

Agenda Item 2. Receive updated report from the Group Disability Income Subgroup of the Product Standards Committee regarding drafting of Group Disability Income Uniform Standards.

Jason Lapham, Kansas, Chair of the Product Standards Committee (PSC), provided an update on the work of the Group Disability Income Subgroup. The Subgroup meets weekly with the focus of the calls to date on the development of the Core Group Disability Income Insurance Policy and Certificate Uniform Standards for Employer Groups. The PSC had a Public Call in January to review the first four sections of the draft and receive Public Comment. Since that time the Product Standards Committee had two member calls to discuss the comments and consider revisions. The Subgroup has now completed revisions to §5. REHABILITATION PROVISIONS and § 6. OPTIONAL PROVISIONS and the purpose of this call is to receive public comments on the redlined draft of these provisions.

Agenda Item 3. Receive Public Comments on additional revisions to “Disability,” “Partial Disability” or “Residual Disability,” and “Total Disability” in §3 TERMS AND CONCEPTS of the draft GROUP DISABILITY INCOME INSURANCE POLICY AND CERTIFICATE UNIFORM STANDARDS FOR EMPLOYER GROUPS.

The Chair noted that prior to the call, the IIPRC office distributed the redline draft of the Group Disability Income Uniform Standards which included recommendations for revisions to the definitions of the terms “Disability,” “Partial Disability” or “Residual Disability,” and “Total Disability.” There were no comments or questions on this agenda item.

Agenda Item 4. Receive Public Comments on §5. REHABILITATION PROVISIONS of the draft GROUP DISABILITY INCOME INSURANCE POLICY AND CERTIFICATE UNIFORM STANDARDS FOR EMPLOYER GROUPS..

The Chair noted that written comments related to §5 were received from the Industry Advisory Committee. Miriam Krol, ACLI, representing the Industry Advisory Committee, provided an overview of the key comments in this section.

In reference to the proposed revisions to (2) (b) and (d), Ms. Krol stated that Industry had concerns with the reference to “any expenses” in the sentence “If the insurance company requires the *Covered Person* to pay any expenses associated with a rehabilitation plan, the *Covered Person’s* participation in the rehabilitation plan shall be voluntary.” She gave examples of insurance companies covering the expenses for major items of a rehabilitation plan but not covering ancillary de minimis expenses such as mileage, internet access or meals.

In reference to the phrase “where ‘good cause’ means a medical reason documented by the *Covered Person’s* treating physician preventing implementation of the rehabilitation plan” added to item (2)(d), Ms Krol stated that insurance companies need the ability to determine good cause like they determine other medical issues relating to disability. While the treating physician’s opinion would be considered, it cannot be binding on the company. Regulators suggested that the next steps in the process should be included in the standards, so the claimant has an ability to appeal if the treating physician’s determination conflicts with the insurance company’s. It was suggested that provisions similar to those under the Additional Standards for Accelerated Death Benefits be considered. Ms Krol stated that Industry would submit additional language for consideration.

There were no further oral comments from other parties on this agenda item.

Agenda Item 5. Receive Public Comments on § 6. OPTIONAL PROVISIONS of the draft GROUP DISABILITY INCOME INSURANCE POLICY AND CERTIFICATE UNIFORM STANDARDS FOR EMPLOYER GROUPS.

Miriam Krol provided an overview of the industry's key written comments in this section. In reference to the recommendation to delete H. Procedures For review of a Denial of a Claim and insert a required provision in §4 Claims Provisions to require Procedures for Review of Claim Determinations, Ms. Krol stated that the language inserted from the Individual Disability Income standards only addresses facility of payment determinations where payment of any indemnity under the policy to an estate or a beneficiary may be challenged. It is Industry's position that the process for each claim is determined by the claim specifics such as type of disability involved, type of injury or sickness involved, timelines involved, information required, etc. Initial claim determinations would require a different process than the process required for determination of ongoing claims. As such, Industry opposes the addition of this requirement.

Industry supported retaining the original language as they drafted it so that employers subject to ERISA can elect to include this information in the certificate and any other employer may also do so, even though not required to by ERISA. Ms. Krol emphasized that reference to ERISA is not included and urged the PSC to reconsider reinstating the deletion and including it in a way that allows the employer and the insurance company to decide what is required or appropriate.

Ms. Krol noted that Industry objected to the additions to the Authority provision that reference "initial" determinations. She stated that the language could be interpreted to mean that a policyholder does not have the right to make "periodic ongoing" determinations which can also require interpretation of the terms of the policy and certificate. Industry submitted written substitute language for consideration. Regulators asked whether it would make sense to delete the provision or to include it under the Claim Provision in § 4. Ms. Krol said she would discuss this with the insurance company representatives.

