid (see "Right of Recovery" provision)	1/29/97 Same	Permitted
New York		9/5/97 Pre-ex limitation	Required
North Carolina		8/4/97	Required
North Dakota	Pre-ex limitation	6/19/97 Same Variation on contestability provision	Required
Ohio		1/24/97	Required
Oklahoma		2/4/97 *No controlled substance exclusion	Required
Oregon	Adult Foster Care is covered under ALF benefit (60%)	1/17/97 Same	Permitted
Pennsylvania	Pre-ex limitation		Permitted
Rhode Island		3/4/97 Suicide exclusion only for 1st two years after effective date	Permitted
South Carolina		4/15/98 Pre-ex limitation ALF called Community Residential Care Facility/paid at 80%	Required
South Dakota		1/28/97	Permitted
Tennessee	ADL or cognitive impairment or medical necessity triggers before 6/4/97 Pre-ex limitation	6/4/97 ADL or cog triggers only after 6/4/97 Pre-ex limitation	No
Texas	7th ADL/mobility Pre-ex limitation		Required
Utah		3/7/97	Permitted
Vermont		3/10/97	?
Virginia	Pre-ex limitation	9/19/97 Same	Permitted
Washington		1/1/97 Pre-ex limitation No psych exclusion	Permitted
West Virginia		2/11/97	Permitted
Wisconsin	May be different benefit triggers	4/28/97 No rehab/alternate care benefit No alcohol abuse exclusion	No

State	NQ	Q	Fraud Reporting
Wyoming		1/3/97	No



UNUM®

Protecting everything you work for

Health Insurance Portability & Accountability Act (HIPAA)

Unum is the marketing brand of UnumProvident Corporation

LTC Tax Clarification

- Premiums paid for a qualified long-term care contract are deductible as medical expenses (subject to limitations).
- Benefits received under long-term care contract are excludable from gross income (subject to limitation for per diem policies).
- NAIC reserve method is LTC tax reserve method.

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Protecting everything you work for

Deductibility of Eligible LTC Premium

- **Deductible as medical expenses (total medical expenses must exceed 7.5% of Adjusted Gross Income)**

Attained Age before Close of Tax Year	Limitation
40 or less	$200
>40 ≥ 50	$375
>50 ≥ 60	$750
>60 ≥ 70	$2,000
>70	$2,500

UNUM

Protecting everything you work for

Deductibility of Eligible LTC Premium

- The per diem limitation for any period is an amount equal to the excess (if any) of:
  - the greater of
    - $175 (or as later adjusted), or
    - the costs incurred for qualified long-term care services provided for the insured for such period *over*
  - the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

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Protecting everything you work for

Deductibility of Eligible LTC Premium

- **Translation: First $175 of per diem benefits are non-taxable unless:**
  - **Cost of LTC services exceeds $175 and/or**
  - **Insured received other LTC reimbursements (e.g., LTC reimbursement policy, Medicare).**

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Deductibility of Eligible LTC Premium

- **Example 1:**

Per diem benefits:	$200
Cost of LTC services:	$100
Other LTC reimbursements:	$0
Non-taxable P/D benefits:	$175
Taxable P/D benefits:	$25

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Deductibility of Eligible LTC Premium

- **Example 2:**

Per diem benefits:	$200
Cost of LTC services:	$225
Other LTC reimbursements:	$0
Non-taxable P/D benefits:	$200
Taxable P/D benefits:	$0

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Deductibility of Eligible LTC Premium

- **Example 3:**

Per diem benefits:	$200
Cost of LTC services:	$100
Other LTC reimbursements:	$50
Non-taxable P/D benefits (175-50):	$125
Taxable P/D benefits:	$75

UNUM®

Protecting everything you work for

Deductibility of Eligible LTC Premium

- **Example 4:**

Per diem benefits:	$200
Cost of LTC services:	$250
Other LTC reimbursements:	$60
Non-taxable P/D benefits (250-60):	$190
Taxable P/D benefits:	$10

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State Regulations

- Limit how restrictive benefits can be
- Objective: Ensure that consumers receive adequate coverage

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HIPAA

- Limits how liberal benefits can be
- Objective: Does not want tax qualified status to be too easy to attain

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Insurer's Objective

- Develop LTC policy that is:
  - restrictive enough to be a tax qualified plan,
  - liberal enough to satisfy state regulations, and
  - marketable

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HIPAA

- The term "qualified long-term care insurance contract" means any insurance contract if:
  - the only insurance protection is coverage of qualified long-term care services,
  - it does not pay for expenses reimbursed by Medicare,
  - it is not guaranteed renewable,
  - it does not provide for a cash surrender value,

(Continued)

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HIPAA (cont.)

- The term "qualified long-term care insurance contract" means any insurance contract if:
  - all refunds of policyholder dividends are applied as a reduction in future benefits (but cash refunds are permitted on death of insured or complete surrender of policy), and
  - it meets the consumer protection requirements of subsection (g).

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HIPAA

- A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period which the payments relate.

  Translation:

  - Per diem policies may pay benefits (subject to limitations) that will not necessarily be used for qualified long-term care services.
  - Per diem policies do not have to coordinate with Medicare.

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HIPAA

- The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which:
  - are required by a chronically ill individual
  - are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

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HIPAA

- The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as:
  - being unable to perform (without substantial assistance from another individual) at least 2 ADLs for a period of at least 90 days due to a loss of functional capacity
  - defined by future regulations

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(Continued)

HIPAA (cont.)

- The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as:
  - requiring substantial supervision to protect such individual from threats to heath and safety due to severe cognitive impairment
  - Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

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Key Terms, Concepts & Requirements

- "Licensed health care practitioner"
- Certification of 90-day ADL loss
- "Substantial assistance"
- "Substantial supervision"
- "Severe cognitive impairment"
- 12-Month Certification

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Reporting Requirements to State

- Lapse/replacement rate reporting (Model Reg. §14)
- Number of claims denied during the reporting period for each class of business (expressed as % of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable pre-existing condition

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Delivery of Policy

- If application approved, insurer must deliver the contract to the applicant no later than 30 days after the date of approval

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Information on Denials

- If claim denied, insurer shall within 60 days of a written request by policyholder:
  - provide a written explanation of the reasons for denial
  - make available all information directly relating to such denial

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Disclosure

- Qualified plan must state in policy and outline of coverage that it is intended to be a qualified long-term care insurance contract under §7702B(b) of the Internal Revenue Code of 1986

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Tax Reporting to IRS

- File a return (according to forms prescribed by Treasury) reporting:
  - amount of LTC benefits paid to any individual for calendar year
  - whether paid as per diem (indemnity) benefit
  - name, address, TIN of beneficiary
  - name, address, TIN of insured

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Tax Reporting to Both Beneficiary & Insured

- Name of insurer
- Aggregate amount of LTC benefits paid to individual
- Furnished to individual before January 31

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Tax for Failing to Meet Standards

- $100 per insured for each day standard is not met

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Effective Dates

- Applies to policies issued after 12/31/96
- LTC policies issued before 1/1/97 will be considered qualified long-term care contracts.

- What does "issued" mean?
- What about certificates issued after 12/31/96 under a group policy issued before 1/1/97?

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ILTC State-Specific Requirements and Variations: 6/1/98

STATE	NQ	Q	FRAUD REPORTING
Alabama			No
Alaska		7/2/97	Required
Arizona	90 days to submit proof of loss variation on psych exclusion rehab/alternate care $ NOT out of benefit cap	7/31/97 *same	Required
Arkansas		3/13/97	Permitted
California	7th ADL/ambulation (policies after 1/1/93) different PHC provision (policies after 1/1/93) DOI language in denial letters ALF is called "resident care faciility" variation on substance abuse exclusion no rehab/alternate care provision		Permitted
Colorado	bed reservation = 31 days per policy year (not calendar)	2/13/97 *same	Permitted
Connecticut	LTC94contract only: variation on psych exclusion variation on contestability	8/7/97	Permitted
Delaware	85% ALF	6/23/97 *85% ALF	Required
DC		2/21/97	No
Florida	FAC only policies not allowed to pay 60% ALF (not covered at all)	Yes (when?) *FAC called "NH w/ ALF" (now allowed to cover ALF at 60%) *no more FAC only policies *variation on contestability clauses new denial of claims provision	Permitted
Georgia			Permitted
Hawaii		3/19/97	No
Idaho		11/24/97	Permitted
Illinois	DOI language in denial and status letters	3/13/97 *DOI language in denials and status letters *9% annual interest	No

STATE	NQ	Q	FRAUD REPORTING
		due if decision not made w/I 30 days of receipt of proof	
Indiana		10/28/97	Permitted
Iowa		1/29/97	No
Kansas	100% ALF medical necessity trigger for FAC ADL trigger for HC	When? *100% ALF	Permitted
Kentucky		3/14/97	Required
Louisiana		7/24/97	Required
Maine		4/17/97	Permitted
Maryland	100% ALF	3/19/98 *100% ALF *variation in nonforfeiture provision *state may recover $ from UNUM if insured receives state assistance	Permitted
Massachusetts	no psych exclusion additional alcohol exclusion	11/14/97 *schedule page will show monthly and daily benefit but benefits paid monthly *variation on EAP = EP credit expires after 180 days regardless of EP length *variation on ALF definition	Permitted
Michigan		2/1/97	No
Minnesota	daily benefit	12/31/97 *daily benefit *variations on commissions of crime and psych exclusions	Permitted
Mississippi		1/30/97*18% annual interest rate if decision no made w/i 45 days of receipt of proof	No
Missouri	ALF is called "Residential Care Facility" w/3 patient minimum	4/8/97 *ALF is called "Res. Care Fac."/ 3 patient minimum *variation on self inflicted injury exclusion	Permitted
Montana		Yes (when?) *6 months to submit proof of loss	Required
Nebraska		1/31/97	Permitted
Nevada			Required

STATE	NQ	Q	FRAUD REPORTING
New Hampshire		10/9/97	Permitted
New Jersey	different ADL definitions ALF has no patient minimum variations on plan exclusions	1/6/98 same	Permitted
New Mexico	variations on "To whom claims are paid" provision	4/9/97 same	Permitted
New York	variation on hospital exclusion variation on "outside of US" exclusion different ADL definitions daily benefit variation on Adult Day Care definition	10/23/97 same	Required
North Carolina		10/20/97	Required
North Dakota		9/11/97 variation on contestability clause	Required
Ohio		2/19/97	Required
Oklahoma	must pay interest if decision not made within 60 days after receipt of proof	3/20/97 same	Required
Oregon		Yes (when?)	Permitted
Pennsylvania	variation on substance abuse exclusion new exclusion re: workers' comp/auto insurance benefits variations on FAC and adult day care definitions no rehab provision no advanced age as cause of loss	7/1/97 same	Permitted
Rhode Island		12/4/97 100% ALF variation on suicide exclusion	Permitted
South Carolina	80% ALF ALF has 5 patient minimum ALF called "Community Residential Care" benefit based on type of care received in facility not licensing of facility	12/8/97 same	Required
South Dakota		4/30/97 ALF has 5 patient minimum adult day care and phc agencies do not have	Permitted

STATE	NQ	Q	FRAUD REPORTING
		to be licensed 1 year contestable period	
Tennessee		7/7/97	No
Texas	ALF has 4 patient minimum 7th ADL – mobility (after 9/1/92)	7/28/97 ALF/4 patient minimum only 6 ADLs after 7/28 (transferring includes mobility) different cognitve impairment definition variation on contestability provision	Required
Utah		5/19/97	Permitted
Vermont	HC provider does not have to be certified by Medicare	3/21/97 60 day to submit notice of claim	?
Virginia		10/14/97	Permitted
Washington	no psych exclusion daily benefit		Permitted
West Virginia		6/2/97	Permitted
Wisconsin	plan of care is trigger/no ADLs or CI no assessments allowed no ALF benefit no rehab provision daily benefit	same	No
Wyoming		1/27/97 60 days to submit notice of claim	No

LifePlans Assessments

LTC has contracted with LifePlans, Inc. to do face-to-face Assessments of claimants or potential policy or coverage purchasers.

LifePlans, headquartered in Massachusetts, provides the Assessment service through a national network of nurses and social workers—geriatric professionals who have been trained by LifePlans to do the Assessments.

The Assessors use a standardized multi-page questionnaire form, to obtain and record such information as:

1. cognition, via a 10 question "short portable" questionnaire, as well as the Assessor's comments as to the claimant's ability to answer questions
2. whether the claimant can perform the major ADLs independently, or, if help is needed, how much help is needed, who provides the help, and how long the help has been needed
3. comments on plans of care
4. miscellaneous observations and comments

Assessors can visit claimants at their homes or in facilities, but also can talk to family members present or facility personnel.

The Assessment form is completed by the Assessor based upon an interview that may last up to 90 minutes. The Assessor may also obtain some facility records.

An Assessment can be obtained relatively quickly. An Assessment request form is completed and faxed to LifePlans, who in turn contact an Assessor near the claimant. The Assessor arranges the interview appointment.

It must be remembered that the Assessment interview is basically a self-report. The Assessment alone is not a substitute for medical documentation. The Assessment is just one tool available to the Analyst to help evaluate a claim.

Individual Long Term Care : Advantage I & II Only
LTC94 Policies and Prior
Questions and Answers

Q. Does time in the hospital count towards the Elimination Period?
A. Time in the hospital only counts towards the Elimination Period if the claimant has the Total Home Care coverage and has met the requirement of a two ADL loss or a cognitive impairment. The definition of Total Home Care is receiving assistance in any location from a formal or informal caregiver. Therefore the hospital stay will count towards the elimination period. However, hospital stays are excluded in the policy and we cannot pay benefits for hospital stays, unless covered under the Bed Reservation Benefit.

Q. What is Bed Reservation Benefit?
A. If the claimant's stay in a Nursing Facility or Assisted Living Facility is interrupted because they are hospitalized and they are receiving a benefit, we will continue to pay benefits for time in the hospital if a charge was made to reserve their accommodations with the facility. The claimant is allowed 31 reservation days per calendar year. Keep in mind that benefits would normally not be payable for time spent in the hospital.

Q. How does the Professional Home Care Benefit work? For Elimination Period and for benefit payment? Is it a reimbursement model?
A. To satisfy the Elimination Period for Professional Home Care, the claimant must have the loss of two or more ADLs and/or a Cognitive Impairment and be receiving Professional Home care from a "licensed agency". For each calendar week that the insured receives at least one day of Professional Home Care service, we will count seven (7) days towards completing the Elimination Period. In order to be considered a PHC visit, the visit must be a minimum of 1hour long.

Once benefits become payable, benefits are paid only for dates of service received from a licensed Professional Home Care Agency. Typically the benefits specialist will be in contact with the agency each month to get a summary of dates of service for that prior month. The benefit payment is based on 1/30th of the monthly benefit amount. For example, if the Professional Home Care monthly benefit amount was $1800 and the claimant received services for 15 days, the equation would be:

$1800/30 = $60 X 15 days = $900 benefit

So although we do ask for service dates, we are not "reimbursing" for services by requesting and paying invoices.

Q. Do we keep a listing of licensed Professional Home Care Agencies or Nursing Facilities?
A. No. We do not have a listing. When someone files a PHC claim, we contact the agency or facility to determine if they are licensed and meet the contract definition. If someone has a certain agency or facility in mind and would like us to check its licensing before using their services, we can do that. Other than that, we can suggest people contact LTC Connect for referral services or call their local Area Agency on Aging for options.

Q. Does receiving Physical Therapy at home count for Professional Home Care?
A. If a person has met the eligibility requirements for benefits (receiving assistance for two or more ADLs or Cognitive Impairment from either an informal or formal caregiver), days on which s/he receive physical therapy from a licensed agency will count towards eligible days for Professional Home Care as long as the visit is 1 hour at minimum.

Q. How do we "justify" informal care for THC? How do we determine if a THC claim is payable?
A. We can use several methods to determine ADL loss and assistance during a THC claim. We obtain information from all sources available; for example, Professional Home Care Agencies, Nursing Homes, Hospitals, attending physicians, etc. By understanding and monitoring the medical condition, we can infer what kind of ADL/Cognitive assistance a claimant should need and therefore be able to tell if assistance received is appropriate. Our Medical Department often helps in this matter. Other tools we use are assessments (which provides us a "snapshot" of the claimant on a particular day) as well as information from caregivers via phone calls and letters. The analyst is looking for consistency in putting together the pieces of the puzzle: the medical diagnosis/prognosis and the type and frequency of care being provided based on that information are consistent and meet the definition for eligibility.

Q. Explain the Advantage II NH and HC pools. If they use up all of one pool can they pull from the other?
A. If the claimant has NH and THC Advantage II, and they use up all the NH pool of dollars, then they can draw from the THC pool since the definition for Total Home Care states once you have lost 2 ADLs, you can be receiving care anywhere.

However, if the claimant uses all of their THC pool of dollars, they cannot pull from the NH pool of dollars to stay at home. They can only access that pool if they move into a NH or ALF.