Under the Subrogation provision, Ms. Krol stated that Industry agreed that any subrogation would be subject to state laws for any right of recovery and would expect that "deducting anticipated recovery" is also addressed by state recovery laws, so the additional language should indicate that the insurance company may only deduct anticipated recovery from a third party from benefits paid if applicable state law permits such deduction. Fred Nepple, of the Consumer Advisory Commission, asked why this issue is included in the proposal since under the principles of subrogation, subrogation rights do not arise until benefits have been paid. The Chair asked Mr. Nepple if he could submit his comments in writing to the Committee.

There were no further oral comments from other parties on this agenda item.

Agenda Item 6. Any Other Matters

The Chair requested that if any parties have additional feedback, they submit written comments to comments@insurancecompact.org. He stated that the PSC will review the comments and consider the revisions to these sections of the Uniform Standards. The Group Disability Income Subgroup will continue its review and development of the Uniform Standards with completion of its review of § 7 PERMISSIBLE LIMITATIONS OR EXCLUSIONS, § 8 PROHIBITED LIMITATIONS AND EXCLUSIONS and §9 BENEFIT PROVISIONS of the draft uniform standards and the PSC will schedule another Public Call to discuss the recommendations.

GROUP DISABILITY INCOME INSURANCE POLICY AND CERTIFICATE UNIFORM STANDARDS FOR EMPLOYER GROUPS

Note: Revisions to the draft for the Scope and § 1 - 6 are in red.

Updates and Public comments are included in bordered and dated notations below each revision

The complete original Industry draft through §9 is available by [clicking here](#). § 10 Incidental Benefits is available [here](#).

Scope: These standards are intended to apply to paper or electronic group disability income insurance policies and certificates that are issued to an employers, or the trustees of a fund established by an employer, that are permitted in the jurisdiction where the policy is delivered or issued for delivery. The policies provide benefits to eligible *Covered Persons*.

~~Separate additional standards will apply to These standards may include~~ business overhead expense benefits, and insurance companies may provide these as part of a group disability income insurance policy and certificate, or the benefits may be provided under a separate group business overhead expense policy and certificate.

As used in these standards, “disability income” means group coverage that provides periodic income if a *Covered Person* becomes *Disabled*.

~~Separate additional standards will apply for buy-sell plans and key-person plans. Consult the Interstate Insurance Product Regulation Commission website to determine when these additional standards are available for filing.~~

Combination policies for IIPRC-approved group life, group disability income and group long term care insurance may be filed with the Interstate Insurance Product Regulation Commission as soon as the standards for these products are available for filing with the Interstate Insurance Product Regulation Commission.

Mix and Match: These standards are available to be used in combination with State Product Components as described in Section 110(b) of the Operating Procedure for the Filing and Approval of Product Filings. These standards are available to be used in combination with IIPRC-approved or state-approved group disability income insurance forms.

Self-Certification: Group disability income insurance policy and certificates filed under these standards are not available to be filed using the Rule for the Self-Certification of Product Components Filed with the Interstate Insurance Product Regulation Commission.

10/28/14 - IIPRC Staff Update: The Subgroup will discuss combination products and Mix and Match once the draft standards are finalized.

As used in these standards the following definitions apply:

“Application” means any form used by a policyholder to apply for a group disability income insurance policy. The application shall be filed for approval.

“Certificate” means the document which describes the *Covered Person’s* benefits and rights under the policy, and which includes any riders, endorsements or amendments, notices or other attachments to the certificate.

“Policy” means the group disability income insurance policy issued to the policyholder that includes any riders, endorsements or amendments, notices or other attachments to the policy.

“Policyholder” means the entity to whom the policy is issued.

“Signed or signature” means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

“Written or writing” means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Drafting Note:

Other terms may be used in the policy and certificate provided that they are used consistently.

10/28/14 - IIPRC Staff Update: The PSC had no further revisions to the Scope

§ 1. ADDITIONAL SUBMISSION REQUIREMENTS

A. GENERAL

The following additional filing submission requirements shall apply:

- (1) For new filings, the filing shall indicate the respective policy, policyholder application, certificate, statement of insurability, as applicable, that will be used with the form(s) being filed.
- (2) All forms filed for approval shall be included with the filing. Changes to a previously approved form shall be highlighted.
- (3) Subsequent group disability income form filings submitted for approval shall include only those forms being submitted for approval and should specify any other forms previously approved by the IIPRC that will be used with the subsequently filed forms.