Q. How does Respite Care work and who can take it?
A. Respite Care is a provision which was intended to provide the primary informal caregiver in a Home Care claim "respite" or a break from providing the care. We would pay benefits to the claimant in order for them to afford to hire another caregiver to provide respite to the primary informal caregiver once it was established that the insured qualified for benefits. The claimant is allowed up to 15 days Respite Care each calendar year. Respite benefits can only be paid if the claimant is not receiving other LTC benefits. Therefore, this time paid as Respite can be applied towards satisfying the claimant's EP.

Q. How is Assisted Living Facility paid and how is it triggered?
A. When someone is admitted to a facility and has filed a claim, one of the claims analyst's first steps is to verify with the facility how they are licensed with the state, and what kind of care the claimant is receiving. An Assisted Living Facility (ALF) can either be a stand alone facility, or it can be a section of a Nursing Home. The ALF provides 24 hour personal care and custodial services to support a person with a Loss of Functional Capacity/ Cognitive impairment. They provide meals and have trained personnel to provide assistance on a daily basis and a physician or nurse to furnish medical care in the event of an emergency. For example, take a claimant with Alzheimer's. Although they physically can perform their ADLs, they need the supervision and reminders to do so. Therefore, an ALF may be a good choice for them as they do not need the skilled nursing care provided in Nursing Homes.

The ALF benefit is based on either a percentage of the Nursing Home Benefit, or the Home Care percentage - whichever is greater. The percentage used to calculate the ALF benefit as a portion of the NH benefit can vary state to state. While the most common is 60%, refer to your state guidelines for exact percentage.

For example, a claimant is residing in an ALF and is eligible for benefits; if his/her monthly benefit amount for Nursing Home was $2000, the ALF benefit would be $1200($2000 X .60 = $1200). In this same example, if the claimant had a 100% Total Home Care rider, the claimant would receive the 100% ($2000) instead of the 60%, since the Home Care percentage is the greater of the two.

Some states, such as California, have a different name for Assisted Living. It is referred to as

Residential Care. If the facility does call itself an ALF, the Customer Care Specialist will make a phone call to determine if it fits the contractual ALF definition and whether it qualifies for the ALF benefits. Other states do not allow ALF benefits. If the claimant has NH and HC, they will be covered under the HC benefits in these states. If they only have NH they will not be eligible.

Q. Some of our competitors offer Personal Care Advocates or Managed Care. Do we have anything similar?
A.The Customer Care Specialist is responsible for adjudicating the claim and in this process, sometimes they are asked for their assistance in finding care. They can verify facilities will meet the definition of the contract. However, for suggestions of facilities or agencies, the benefits specialist will generally refer them to LTC Connect referral service or their local Area Agency on Aging.

Q. Describe the Rehabilitation and Alternate Care provision?
A. If you are on claim, we may "suggest" participation in an alternate care plan designed to help the insured regain his/her functional capacity and ability to perform ADLs. Terms of the alternate care plan and expenses covered will be subject to written mutual agreement between the claimant and us. The expenses associated with any payment for Alternate Care come out of the claimant's Maximum Benefit Cap.

Q. Can a claimant just take a portion of their benefit each month to make their benefits last longer? For example, if they have a $3000/month total home care benefit, can they choose to receive only $1500/month?
A. No. If the monthly benefit amount to be paid to the eligible claimant is $3000, that is what will be paid. The exception to this is Professional Home Care where benefits are only paid for dates of service during that month. The daily payment is based on 1/30th of the total monthly benefit amount.

Q. Who are benefits paid to? Can the client designate this "up front"?
A. Unless otherwise noted, benefits are payable directly to the claimant. If the policyholder wishes to assign benefits to someone before filing a claim, this must be done in writing and this letter should be kept in the front of the Underwriting jacket. Another possibility is that when someone goes on claim, there is an individual with Power of Attorney (POA). If we have a copy of the POA agreement, benefits can be paid directly to the POA, or to whomever the POA designates.

Q. What proof must be submitted if someone dies?
A. If the claimant dies, we would need a copy of the obituary or death certificate. This information is needed by the LTC Billing area in order to process any refund of premium that may be due.

Q. What happens if a claimant files a claim but dies prior to a decision being made?
A. If a claimant dies after filing a claim but prior to a decision being made, the Customer Care Specialist continues tto evaluate the claim and will make a determination whether or not the claimant was eligible for benefits. If the claimant was eligible for benefits, the specialist would pay benefits from the date of completion of the EP to the date of death for all eligible days. If the claimant died prior to satisfying the EP, no benefits would be due and the claim would be closed. Notify the Billing area and any unearned premium (for the period following the insured's death) would be refunded to the claimant's estate.

Q. What is the Elimination Accumulation Period?
A. The Elimination Accumulation Period (EAP) is the amount of time in which the claimant must satisfy his or her Elimination Period. For "cumulative" Elimination Periods, the EAP is three (3) times the length of time of the EP. For example, a 100-day EP needs to be satisfied within 300 days. With cumulative EPs, we can credit days toward the Elimination Period if the claimant recovers at some point prior to reaching the full EP. However, the credit only lasts until the EAP expires so if there is no other claim within this time, the credit is lost.

For example, assume a person has a 100 day Elimination Period. He fractures an ankle on July 1, 1996 and only needs help for 45 days. Then he recovers and no longer needs help. Since he did need help for 45 days, we can credit 45 days to his EP. If he has another disability within 300 days of the original disability (in this example, April 27, 1997), he will only have 55 days (100 days less 45 days), before he satisfies his full EP. In this example, for any claim received on or before April 27, 1997, the claimant would have a 45-day credit. However, for each day after April 27, 1997, s/he begin to lose their credit (i.e. on April 28th s/he have 44 days, on April 29th s/he have 43 days, etc.) If a cumulative EP is satisfied once, it never has to be satisfied again.

Consecutive EPs, such as 30 day and 20 day, need to be satisfied per occurrence, unless the second disability occurs within 6 months of the first. If this happens, we can consider it the same disability and a new EP does not have to be satisfied.

Q. Explain the psychiatric exclusion in the policy and what does it mean?
A. The exclusion states that if a disability is caused by a psychiatric, psychological or mental condition (i.e. depression, anxiety, personality disorders), then the insured will not be eligible for benefits. These conditions do not exist due to a physical alteration in the brain. The benefits specialist must be able to verify that the "PRIMARY" cause of the disability is psychiatric in nature. For example, if a claimant's only diagnosis is severe depression and cataracts, if the 2 ADL loss or need for supervision can be attributed to the depression alone, that claim would be denied based on the psychiatric exclusion. However, if the diagnoses were severe depression, severe osteoarthritis and CVA, the need for assistance with ADLs would most likely be due to residuals from the CVA and joint pain and stiffness from the osteoarthritis. Since these would be the 'PRIMARY" causes of the disability, we would pay the claim.

The insured will be eligible for benefits if s/he suffers a loss that is physical in nature such as Alzheimer's, Parkinson's, brain injury or other conditions that do involve physical alterations of the brain.

These kinds of claims will be reviewed by our Medical Department and input will be obtained from the insured's own doctor as well.

Q. Can we sell a policy to someone who is not a United States Citizen?
A. Yes. We can sell them a policy. However, in order to collect benefits, the claimant must be receiving care within Alaska, Hawaii or the continental United States so his/her care can be assessed by U.S. standards. We do not have an international standard for care and therefore could not adequately assess an illness or need for assistance if the insured is being cared for in another country. If there is adequate information available to us to provide proof of loss and care provided, we have the authority to make an exception on this restriction.

Also, as stated in the contract under plan exclusions: if a person is currently eligible and receiving benefits and is outside of Alaska, Hawaii and the continental U.S for more than 30 days, benefit payments will cease.

"LTC Connect" Referral Service

Effective 1/l/97, we have contracted with Employee Assistance Referral ("EAR") to provide counseling/referral "hotline" assistance to ILTC policyholders and their families, as well as employees and families of covered GLTC policyholders.

To be eligible to use the service, GLTC/ILTC coverage of the Insured individual must be effectuated l/l/97 or later. This service is referred to as "LTC Connect." The telephone number for this service is 1-800-671-9764.

The 24 hour telephone service will provide assistance on such topics as:

- financial counseling
- retirement, estate, and will planning
- selecting housing and care alternatives
- caregiver and family issues
- health and medical concerns

The phones are manned by highly educated and trained counseling professionals. Confidentiality and privacy are respected.

"LTC Connect" will be available directly to employees and families. At the same time, Benefits personnel should feel comfortable in referring callers to "LTC Connect" when issues/crises are identified in the claims process.

NAIC 640-1

National Association Of Insurance Commissioners (N.A.I.C.)
Model Laws, Regulations And Guidelines
Long-Term Care Insurance
Long-Term Care Insurance Model Act

Current through October 1999

Table of Contents

1. Purpose

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

Comment: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Comment: The Task Force recognizes the viability of a long-term care product funded through a life insurance vehicle, and this Act is not intended to prohibit approval of this product. Section 4 now specifically addresses this product. However, states must examine their existing statutes to determine whether amendments to other code sections such as the definition of life insurance and accident and health reserve standards and further revisions are necessary to authorize approval of the product.

2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Note: See Section 6I.

Comment: This section makes clear that entities subject to the Act must continue to comply with

other applicable insurance legislation not in conflict with this Act.

3. Short Title

This Act may be known and cited as the "Long-Term Care Insurance Act."

4. Definitions

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

A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; 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 term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this Act.

B. "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.

C. "Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "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) One or more employers or labor organizations, or to a trust or to the trustees of a fund

established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that:

(a) The association or associations hold regular meetings not less than annually to further purposes of the members;

(b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Act, 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.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long- term care provider or swing bed.

5. Extraterritorial Jurisdiction - Group Long-Term Care Insurance

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 Section 4E(4), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Drafting Note: By limiting extraterritorial jurisdiction to "discretionary groups," it is not the drafters' intention that jurisdiction over other health policies should be limited in this manner.

6. Disclosure and Performance Standards for Long-Term Care Insurance

A. The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Comment: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

B. No long-term care insurance policy may:
(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 significantly more coverage for skilled care in a facility than coverage for lower levels of care.

C. Preexisting condition:

(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not 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. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization:

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2) (a) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(b) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

(3) No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

Editors Note: Section 6D(3) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(3) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

E. The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return - free look:
Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act, the applicant is not satisfied for any reason.

G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.
(a) The Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.
(b) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.
(c) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.
(d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6G(2)(a) through (f) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the Commissioner.

Drafting Note: States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:
(a) A description of the principal benefits and coverage provided in the policy;
(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;
(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;
(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;
(e) A description of the terms under which the policy or certificate may be returned and premium refunded; and
(f) A brief description of the relationship of cost of care and benefits.

H. A certificate issued pursuant to a group long-term care insurance policy which policy is 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.

Comment: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

I. At the time of policy delivery, a policy summary shallbe delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:
(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;
(3) Any exclusions, reductions and limitations on benefits of long-term care;
(4) A statement that any long-term care inflation protection option required by [cite to state's inflation protection option requirement comparable to Section 11 of the Long-Term Care Insurance Model Regulation] is not available under this policy;
(5) If applicable to the policy type, the summary shall also include:
(a) A disclosure of the effects of exercising other rights under the policy;
(b) A disclosure of guarantees related to long-term care costs of insurance charges;
(c) Current and projected maximum lifetime benefits; and
(6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with [cite to state's basic illustration requirement comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation] or into the life insurance policy summary which is required to be delivered in accordance with [cite to state's life insurance policy summary requirement comparable to Section 5 of the Life Insurance Disclosure Model Regulation].

J. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:
(1) Any long-term care benefits paid out during the month;
(2) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and
(3) The amount of long-term care benefits existing or remaining.

K. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

7. Incontestability Period

A. For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.
B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.
C. After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating

to the insured's health.

D. (1) No long-term care insurance policy or certificate may be field issued based on medical or health status.
(2) For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

F. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by [cite to state's life insurance incontestability clause]. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

8. Nonforfeiture Benefits

No long-term care insurance policy or certificate may be delivered or issued for delivery in this state unless the policy or certificate provides for nonforfeiture benefits to the defaulting or surrendering policyholder or certificateholder. The commissioner shall promulgate a regulation specifying the type or types of nonforfeiture benefits to be included in such policies and certificates and the standards for the benefits.

9. Authority to Promulgate Regulations

The commissioner shall issue reasonable regulations to establish minimum standards for marketing practices, premium rate stabilization agent compensation, agent testing, penalties and reporting practices for long-term care insurance.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

10. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

11. Severability

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

12. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intention of this section is to authorize separate fines for both the insurer and the agent in the amounts suggested above.

13. Effective Date

This Act shall be effective [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 19, 655, 677-680, 700 (adopted).
1987 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. I 9, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 479-484 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 556-561 (amended and reprinted).
1991 Proc. I 9, 17, 609-610, 662, 666-671 (amended and reprinted).
1993 Proc. I 8, 136, 819, 844, 845 (amended).
1993 Proc. 1st Quarter 3, 34, 267, 275, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 458 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 823-824 (amended).
1997 Proc. 1st Quarter (amended).

END OF DOCUMENT

National Association Of Insurance Commissioners (N.A.I.C.)
Model Laws, Regulations And Guidelines
Long-Term Care Insurance
Long-Term Care Insurance Model Regulation

Current through October 1999

Table of Contents

1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Long-Term Care Insurance Model Act], 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.

2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite sections of law enacting the NAIC Long-Term Care Insurance Model Act and establishing the commissioner's authority to issue regulations].

3. Applicability and Scope

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

Drafting Note: This regulation, like the NAIC Long-Term Care Insurance Model Act, is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these plans, organizations and arrangements (e.g., contract, policy, certificate, subscriber, member) may be substituted for, or added to, the corresponding terms used in this regulation.

4. Definitions

For the purpose of this regulation, the terms "long-term care insurance,""group long-term care insurance," "commissioner," "applicant," "policy" and "certificate" shall have the meanings set forth in Section 4 of the NAIC Long- Term Care Insurance Model Act.

Drafting Note: Where the word "commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To the extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated into this section.

5. Policy Definitions

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:

A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

B. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit
from care in a group setting outside the home.

D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the

task of getting into or out of the tub or shower.

E. "Cognitive impairment" means a deficiency in a person's short or long- term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

H. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

J. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. "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.

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

M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

N. "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.

O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. "Transferring" means moving into or out of a bed, chair or wheelchair.

Q. 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 may require that the provider be appropriately licensed or certified.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to or incorporation of the individual state law may be required in structuring each definition.

Comment: This section is intended to specify required definitional elements of several terms commonly found in long-term care insurance policies, while allowing some flexibility in the

definitions themselves.

6. Policy Practices and Provisions

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 9 of this regulation.
(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."
(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
(3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
(1) Preexisting conditions or diseases;
(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
(3) Alcoholism and drug addiction;
(4) Illness, treatment or medical condition arising out of:
(a) War or act of war (whether declared or undeclared);
(b) Participation in a felony, riot or insurrection;
(c) Service in the armed forces or units auxiliary thereto;
(d) Suicide (sane or insane), attempted suicide or intentionally self- inflicted injury; or
(e) Aviation (this exclusion applies only to non-fare-paying passengers).
(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 B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

Drafting Note: Paragraph (6) is intended to permit exclusions and limitations for payment for services provided outside the United States and legitimate variations in benefit levels to reflect differences in provider rates.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be 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.

D. Continuation or Conversion.
(1) Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.
(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would

otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to usecertain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, providersystem arrangements, service availability, benefit levels and administrative complexity.

(3) 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 the 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.

(4) For the purposes of this section, "converted policy" means an individual 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. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(5) 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 thirty-one (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.

(6) 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.

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

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

(b) The terminating coverage is replaced not later than thirty-one (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 Paragraph (6) of this section.

(8) 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 that provides benefits on the basis of incurred expenses, may contain a provision that 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. The 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.

(9) 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.

(10) Notwithstanding any other provision of this section, an 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) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and Replacement
If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:
(1) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

F. Premium Rate Restrictions
(1) The initial premium charged an insured covered by a long-term care policy shall not increase during the initial four (4) years in which the policy is in force.
(2) Except as provided in Paragraph (4) of this subsection, any premium rate increases after the initial four-year period are subject to the following restrictions:
(a) For insureds age eighty (80), and over, the premium charged may not increase more than ten percent (10%) in the aggregate during any five- year period;
(b) For insureds age sixty-five (65) to age eighty (80), the premium charged may not increase more than fifteen percent (15%) in the aggregate during any five-year period; and
(c) For insureds under the age of sixty-five (65), the premium charged may not increase more than twenty-five percent (25%) in the aggregate during any four-year period.
(d) The premium charged to an insured shall not increase due to either:
(i) The increasing age of the insured at ages beyond sixty-five (65); or
(ii) The duration the insured has been covered under the policy.
(3) Policies that provide for inflation protection shall be subject to the restrictions in Paragraphs (1) and (2) of this subsection; however, the purchase of additional coverage shall not be considered a premium rate increase for purposes of determining compliance with Paragraph (2) at the time additional coverage is purchased. The premium charged for the purchase of additional coverage shall be subject to Paragraph (2) for any subsequent premium rate increases where no additional purchases of coverage are made.
(4) The commissioner may amend, for universal application, the premium rate restrictions imposed by this subsection, in appropriate circumstances, including but not limited to the following:
(a) State or federal law is amended, materially affecting the insured risk;
(b) Unforeseen changes occur in long-term care delivery, insured morbidity or insured mortality; or
(c) Judicial interpretations or rulings are rendered regarding policy benefits or benefit triggers resulting in unforeseen claim liabilities.
(5) Nothing in Paragraph (4) shall limit the commissioner's authority pursuant to other sections of the insurance code of this state.
(6) Except as provided in Paragraph (7), the provisions of this Subsection F shall apply to any long-term care policy or certificate issued in this state on or after the effective date of this amended regulation.
(7) For certificates issued on or after the effective date of this Subsection F, under a group long-term care insurance policy as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this amended Subsection F shall not apply.
(8) This subsection shall not apply to life insurance policies that accelerate benefits for long-term care, provided that maximum premiums or minimum interest rates and maximum cost of

insurance charges applicable to all policy benefits are specified over the entire duration of the life insurance policy.