- (4) The specifications page of the policy and certificate shall be completed with hypothetical data that is realistic and consistent with the other contents of the policy or certificate.
- (5) If a filing is being submitted on behalf of an insurance company, include a letter or other document authorizing the firm to file on behalf of the insurance company.
- (6) If the filing contains an insert page, include an explanation of when the insert page will be used.
- (7) If the policy or certificate contains variable items, include the Statement of Variability. The submission shall also include a certification that any change or modification to a variable item shall be administered in accordance with the requirements in the Variability of Information section, including any requirements for prior approval of a change or modification.
- (8) Include a certification signed by an insurance company officer that the policy and certificate forms each have a minimum Flesch Score of 50.
- (9) Include a description of any innovative or unique features of each form.

B. VARIABILITY OF INFORMATION

- (1) Any information appearing in the policy and certificate that is variable shall be bracketed or otherwise marked to denote variability. The submission shall include a Statement of Variability that will discuss the conditions under which each variable item may change.
- (2) Variability shall be limited to policy and certificate definitions, periods of time, percentages, numerical values, benefits available, benefit schedules and amounts, eligibility rules and other plan parameters that are subject to the policyholder's plan design.
- (3) Variability may not be used unilaterally by the insurance company to change or modify in-force group coverage if such change or modification would have the effect of increasing premiums or decreasing benefits, unless the policy reserves the right of the policyholder or the insurance company to effect such change or modification under the terms of the group coverage, or unless such change or modification is required by state or federal law.
- (4) The Statement of Variability shall discuss both the conditions under which each variable item may change as well as alternative content to which the item may change. The Statement of Variability shall present reasonable and realistic ranges for the item that may change. A zero entry for a range of values on the specifications page for any benefit or credit provided for in the policy or certificate is unacceptable. Any change to a range requires a re-filing for prior approval.

Drafting Note: In situations where multiple classes are included in one certificate or multiple benefits options are included in one certificate an entry such as “not applicable” or “not applied for” or “as shown in the enrollment form” is acceptable.

- (5) Notwithstanding paragraph (1) above, the following items may be denoted as variable and changed without notice or prior approval:
 - (a) Items such as the insurance department address and telephone number, insurance company address and telephone number, officer titles, and signatures of officers located in other areas of the policy and certificate; and
 - (b) Items that would be considered illustrative such as name of policyholder or *Certificateholder*, policy and certificate number, covered or eligible class, effective dates, the jurisdiction where the policy is delivered or issued for delivery, etc.

C. READABILITY REQUIREMENTS

- (1) The policy and certificate text shall achieve a minimum score of 50 on the Flesch reading ease test or an equivalent score on any other approved comparable reading test. See Appendix A for Flesch methodology.
- (2) The policy and certificate shall be presented, except for specification pages, schedules and tables, in not less than ten point type, one point leaded.
- (3) The style, arrangement and overall appearance of the policy and certificate shall give no undue prominence to any portion of the text of the policy or to any riders, endorsements or amendments.
- (4) The policy and certificate shall contain a table of contents or an index of their principal sections, if the policy and certificate have more than 3,000 words printed on three or fewer pages of text or if the policy and certificate have more than three pages regardless of the number of words.

11/4/14 - IIPRC Staff Update: The Group DI Subgroup had no recommended revisions to § 1.

§ 2. GENERAL FORM REQUIREMENTS

A. POLICY AND CERTIFICATE STRUCTURE

- (1) The policy shall include the provisions applicable to the policyholder and may or may not include the provisions applicable to *Covered Persons* if such provisions are included in a separate certificate. Regardless of the structure selected, the certificate shall always include the provisions applicable to *Covered Persons*. These group disability income standards assume that the policy includes the provisions applicable to the policyholder and the certificate includes the provisions applicable to *Covered Persons*.

- (2) A *Covered Person's* benefits and rights under the policy shall not be less than those stated in the certificate.
- (3) The standards allow policies or certificates to be delivered in a paper or electronic format. If electronic format is used, the insurance company shall describe the procedures that will be used to deliver the policy or certificate. Upon request, the policyholder or its plan administrator shall deliver a paper copy of the certificate to the *Covered Person*.