G. Electronic Enrollment for Group Policies
(1) In the case of a group defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:
(a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;
(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and
(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by [insert reference to state law comparable to Section 2W of the NAIC Insurance Information and Privacy Protection Model Act], is maintained.
(2) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

7. Unintentional Lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.
(2) When the policyholder or certificateholder pays premium for a long- term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.
(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

B. Reinstatement. In addition to the requirement in Subsection A, a long- term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was

cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Drafting Note: The language in Subsection B addressing the provision of proof of cognitive impairment or loss of functional capacity has been amended to more precisely clarify the original intent in adopting the reinstatement provision. The model language that was in effect in 1993 is referenced in P.L. 104-191, but regulations have not yet been drafted by the Department of the Treasury. Pending federal clarification, the language mentioned above may allow contracts and policies that contain this language to be considered as qualified long-term care contracts as set forth in P.L. 104-191.

8. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. The 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. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

B. Riders and Endorsements. 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 that 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, the premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy that 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 these terms and an explanation of the terms in its accompanying outline of coverage.

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

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of the 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. Disclosure of Tax Consequences. With regard to life insurance policies that provide an

accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall 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 shall be specified.

9. Prohibition Against Post-Claims Underwriting

A. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B. (1) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.
(2) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:
(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.
(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery: Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]
(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, theinsurer shall obtain one of the following:
(a) A report of a physical examination;
(b) An assessment of functional capacity;
(c) An attending physician's statement; or
(d) Copies of medical records.

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

10. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:
(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
(2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;
(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;
(5) By excluding coverage for personal care services provided by a home health aide;
(6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
(7) By requiring that the insured or claimant have an acute condition before home health care services are covered;
(8) By limiting benefits to services provided by Medicare-certified agencies or providers; or
(9) By excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when
determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection C permits the home health care benefits to be counted toward the maximum length of long-term care
coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the
benefit illusory. It is suggested that fewer than 365 benefit days and less than a $25 daily maximum benefit constitute illusory
home health care benefits.

11. Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:
(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);
(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has

not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in [Section 4E(4) of the Act] other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in Subsection A above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. (1) Insurers shall include the following information in or with the outline of coverage:
(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.
(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Drafting Note: It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

E. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. (1) Inflation protection as provided in Subsection A(1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.
(2) The rejection shall be considered a part of the application and shall state:I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

12. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A

supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by [insert reference to Section 4(E)(1) of the Model Act], the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

B. (1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
(2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?
(a) If so, with which company?
(b) If that policy lapsed, when did it lapse?
(3) Are you covered by Medicaid?
(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.
(1) List policies sold that are still in force.
(2) List policies sold in the past five (5) years that are no longer in force.

C. Solicitations Other than Direct Response. 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 sickness or long-term care coverage. One copy of the 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 SICKNESSOR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness 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. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:
1. Health conditions that 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. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, 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.
4. 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 your sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)
[Typed Name and Address of Agent or Broker]
The above "Notice to Applicant" was delivered to me on:

_____

(Applicant's Signature)

_____

(Date)

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness 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 SICKNESS OR LONG-TERMCARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness 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 the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.
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. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, 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.
4. [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]

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of [cite to state's life insurance replacement regulation similar to the NAIC Replacement of Life Insurance and Annuities Model Regulation]. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long- term care and the life insurance replacement requirements.

13. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above.

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

F. For purposes of this section, "policy" shall mean only long-term care insurance and "report" means on a statewide basis.

14. Licensing

No agent is authorized to market, sell, solicit or otherwise contact a person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.

15. Discretionary Powers of Commissioner

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

A. The modification or suspension would be in the best interest of the insureds;

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
(2) 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
(3) 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.

Drafting Note: This provision is intended to provide the commissioner with limited discretion and flexibility to accommodate specific and innovative long- term care insurance products which are shown to be in the public's best interest. This provision is intended to be used sparingly for this purpose.

16. Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with [cite the standard valuation law for life insurance, which contains a section referring to "special benefits" for which tables must be approved by the commissioner]. Claim reserves shall also be established in the case when the policy or rider is in claim status.Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:
(1) Definition of insured events;
(2) Covered long-term care facilities;
(3) Existence of home convalescence care coverage;
(4) Definition of facilities;
(5) Existence or absence of barriers to eligibility;
(6) Premium waiver provision;
(7) Renewability;
(8) Ability to raise premiums;
(9) Marketing method;
(10) Underwriting procedures;
(11) Claims adjustment procedures;
(12) Waiting period;
(13) Maximum benefit;
(14) Availability of eligible facilities;

(15) Margins in claim costs;
(16) Optional nature of benefit;
(17) Delay in eligibility for benefit;
(18) Inflation protection provisions; and
(19) Guaranteed insurability option.
Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with [cite law referring to minimum health insurance reserves, the NAIC version of which requires reserves using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner].

17. Loss Ratio

A. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
(1) Statistical credibility of incurred claims experience and earned premiums;
(2) The period for which rates are computed to provide coverage;
(3) Experienced and projected trends;
(4) Concentration of experience within early policy duration;
(5) Expected claim fluctuation;
(6) Experience refunds, adjustments or dividends;
(7) Renewability features;
(8) All appropriate expense factors;
(9) Interest;
(10) Experimental nature of the coverage;
(11) Policy reserves;
(12) Mix of business by risk classification; and
(13) Product features such as long elimination periods, high deductibles and high maximum limits.

B. Subsection A shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:
(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
(3) The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;
(4) Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and
(5) An actuarial memorandum is filed with the insurance department that includes:
(a) A description of the basis on which the long-term care rates were determined;
(b) A description of the basis for the reserves;
(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
(e) A description and a table of the anticipated policy reserves and additional reserves to be held

in each future year for active lives;
(f) The estimated average annual premium per policy and the average issue age;
(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Drafting Note: The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section 18 above which removes the word "individual": (1) reflects the fact that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

18. Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 5 of the Long-Term Care Insurance Model Act, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

19. Filing Requirements for Advertising

A. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

20. Standards for Marketing

A. Every insurer, health care service plan or other entity marketing long- term care insurance coverage in this state, directly or through its producers, shall:
(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
(2) Establish marketing procedures to assure excessive insurance is not sold or issued.
(3) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:
"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.
(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.
(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a

senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.
(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 6 A(3) of this regulation.

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:
(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.
(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in [insert citation to Section 4E(2) of the NAIC Long-Term Care Insurance Model Act], when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.
(2) The insurer shall file with the insurance department the following material:
(a) The policy and certificate,
(b) A corresponding outline of coverage, and
(c) All advertisements requested by the insurance department.
(3) The association shall disclose in any long-term care insurance solicitation:
(a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and
(b) A brief description of the process under which the policies and the insurer issuing the policies were selected.
(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.
(5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.
(6) The association shall also:
(a) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;
(b) Actively monitor the marketing efforts of the insurer and its agents; and
(c) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Drafting Note: The materials specified for filing in this section shall be filed in accordance with a state's filing due dates and procedures.

(7) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.

(8) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.
(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of [insert citation to corresponding section of state Unfair Trade Practices Act].

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to long-term care insurance policies and certificates.

21. Suitability

A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer, health care service plan or other entity marketing long- term care insurance (the "issuer") shall:
(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
(2) Train its agents in the use of its suitability standards; and
(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

C. (1) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:
(a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
(b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
(c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.
(2) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.
(3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long- term care insurance to employees and their spouses.
(4) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the

applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

22. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a long-term care insurance policy or certificate replaces another long- term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

23. Nonforfeiture Benefit Requirement

A. No policy or certificate may be delivered or issued for delivery in this state unless the policy or certificate provides for nonforfeiture benefits to the defaulting or lapsing policyholder or certificate holder.This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Drafting Note: It should be noted that there may be certain situations where it is appropriate to exempt public-private partnerships from the mandatory inclusion of nonforfeiture benefits.