B. CERTIFICATES

- (1) The policy shall include a provision regarding certificates. The provision shall state that the insurance company shall provide certificates for delivery to each *Covered Person*.
- (2) The certificate shall describe the benefits and rights under the certificate.
- (3) The certificate shall state that the insurance company certifies that the *Covered Person* is insured for the benefits described in the certificate, subject to the provisions of the certificate.
- (4) The certificate may state that the policy is a contract between the insurance company and the policyholder and may be changed or ended without the *Covered Person's* consent.
- (5) The certificate shall include a statement in prominent print instructing the *Covered Person* to read the certificate carefully and note that insurance benefits may be subject to certain requirements, reductions, limitations and exclusions. "Prominent print" means, for example, all capital letters, contrasting color, underlined or otherwise differentiated from the other type on the form.
- (6) If the certificate is issued to replace a certificate previously issued by the insurance company, the certificate shall state that it replaces such previous certificate.
- (7) The certificate may state that it is not valid unless the insurance company's certificate confirmation statement is attached to the certificate. The confirmation statement may include its date of print, insurance company name, *Covered Person's* name, address, tax identification number, date of hire, insurance benefits, amounts and effective dates.
- (8) The certificate shall state that the *Covered Person* may inspect a copy of the policy.

C. COVER PAGE OR FIRST PAGE

- (1) The full corporate name, including city and state of the insurance company shall appear in prominent print on the cover page or first page of the policy and the certificate.

- (2) A marketing name or logo may also be used on the cover page or first page of the policy and certificate provided that the marketing name or logo does not mislead as to the identity of the insurance company.
- (3) The insurance company's complete mailing address for the home office or the office that will administer the benefit provisions of the policy shall appear on the cover page or first page of the policy and the certificate. The cover page or first page of the policy and the certificate shall include a telephone number of the insurance company or, if available, some method of Internet communication.
- (4) The telephone number of the insurance department of the state where the policy is delivered or issued for delivery is required on either the cover page or first specifications page of the certificate.
- (5) Two signatures of insurance company officers shall appear on the cover page of the policy.
- (6) A form identification number shall appear at the bottom of the form in the lower left hand corner of the policy and certificate. The form number shall be adequate to distinguish the form from all others used by the insurance company. The form number shall include a prefix of ICCxx (where xx represents the appropriate year the form was submitted for filing) to indicate it has been approved by the Interstate Insurance Product Regulation Commission.
- (7) A brief description shall appear in prominent print on the cover page or first page of the policy or be visible without opening the policy. A brief description shall appear in prominent print on the cover page or first page of the certificate or be visible without opening the certificate. The brief description shall contain at least a caption of the type of coverage provided, such as group disability income insurance. The brief description of the policy shall also indicate whether the policy is participating or nonparticipating.
- (8) The policy cover page or first page, or specifications page, shall identify:
 - (a) The name of the policyholder;
 - (b) The policy number;
 - (c) The effective date of the policy; and
 - (d) The jurisdiction in which the policy is issued for delivery, and the policy shall state that the laws of such jurisdiction shall govern the policy.
- (9) The certificate may be issued on a named basis or no-name basis.
 - (a) For named basis certificates, the certificate cover page or first page, or specifications page, shall identify:
 - (i) The name of the policyholder;

- (ii) The policyholder's policy number;
 - (iii) The policyholder's mailing address and telephone number and, if available, some method of Internet communication;
 - (iv) The name of the *Covered Person*;
 - (v) The certificate number; and
 - (vi) The effective date of the *Covered Person's* insurance provided by the certificate; and
- (b) For no-name basis certificates, the certificate cover page or first page, or specifications page, shall identify:
- (i) The name of the policyholder;
 - (ii) The policy number; and
 - (iii) The policyholder's mailing address and telephone number and, if available, some method of Internet communication.

The eligibility requirements and the rules for determining the effective date of insurance for *Covered Persons* shall be included in the certificate.

D. SPECIFICATIONS PAGE

- (1) The specifications page of the policy and certificate shall include the benefits, amounts, durations, which insurance is contributory and which insurance is noncontributory, and any other benefit data applicable to each class of eligible *Covered Persons*. As an alternative to the completion of a policy specifications page only, the insurance company may attach a sample of each certificate representing each eligible class and its corresponding benefits provided under the policy or refer to the certificates.
- (2) If the policy is a participating policy, the policy specifications page shall indicate that the dividends are not guaranteed. However, if the insurance company does not expect to credit dividends, then the policy specifications page shall state that dividends are not expected to be paid.

E. FAIRNESS

The policy and certificate shall not contain inconsistent, ambiguous, unfair, inequitable or misleading clauses, provisions that are against public policy as determined by the Interstate Insurance Product Regulation Commission, or contain exceptions and conditions that

unreasonably affect the risk purported to be assumed in the general coverage of the policy and certificate.

11/4/14 - IIPRC Staff Update: The Group DI Subgroup had no recommended revisions to § 2.

§ 3. TERMS AND CONCEPTS

The policy and the certificate shall define certain terms or describe concepts that, as used, will have specific meanings. If the policy or certificate includes the terms ~~and~~ or describes the concepts set forth below, the definitions of the terms or descriptions of the concepts shall be consistent with the standards set forth below. ~~policy and certificate shall define the terms or describe the concepts in a manner consistent with the policyholder's plan and the insurance company's underwriting guidelines. The terms and concepts included below reflect the parameters that are common in the group disability income market today, but may vary from insurance company to insurance company and policyholder to policyholder. Consequently, the terms included below are examples of language used in group disability income filings today, but are not intended to prescribe how each insurance company and each policyholder should define their terms or describe their concepts. The actual terms or concepts may vary as long as the language used to define the actual terms or describe the concepts is consistent with the standards set forth below.~~ The insurance company may identify defined terms or concepts by initial capitalization, italicizing, bolding or other form of highlighting. The plural use of terms defined in the singular shall share the same meaning.

10/28/14 - IIPRC Staff Update: The PSC believes the changes proposed are consistent with other approved Uniform Standards and allow the flexibility that industry states it is seeking. Comments received to date have not explained why the revisions do not provide the flexibility and variability needed to accommodate group products.

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC provided the following comments for the PSC's consideration:

Preamble The requirement for "consistency" side by side with the permitted variability requires further discussion. For example, in item (1) "Actively at Work or Active Work", will a company be permitted to file a definition/concept that will include "on a *Full-Time* basis" and show the specified period of time in the definition/concept of item (17) "Full-Time"? If the answer is "yes", then why is the proposed change necessary, especially when the item is reflecting what is currently operational for Group Term Life products?

The omitted reference to "in a manner consistent with the policyholder's plan" would enable a trustee arrangement or an association arrangement to include concepts not included in this section because the standards currently address "single employer groups" but will change in the future to accommodate other group types. The reference to "in a manner consistent with the insurance company's underwriting guidelines" was intended to only allow companies to include concepts/definitions that can be supported by underwriting guidelines, such as definition/concept of Total, Partial/Residual or Presumptive Disability. One may argue these are not necessary; we argue that these references are helpful in documenting the intent of the section.

2/4/15 IIPRC Staff Update following the PSC Member Call 1/27/15: The PSC reiterated its observations that unlike the Group Term Life Terms and Concepts, this draft contained some terms and concepts that impacted eligibility and benefits. As such, they believe it is important that the preamble states that definition, although not required to contain the exact language, must be consistent with the standard. Once the Group Disability Income Uniform Standards are finalized, the PSC observed that they will review whether a conforming amendment is warranted for the Group Term Life uniform Standards.

- (1) “**Actively at Work or Active Work**” means that a *Covered Person* is performing all of the *Substantial and material duties* of the *Covered Person’s Job, Occupation or Specialty*, as applicable, ~~on a Full-Time basis~~ for at least the number of hours required for coverage eligibility. This may be done at the policyholder’s place of business, an alternate place approved by the policyholder, or a place to which the policyholder’s business requires the *Covered Person* to travel. ~~The concept may state that a~~ A *Covered Person* will be deemed to be *Actively At Work* on weekends or policyholder approved vacations, holidays or temporary business closures if the *Covered Person was Actively at Work* on the last scheduled work day preceding such time off. As used in this definition/concept, ‘temporary business closure’ shall include temporary closure required for reasons such as inclement weather, power outage, public health agency orders.

1/21/15 - IIPRC Staff Update following the Public Call 1/13/15: Following the Public Call, the IAC offered the following revised comments:

“*Actively at Work or Active Work*” We noted that the IIPRC would allow a company to file the definition/concept with “on a Full-Time basis”, so we question the need to delete these words.

In addition, the suggested rewrite is not appropriate since there is a significant difference between “eligibility for the coverage” and “eligibility for a benefit”. A *Covered Person* may be covered under the policy but still not qualify (be eligible) for a benefit provided under the policy. Accordingly, the use of “benefit eligibility” is inaccurate and misleading.

We strongly recommend that you reinstate the reference to “Full-Time” and maintain the consistent approach to group standards.

While it is unlikely that an employer/policyholder will not allow the “actively at work” status on weekends or for approved vacations or holidays, or for temporary business closures for reasons such as inclement weather, power outage, or public health issues (workplace contamination), a business closure for longer durations is another matter.