(1) For purposes of this section, attained age rating is defined as a schedule of premiums starting from the issue date which increases with increasing age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).
(2) For purposes of this section, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).
(3) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection B.
(4) No policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
(a) The end of the tenth year following the policy or certificate issue date; or
(b) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

B. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

C. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

D. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:
(1) Except as provided in Paragraph (2), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.
(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

E. Premiums charged for a policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements of Section 17 treating the policy as a whole.

24. Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B. (1) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:
(a) Bathing;
(b) Continence;
(c) Dressing;
(d) Eating;
(e) Toileting; and
(f) Transferring;
(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.
C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.
D. For purposes of this section the determination of a deficiency shall not be more restrictive than:
(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.
E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.
F. Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.
G. The requirements set forth in this section shall be effective [insert date 12 months after adoption of this provision] and shall apply as follows:
(1) Except as provided in Paragraph (2), the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.
(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the Long-Term Care Insurance Model Act] that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

25. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of

[Section 6G of the Long-Term Care Insurance Model Act] [cite provision of law requiring the commissioner to prescribe the format and content of an outline of coverage] in prescribing a standard format and the content of an outline of coverage.

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

B. The outline of coverage shall contain no material of an advertising nature.

C. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

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

E. Format for outline of coverage:
[COMPANY NAME]
[ADDRESS - CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]
[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]
Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. THIS POLICY IS [AN INDIVIDUAL POLICY OF INSURANCE]([A 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 CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:
(1) Policies and certificates that are guaranteed renewable shall contain the following statement:]
RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.
(2) [Policies and certificates that are noncancellable shall contain the following statement:]

RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.
(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]
(c) [Describe waiver of premium provisions or state that there are not such provisions;]
(d) [State whether or not the company has a right to change premium, and if such right exists, describe clearly and concisely each circumstance under which premium may change.]

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

(a) [Provide a brief description of the right to return--"Gfree look" provision of the policy.]
(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

5. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.
(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

6. 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.]

7. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]
(b) [Institutional benefits, by skill level.]
(c) [Non-institutional benefits, by skill level.]
(d) Eligibility for Payment of Benefits
[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]
[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers 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.]

8. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;
(b) Non-eligible facilities and provider;
(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
(d) Exclusions and exceptions;
(e) 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 Number 6 above.]
THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

9. 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:
(a) That the benefit level will not increase over time;
(b) Any automatic benefit adjustment provisions;
(c) 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;
(d) 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;
(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

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.

[(a) State the total annual premium for the policy;
(b) 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.
[(a) Indicate if medical underwriting is used;
(b) Describe other important features.]

26. Requirement to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.
(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.
(2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.
B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under [cite for Section 6 of Long-Term Care Insurance Model Act].

27. Penalties

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intent of this section is to authorize separate fines for both the company and the agent in the amounts suggested above.

OPTIONAL PROVISION

[ ]. Permitted Compensation Arrangements

A. An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.
B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.
C. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.
D. For purposes of this section, "compensation" includes pecuniary or non- pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Drafting Note: The NAIC recognizes that long-term care insurance is in an evolutionary stage. The product market needs to be able to develop in order to be responsive to the needs of consumers. In addition, since long-term care insurance and long-term care insurance regulations are continually changing, a state should consider the fact that not all replacements are improper. The NAIC also recognizes that currently, long-term care insurance products are being primarily sold to the senior citizen market, a market that has been identified as being susceptible to abusive marketing practices. In response, the NAIC has adopted consumer protection amendments in its model regulation for Medicare supplement insurance. The Medicare supplement insurance model regulation limits agents' compensation in order to address the potential for marketing abuses resulting from the large difference between first year and renewal commissions. If a state believes that there is evidence that the long-term care insurance market is experiencing similar abuses, it may wish to consider adopting the optional agent compensation provision above. In considering these agent compensation limitations, states should recognize the emerging nature of the long-term care insurance market. Long-term care insurance is evolving along both health insurance indemnity and life insurance lines. A state may want to consider that, since life insurance products usually contain nonforfeiture and cash value accumulation features and are normally targeted to a younger age group than long-term care indemnity products, such life insurance products could be exempted from these compensation limitation requirements. The compensation provision such as provided above should not be enacted in lieu of the penalty and other consumer protection provisions contained in the regulation, but in addition to them.

A. RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF _____ FOR THE REPORTING YEAR 19[ ]

Company Name: _____

Address: _____
Phone Number: _____
Due: March 1 annually
Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy #Policy and #Name ofDate ofDate/sDate of
FormCertificateInsuredPolicyClaim/sRescission
Issuance Submitted

Detailed reason for rescission: _____

_____
Signature

_____
Name of Title (please type):

_____
Date

B. Long Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone. By state law, the insurance company must ask you to fill out this worksheet to help you and the company decide if you should buy this policy.

Premium

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]
[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up by an average of _____%]. [The company has not raised its rates for this policy.]

Drafting Note: The issuer shall use the bracketed sentence or sentences applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage. The issuer may include rate information for up to two policy forms if the issuer has not changed rates on either policyform or for prior policies providing essentially similar coverage.

[ ] Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

Drafting Note: The issuer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

How will you pay each year's premiums?
[ ]From my Income [ ]From my Savings<<backslash>>Investments [ ]My Family will pay

Income

What is your annual income? (check one)
[ ]Under $10,000 [ ]$[10-20,000] [ ]$[20-30,000] [ ]$[30-50,000] [ ]Over$50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years?.(check one)
[ ]No change [ ]Increase [ ]Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Savings and Investments

Not counting your home, about how much are all of your assets worth (your savings and investments)? (check one)
[ ]Under $20,000 [ ]$20,000-$30,000 [ ]$30,000-$50,000 [ ]Over $50,000

How do you expect your assets to change over the next ten years? (check one)
[ ]Stay about the same [ ]Increase [ ]Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

[ ] The answers to the questions above describe[ ] I choose not to complete my financial situation.this information.

Signed:_____
(Applicant)

_____
(Date)
[[ ] I explained to the applicant the importance of completing this information.
Signed:_____
(Agent)

_____
(Date)
Agent's Printed Name: _____]

[Note: In order for us to process your application, please return this signed statement to [name of company], along with your application.]
[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.
Signed:_____
(Applicant)

_____]
(Date)
Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.
The company may contact you to verify your answers.
Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

C. Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
[You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

Medicare does not pay for most long-term care.

Medicaid

Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy ifyou are now eligible for Medicaid.

Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

D. Long-Term Care Insurance Suitability Letter

Dear [Applicant]:
Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your

application, to avoid selling a policy to those who may not need coverage. [Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards. If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy. Please check one box and return in the enclosed envelope.

[ ] Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

rafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

[ ] No. I have decided not to buy a policy at this time.

_____
APPLICANT'S SIGNATURE

_____
DATE
Please return to [issuer] at [address] by [date].

Legislative History (all references are to the Proceedings of the NAIC).
1988 Proc. I 9, 20-21, 629-630, 652, 656-661 (adopted).
1989 Proc. I 9, 24-25, 703, 754-755, 791-794 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 484-493 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 545-556 (amended and reprinted).
1990 Proc. II 7, 16, 600, 617, 649 (amended).
1991 Proc. I 9, 17-18, 609-610, 662, 672-687 (amended and reprinted).
1992 Proc. I 86, 95, 914, 954, 963, 967-982, 987 (amended and reprinted).
1992 Proc. II 9, 11, 672, 687, 696 (amended).
1993 Proc. I 8, 136, 819, 843-844, 846-848 (amended).
1993 Proc. 1st Quarter 3, 34, 267, 274, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 451, 457-459 (amended).
1994 Proc. 4th Quarter 17, 26, 713-714, 722, 731, 737, 739-761 (amended and reprinted).
1995 Proc. 2nd Quarter 2, 36, 553, 651, 653-659 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 825 (amended).
1997 Proc. 1st Quarter (amended).
1997 Proc. 2nd Quarter (amended).
END OF DOCUMENT

National Association Of Insurance Commissioners (N.A.I.C.) Model Laws, Regulations And Guidelines Long-Term Care Insurance Proposed Circular Letter And Report Form For Gathering Information On LTC Policies

Current through October 1999

LONG-TERM CARE INSURANCE PROPOSED CIRCULAR LETTER

Dear _____:
This office recently approved/received a long-term care insurance policy filed by your company. This policy will be added to the List of Approved Long- Term Care Insurance Policies published and distributed by the office on a quarterly basis.To assure the accuracy of this list, it is necessary for us to request you to complete and return the attached form. The form should be addressed to _____.

Your company's policy will appear on the next quarterly list. Please inform the office of any future changes in the information contained on the form.