We suggest that we change “business closure” to say “temporary business closure” and define “temporary business closure” by adding the following to the end of the definition/concept:

“As used in this definition/concept, ‘temporary business closure’ shall include temporary closure required for reasons such as inclement weather, power outage, public health agency orders, and only in situations where the policyholder has notified *Covered Persons* of such temporary closure.”

If these changes are agreed to, then we suggest that the same changes be made to the Group Term life standards so that there is a uniform approach to this definition/concept.

Based on those comments, the following revision is proposed for the PSC's consideration. The PSC may also wish to discuss if it wants to revert to the "on a *Full Time* basis" language or make consistent changes to the Group Term Life Uniform Standards.

"Actively at Work or Active Work" means that a *Covered Person* is performing all of the *Substantial and material duties* of the *Covered Person's Job, Occupation or Specialty*, as applicable, ~~on a *Full Time* basis~~ for at least the number of hours required for benefit coverage eligibility. This may be done at the policyholder's place of business, an alternate place approved by the policyholder, or a place to which the policyholder's business requires the *Covered Person* to travel. ~~The concept may state that a~~ A *Covered Person* will be deemed to be *Actively At Work* on weekends or policyholder approved vacations, holidays or **temporary** business closures if the *Covered Person was Actively at Work* on the last scheduled work day preceding such time off. As used in this definition/concept, 'temporary business closure' shall include temporary closure required for reasons such as inclement weather, power outage, public health agency orders, and only in situations where the policyholder has notified Covered Persons of such temporary closure.

2/4/15 IIPRC Staff Update following the PSC Member Call 1/27/15: The PSC did not agree with the Industry comment to revert to the original draft language of "on a Full-Time basis" and using variability to cover Part Time employees. They agreed to the Industry comment that there is a difference between "eligibility for the coverage" and "eligibility for a benefit." They also agreed in part with the recommendations for referencing temporary business closure, questioning why it was limited to only situations where the policyholder has notified *Covered Persons* of such temporary closure. The PSC agreed to the following revision to the definition:

"Actively at Work or Active Work" means that a *Covered Person* is performing all of the *Substantial and material duties* of the *Covered Person's Job, Occupation or Specialty*, as applicable, ~~on a *Full Time* basis~~ for at least the number of hours required for benefit coverage eligibility. This may be done at the policyholder's place of business, an alternate place approved by the policyholder, or a place to which the policyholder's business requires the *Covered Person* to travel. ~~The concept may state that a~~ A *Covered Person* will be deemed to be *Actively At Work* on weekends or policyholder approved vacations, holidays or **temporary** business closures if the *Covered Person was Actively at Work* on the last scheduled work day preceding such time off. As used in this definition/concept, 'temporary business closure' shall include temporary closure required for reasons such as inclement weather, power outage, public health agency orders.

- (2) **"Benefit Period"** means, subject to satisfaction of all certificate terms and conditions by the *Covered Person*, the length of time for which a *Disabled Covered Person* can be paid periodic income benefit amounts under the certificate. A certificate shall provide for at least 4 weeks of periodic income benefits for short term disability plans, and 12 months of periodic income benefits for long term disability plans.

- (3) “*Certificate Anniversary*” means the specified period of time (such as one year) following the effective date of the certificate, and each subsequent period.
- (4) “*Certificate Month*”. The first certificate month begins on the effective date of the certificate. Subsequent certificate months will begin on the same day of each subsequent calendar month.
- (5) “*Child*” shall include any children ~~required to be covered under the~~ of a civil union, domestic partnership, marriage or other family or domestic relationship where required by laws of the state where the policy is delivered or issued for delivery. The term may include the *Covered Person’s* biological/natural children, adopted children, children placed for adoption, and other children in whose lives the *Covered Person* has an insurable interest. The limiting age for a child will be specified in the appropriate benefit sections that provide benefits for a child.
 - (a) Any or all of the following conditions may also be included for the definition of “*Child*”:
 - (i) That the *Child* shall be unmarried or not in a legally-sanctioned domestic partnership or civil union as recognized by applicable state law in the state where the policy is delivered or issued for delivery;
 - (ii) That the *Child* shall reside with the *Covered Person*;
 - (iii) That the *Child* shall be supported by the *Covered Person*, whether in whole or in part;
 - (iv) That the *Child* shall be eligible to be claimed by the *Covered Person* for federal income tax purposes;
 - (v) That the *Child* shall not be on full-time active duty in the armed forces of any country or subdivision thereof;
 - (vi) That the *Child’s* legal residence shall not be outside the United States, its territories or possessions, or Canada; and/or
 - (vii) That the *Child* shall not be insured under the policy in any other capacity, such as an *Employee*;
 - b) Beginning at age 19, the following conditions may also be included:
 - (i) A condition that the *Child* not be employed on a *Full-Time* basis; and/or.
 - (ii) A condition that the *Child* be a full-time student at a school, college or university (an accreditation requirement and/or a requirement that the school, college or university is licensed in the jurisdiction where it is located may also be included); coverage may also be extended to part-time