Thank you for your help.

Sincerely,

_____
[Commissioner/Director/Superintendent] of Insurance

LONG-TERM CARE INSURANCE REPORT FORM

This form will be used to prepare the List of Approved Long-Term Care Insurance Policies which is distributed by the Office of the Commissioner of Insurance.Please complete the form promptly and return it, along with (5) copies of the approved policy, (5) outlines of coverage for the policy and (5) copies of any advertising or promotional materials which will be used in connection with the sale of this policy.
The form and other material should be returned to the _____.
This request is made pursuant to [cite pertinent statute].
Company Name: _____
Company Address:

_____
_____
_____
_____
Type of Policy or Rider: Group ____ Individual ____
Form No. of Policy: _____
Form No. of Rider: _____
Kind of Insurance: Life ____ Health ____ Annuity ____
First Year Commission to Agent: _____ Subsequent Commissions: _____
Eligibility Standards:
____ No health questions asked
____ General health questions asked
____ Detailed health history requested

_____ Other
Waiting Periods for Preexisting Conditions
Number of months: _____
Renewability:
_____ Guaranteed renewable
_____ Guaranteed renewable for life
_____ Noncancellable
_____ Other
Inflation Protection:
Indicate the manner in which inflation protection is offered by the policy:
_____ Compounded
_____ Level Premium
_____ Other Explain:_____
_____ Simple
_____ Inflated Premium
Description of Benefits: (Please include information on daily benefit amounts, elimination periods, and benefit periods for each type of care following the format shown in the example.)
Example:
Skilled care: $30 to $100 per day for 1, 2, 3, or 5 year benefit period; 20 or 100-day elimination period.
Intermediate care: $30 to $100 per day for 1, 2, 3, or 5 year benefit period; 20 or 100 day elimination period.
Custodial care: $30 to $100 per day for 1, 2, 3, or 5 year benefit period. Confinement must begin after a skilled or intermediate stay of at least 20 days in a row.
Home health care: $30 to $60 per day for up to 90 visits following a skilled or intermediate stay of at least 20 days in a row.
Skilled care:
Intermediate care:
Custodial care:
Home health care:
Waiver of premium and Nonforfeiture Benefits:
Other benefits:
Description of Policy Limits: (Please include any upper limits)

_____
Describe any limitations on type of covered facilities:
_____ Medicaid/Medicare approved
_____ State certified
_____ Other

_____
Premium: (Please complete the following chart.) Note that it is for a $50 per day benefit. If necessary, change the specifications in the chart to fit those of the policy as it most closely approximates the specifications.

Annual Premium - $50 per day benefit

One-year benefit period Three year benefit period

Age Elimination period [FNa1] (inElimination period [FNa1] (in days)days)
---
020 100020 100

50

65

70

75

80

FNa1. Elimination period means the days of covered services before benefits begin.

The following information is for Department use only:
Name and phone number of contact person in Claim Department: _____
Name, address, and phone number of General Agent in _____:
Name, address, and phone number of supervising or regional agents in ____:

Legislative History (all references are to the Proceedings of the NAIC).
1991 Proc. I 9, 17, 609-610, 663, 668-690 (adopted).

END OF DOCUMENT

Respite Care Benefits

Respite care is defined as substitute care provided for a short period of time to give an informal caregiver a break from his/her normal caregiving responsibilities. Up to 15 days a year of respite care benefits could be payable to individuals with 2 ADL Loss or disabling cognitive impairment.

In determining the applicability of respite care benefits, the Analyst should assess the following:

1. who is the primary caregiver
2. who provided the respite care
3. how long the respite care was provided
4. was the claimant disabled with 2 ADL Loss or cognitive impairment at the time the respite care was provided, and
5. documentation from the claimant, family, caregiver, respite caregiver, re: the extent and days respite care was actually provided

UnumProvident's Appeal Process

UnumProvident is committed to accuracy and fairness in the assessment and determination of all claims submitted to it. As part of meeting that commitment and the guiding principles of the Customer Care Center, UnumProvident has established an appeals operation in 3 of its major claims operation sites: Portland, Maine, Worcester, Massachusetts, and Chattanooga, Tennessee.

What Is An Appeal?
An appeal is a written communication from a claimant or the claimant's authorized representative that disputes a final claim decision made by the customer care specialist. That claim decision may take the form of a decision that:

- the claimant is not entitled to benefits under the applicable policy or benefits plan;
- the claimant is not covered under the applicable policy or benefits plan;
- the claim is not covered or payable under the applicable policy or benefits plan;
- the claim is payable for a specified duration; or
- the benefits payable on the claim are not as much as the claimant contends he/she is due.
- The claimant is disputing an offset or overpayment.

What Is Not An Appeal?
If the claimant calls UnumProvident to dispute a claim decision of the type described in (a) – (e) above, that phone call will not be treated as an appeal. The claimant should be advised that s/he need to submit a written appeal in order for us to thoroughly review his/her request. They should submit any documentation, such as additional medical records, employment records etc., which s/he believe will support his/her appeal.

Similarly, if an individual other than the claimant contacts UnumProvident in writing to dispute a claim decision, without written authorization from the claimant to act on his/her behalf, that contact will not be treated as an appeal.

Purpose of Claim Appeals

As set forth in the Claims Manual, UnumProvident is committed to thorough, fair and accurate claims evaluations and decision making. As part of that commitment, UnumProvident offers each claimant who is dissatisfied with a claim decision, the right (in ERISA settings) and the option (in non-ERISA settings) of an appeal. This opportunity for an appeal extends to each of UnumProvident's product lines and claims operations.

To conduct manage, evaluate and decide these appeals, UnumProvident maintains separate appeals units in three of its largest Customer Care Centers - Chattanooga, Portland and Worcester. These appeals units provide a fresh and independent review of any initial claim decision with which the claimant disagrees (as explained in the section of this manual entitled "What is an Appeal?"). As with each Customer Care operation, these appeals units are committed to thorough, fair and accurate claims evaluations and decision-making.

Conduct of the Appeal
In handling and completing an appeal, the appeals specialist or consultant will follow, as applicable, the guidelines set forth in this Claims Manual. Among other things, the appeals specialists and consultants will:

- thoroughly review the entire claim file
- gather additional or clarify information if and as needed or appropriate
- request reviews and/or guidance from expert resources, as needed or appropriate
- be responsive, timely and courteous in all interactions with the claimant
- comply with any applicable laws
- reach appropriate and fact-based decisions
- communicate the appeals decision clearly and completely to the claimant verbally (if reasonably possible to do so) and in writing.

Possible Appeals Outcome
There are several possible outcomes from the independent review and evaluation of claim appeals to UnumProvident:

- The claim decision is upheld.
- The claimant provides new information on appeal which warrants the claim being returned to the specific Customer Care unit from which the claim originated for further investigation.
- The claimant provides new information on appeal which warrants the claim being paid and returned to the applicable Customer Care unit for further handling.
- The claim decision is reversed, and sent back to the applicable Customer Care unit for further handling.
- The claim is resolved.

The relevant and persuasive facts determine what the appropriate outcome should be on appeal.

ERISA's Appeal Requirement
The Employee Retirement Income Security Act of 1974 ("ERISA") requires that each ERISA-governed employee benefit plan provide the participants with the right to a full and fair review of any adverse benefit decision. ERISA further mandates, with a few specific exceptions, that a participant must exhaust (i.e., utilize and complete) this appeal process before he/she may take further legal action, e.g., a lawsuit, against the plan or it's insures based on the denial of benefits. If the participant fails to exhaust this appeal right prior to a lawsuit, generally, the court will consider that lawsuit premature and dismiss it.

ERISA further sets forth specific timeframes in which a participant must submit an appeal, and the plan, or its representative, must decide that appeal. Specifically, the minimum time limit set

by ERISA in which a participant may be required to submit an appeal is 60 days from the date the participant receives the written benefit decision.

The plan, or its representative/designee, is required to decide the appeal within 60 days from the date the appeal is received. Additional time may be reasonably necessary to complete the evaluation of and decide the appeal, provided the appeals operation notifies the participant of the need for this extension prior to the end of the first 60 day period. Any benefit appeal which is not decided within the initial 60 day period, or the 120 day period (if applicable) shall be deemed denied.

ERISA also gives the participant the right to obtain a copy and review any and all documents compiled, gathered and created the benefits operation in regards to the participant's benefits claim excluding attorney/client and other business sensitive documents.

ERISA mandates that the appeals decision must be set forth in writing and sent to the participant. This written communication of the decision to the participant must articulate the decision fully and explain in complete detail, the reasons for the decision.