students of such institutions and/or a *Child* in the service of a non-profit organization during the period of such service.

For purposes of this subparagraph (ii) above, the terms “full-time” and “part-time” may be defined based on credit or course load requirements; and

- (c) If the policy and certificate are delivered or issued for delivery in different states, the certificate shall, if required, comply with the applicable marriage laws, including marriage case law, of the state where the certificate is delivered or issued for delivery and, if required, with the applicable domestic partnership and civil union laws of such state, with respect to coverage available for marital relationships, domestic partnerships, or civil unions.

10/28/14 - IIPRC Staff Update: The PSC had no further revisions to this definition.

- (6) “**Conditionally Renewable**” means that renewal of the policy is based on certain conditions, which shall be clearly described in the policy.
- (7) “**Contribution**” means the amount the policyholder may require the *Covered Person* to pay towards the total premium that the insurance company charges for the insurance provided under the policy.
- (8) “**Contributory Insurance**” means insurance for which the policyholder requires the *Covered Person* to pay any part of the premium. The certificate shall specify which insurance is contributory.
- (9) “**Cost of Living Index**” means an index used to measure the rate of change over time of the cost of living, such as the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. The index shall be specified in the certificate. The certificate shall state that if any index is discontinued or if the calculation of any index is changed substantially, the insurance company may substitute a comparable index subject to approval by the Interstate Insurance Product Regulation Commission. The approval shall be contingent on the insurance company providing the Interstate Insurance Product Regulation Commission with either confirmation that the index has been discontinued or documentation of the substantial change to the index and the reasons supporting the need for the index to be discontinued. The certificate shall also state that, before a substitute index is used, the insurance company shall notify the *Covered Person* of the substitution.

If the index is temporarily delayed, the insurance company may compute the value of any benefits due during the period the index is unavailable using any method that takes into consideration the most recently available information with respect to the index. Once the index becomes available, the insurance company shall adjust any future benefits payable to reflect any benefit overpayments or underpayments made while the index was unavailable.

(10) **“Covered Person”** means each person insured under the group policy as defined by the policyholder. Covered Person shall be all of the employees of the employer, or all of any class or classes thereof. The policy may define “employees” to include:

- a) the employees of one or more subsidiary corporations;
- b) the employees, individual proprietors and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;
- c) the retired ~~e~~Employees, or former ~~e~~Employees and directors of a corporate policyholder/employer; and
- d) the directors of a corporate policyholder/employer; and
- e) for a policy issued to insure the employees of a public body, elected or appointed officials.

Covered Person does not include third party administrators, associations, discretionary trusts and other groups where there is not a direct working relationship with the policyholder.

10/23/14 - IIPRC Staff Update: The PSC provides the following options for comment:

Option 1: (Language proposed by the Industry and amended by the Subgroup) Such person will have a working relationship with the policyholder, such as employees, members of the policyholder’s Board of Directors, members of a limited liability company if the policyholder is a limited liability company, and business partners of the policyholder. For each working relationship, the certificate will include the specific eligibility requirements, and some definitions/concepts will be adapted accordingly so that they are specific to the working relationship. Examples of some definitions/concepts that would need adaptation are: “full-time”, “actively at work or active work”, “disability or disabled”, “job”, “occupation”, “regular job”, “regular occupation”, “regular specialty”, “specialty”, “substantial and material duties”.

Covered Person does not include third party administrators, associations, discretionary trusts and other groups where there is not a direct working relationship with the policyholder.

The following would include the language found under Section 4. Permitted Groups in Model 100. Model 100 or related state laws or regulations have been adopted by all but two IIPRC member states.

Option 2: (10) **“Covered Person”** means each person insured under the group policy as defined by the policyholder. Covered Person shall be all of the employees of the employer, or all of any class or classes thereof. The policy may define “employees” to include:

- a) The employees of one or more subsidiary corporations;
- b) The employees, individual proprietors and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;
- c) The retired employees, former employees and directors of a corporate employer; and

- d) For a policy issued to insure the employees of a public body, elected or appointed officials.