UnumProvident's Compliance with ERISA Appeals Rules
The appeals units operated by UnumProvident must comply fully with these ERISA requirements. As set forth in this Manual, UnumProvident provides each ERISA plan participant with the written right of appeal and directions on how to pursue that appeal, in each adverse claim decision letter. Moreover, UnumProvident sets a 90 day time limit (as opposed to the ERISA minimum mandate of 60 days) for a participant to submit his/her appeal. In the handling of these appeals, UnumProvident further complies with each of the applicable substantive and procedural requirements in ERISA.

Non-ERISA Appeals
On non-ERISA benefits claim disputes, there is no mandate that a claimant file an appeal. However, as a matter of good faith and customer service, UnumProvident offers each non-ERISA claimant the option and opportunity for a full and fair review of any adverse claim decision. UnumProvident's separate appeals units, as noted above, also handles these appeals.

UnumProvident handles, evaluates and decided each benefits claim in the same thorough, fair and accurate manner, without regard to whether the claim is or is not governed by ERISA.

Age Discrimination In Employment Act (ADEA)

NOTE: Also refer to the section on ADEA in Chapter 2: General Topics.

ADEA I

Age at Disability	Benefit Duration
Less than 60	To age 65, but not less than 5 years
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

T67 ADEA (CXC)

Age at Disability	Benefit Duration
Less than 62	To age 67
62	60 months
63	48 months
64	42 months
65	36 months
66	30 months
67	24 months
68	18 months
69 and over	12 months

ADEAII

Age at Disability	Benefit Duration
Less than 60	To age 65, but not less than 5 years
60-64	5 years
65-69	To age 70, but not less than 1 year of benefits
70 and over	1 year

ADEA III

Age at Disability	Benefit Duration
Less than 70	To age 70, but not less than 1 year of benefits
70 & over	1 year

Customer Care Call Center Quick Code Definitions

Quick Codes	Reason for Call
01	Has medical been received?
02	Have all sections of the claim form been received?*
03	Calling to check the status of claim and is requesting a call back.
04	Change of address: Genesis updated
05	Change of address: Genesis not updated
06	Calling regarding benefit checks
07	Explained DG letter
08	Requesting to speak with a Supervisor

* Sections of the claim form will still be identified as EE, ER, AP & AU

COLA Benefits

	Announced	Withdrawn
Old COLA	5/1/80	———
Increased from 6% to 7%	3/1/82	———
7% COMPOUND COLA (COLA-83)	5/3/83	———
COLA/GPI	3/4/85	———
COLA/Gi Simple 8/9/93	Replaced COLA/GPI, for new issues only.	
COLA/GI Compound	3/9/93	Replaced 7% compand COLA, new issue only

OLD COLA

Any Occ
For Total Disability, Cost of Living Adjustments applied to Monthly Benefit. (Changed from 6% to 7% for periods of disability starting after 10/1/81)
If Residual Disability followed Total Disability during which the Monthly Benefit was increased by COLA, the last Monthly Benefit paid would be frozen and would be used in the formula for Residual while it continued.
For Residual Disability, Cost of Living Adjustments Were applied to Prior Monthly Income (7%)
not operative for Presumptive if Insured was working.
Not operative for 100% Residual claim

7% COMPOUND COLA (previously called COLA-83

Your Occ
For Total disability. Cost of Living Adjustments applied to Monthly Benefit (7%). COLA also applied to the Monthly Benefit used in the Residual formula.
COLA would apply to the Monthly Benefit used in the Residual formula after 12 months regardless of prior Total Disability and would continue to apply while Residual continued.
Cost of Living Adjustments of Prior Monthly Income not included. (This feature was included with Residual* with no percentage limit.)
Operative for Presumptive even if Insured was working
Operative for a 100% Residual claim
Policies 334, 330 and 270 with benefit periods of To Age 65 or longer contained a qualified right to increase the Monthly Benefit to the Adjusted amount (less SIS) after a COLA claim ended and the Insured returned to full-time work.

NOTE: The old COLA on **294. 284 and 273 in-force policies was administratively interpreted as if the policy contained "Your Occ" 7% COMPOUND** COLA. The same premium applied to both.

COLA/GPI vs. 7% COLA (previously called COLA-83)

COLA/GPI contained the features of 7% COMPOUND COLA except for the following differences and additional features:

1. Under COLA/GPI, from 4% up to 12% COLA could be selected.

2. Maximum adjustments to the Monthly Benefit depended on the Maximum COLA Percentage selected and were calculated on a simple interest basis (percentage of original Monthly Benefit) rather than compounded (percentage of preceding Monthly Benefit).

3. No limit OF TWO TIMES THE Monthly Benefit, and no cap (other than age 65).

4. 4% floor for COLA. Should the CPI-U go down during a claim, the Monthly Benefit could decrease, but it could never be less than its original amount at the start of disability increased by 4% of such original amount for each full year of disability

5. There were two portions of this benefit: the pure COLA portion and the Guaranteed Percentage Increase (GPI) option. COLA/GPI offered great flexibility with five combinations shown below to choose from at time of application. If the Maximum COLA Percentage was less than 12%. the Insured could increase the Maximum COLA Percentage by all or part of the remaining/purchased Available GPI in 2% increments. This could be done on any policy anniversary starting with the first and ending with the age 60 policy anniversary without submitting evidence
of physical or financial insurability. An increase in percentage would apply to periods of 'disability starting thereafter.

Maximum COLA Percentage	Available GPi	Aggregate
4%	8%	12%
6%	6%	12%
8%	4%	12%
10%	2%	12%
12%	0%	12%

Neither COLA/GPI nor 7% COMPOUND COLA (COLA-83) could be issued with Residual I or 11. The old Residual had to be replaced by Residual (Otherwise, the policy would be left without indexing of Prior Monthly Income.)

COLA/GI-Simple and COLA/GI-Compound

With the introduction of 338-COLA/GI-S and 338-COLA/GI-C, the Guaranteed Percentage Increase Option was available with simple or compound interest as follows:

1. COLA/GI-Simple continued to have a 4% floor and no cap other than age 65.

2. COLA/Gi-Compound maintained a 4% floor and a cap of two times the monthly benefit.

3. The maximum COLA percentage on both COLAs was lowered from 12% to 10%.

Available combinations for both COLAs:

Maximum COLA Percentage	Available GPI	Aggregate
4%	6%	10%
6%	4%	10%
8%	2%	10%
10%	0%	10%

12/93

U. S. Consumer Price Index File

FROM JAN 80

	1980	1981	1982	1983	1984	1985	1986	1987	1988
JAN	233.20	260.50	282.50	293.10	305.20	316.10	328.40	333.10	346.70
FEB	236.40	263.20	283.40	293.20	306.60	317.40	327.50	334.40	347.40
MAR	239.80	265.10	283.10	293.40	307.30	318.80	326.00	335.90	349.00
APR	242.50	266.80	284.30	295.50	308.80	320.10	325.30	337.70	350.80
MAY	244.90	269.00	287.10	297.10	309.70	321.30	326.30	338.70	352.00
JUN	247.60	271.30	290.60	298.10	310.70	322.30	327.90	340.10	353.50
JULY	247.80	274.40	292.20	299.30	311.70	322.80	328.00	340.80	354.90
AUG	249.40	276.50	292.80	300.30	313.00	323.50	328.60	342.70	356.60
SEP	251.70	279.30	293.30	301.80	314.50	324.50	330.20	344.40	358.90
OCT	253.90	279.90	294.10	302.60	315.30	325.50	330.50	345.30	360.10
NOV	256.20	280.70	293.60	303.10	315.30	326.60	330.80	345.80	360.50
DEC	258.40	281.50	292.40	303.50	315.50	327.40	331.10	345.70	360.90

	1989	1990	1991	1992	1993	1994	1995	1996
JAN	362.70	381.50	403.10	413.80	427.00	437.80	450.30	462.50
FEB	364.10	383.30	403.80	415.20	428.70	439.30	452.00	464.20
MAR	366.20	385.50	404.30	417.20	430.10	441.10	453.50	466.50
APR	368.80	386.20	405.10	417.90	431.20	441.40	455.00	468.20
MAY	370.80	386.90	406.30	418.60	432.00	441.90	455.80	469.00
JUNE	371.70	389.10	407.30	419.90	432.40	443.30	456.70	469.50
JULY	372.70	390.70	408.00	420.80	432.60	444.40	457.00	470.40
AUG	373.10	394.10	409.20	422.00	433.90	446.40	458.00	471.10
SEPT	374.60	397.50	411.10	423.10	434.70	447.50	459.00	
OCT	376.20	400.00	411.50	424.70	436.40	448.00	460.30	
NOV	377.00	400.70	412.70	425.30	436.90	448.60	360.10	
DEC	377.60	400.90	413.00	425.20	436.80	448.90	459.90	