11/4/14 - IIPRC Staff Update: The Group DI Subgroup deferred further discussion on this definition pending further input and seeks Public Comment on the two options.

1/21/15 - IIPRC Staff Update following the Public Call 1/13/15: The IAC provided the following comments:

“Covered Person” The language we proposed was supported by the Model but since Option 2 Model approach is more inclusive in its items (c) and (d), we recommend the Option 2 Model approach. We note that the proposed language is not consistent with the terminology used in the standards, and we also note that the Model item (c) can lead to a misinterpretation that only retired employees and former employees of corporate employers can be covered; we believe the intent was to have “of corporate employers” only modify the terms “directors”. In addition, since the policyholder may be a single employer trustee, we need to address the policyholders who are employers

Based on the IAC’s comment, the PSC may wish to consider the following revision to the definition of *Covered Person* listed as Option 2:

“***Covered Person***” means each person insured under the group policy as defined by the policyholder. *Covered Person shall be all of the employees of the employer, or all of any class or classes thereof. The policy may define “employees” to include:*

- a) the employees of one or more subsidiary corporations;
- b) the employees, individual proprietors and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;
- c) the retired ~~e~~Employees; or former ~~e~~Employees ~~and directors~~ of a ~~corporate~~ policyholder/employer; ~~and~~
- d) the directors of a corporate policyholder/employer; and
- e) for a policy issued to insure the employees of a public body, elected or appointed officials.

2/4/15 IIPRC Staff Update following the PSC Member Call 1/27/15: The PSC agreed to the second option with the recommended changes proposed by Industry. They also wanted to add the sentence currently listed in the first option making it clear that certain entities without a direct working relationship with the policyholder are not *Covered Persons*.

“***Covered Person***” means each person insured under the group policy as defined by the policyholder. *Covered Person shall be all of the employees of the employer, or all of any class or classes thereof. The policy may define “employees” to include:*

- f) the employees of one or more subsidiary corporations;
- g) the employees, individual proprietors and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

- h) the retired ~~e~~Employees; or former ~~e~~Employees ~~and directors~~ of a corporate policyholder/employer; ~~and~~
- i) the directors of a corporate policyholder/employer; and
- j) for a policy issued to insure the employees of a public body, elected or appointed officials.

Covered Person does not include third party administrators, associations, discretionary trusts and other groups where there is not a direct working relationship with the policyholder.

(11) **“Dependent”** means the *Covered Person’s Child(ren)* and/or *Spouse*.

(12) **“Disability”** or **“Disabled”** means that due to *Injury* or *Sickness*, a *Covered Person* meets ~~definition of *Partial Disability*, *Residual Disability* or *Total Disability*, or other types of disability approved by the Interstate Insurance Product Regulation Commission.~~ benefit triggers specified in the certificate.

As stated in §4.N. of these standards, a Disability income certificate shall provide a benefit for at least Total Disability. In addition to the Total Disability benefit, and at the insurance company’s option, a Disability income certificate may or may not provide coverage for any one or more of the other Disability benefit triggers shown below.

If Total Disability and an additional Disability benefit, such as Partial Disability or Residual Disability benefit, are included in the certificate, the certificate shall specify if such additional Disability benefit triggers may only apply after a specified period of Total Disability benefits have been paid under the certificate, or if such benefit triggers shall apply as soon as the Covered Person meets such benefit triggers.

A certificate may specify that the Total Disability requirements will apply for a specified period of time, after which other benefit triggers shall apply. In this case, the certificate shall specify the period of time for which the Total Disability requirements shall apply and one or more of the other benefit triggers that would apply after the end of the specified period for Total Disability. [For example, a certificate would include a Total Disability benefit with the specified triggers in item (43) for the first 24 months of Total Disability, and specify activities of daily living deficiency or cognitive impairment Disability benefit triggers thereafter.]

The additional Disability benefit triggers are:

(a) *Partial Disability* or *Residual Disability*;

(b) *Presumptive Disability*;

(c) a Covered Person is terminally ill with a life expectancy of 12 months or less, as certified by a Physician;

- (d) a Covered Person is unable to perform one or two of the following six activities of daily living : bathing, dressing, toileting, transferring, continence or eating;
- (e) a Covered Person is cognitively impaired, suffering significant and irreversible deterioration or loss of intellectual capacity, as measured by clinical evidence and standardized tests commonly accepted for use in the medical community;
- (f) a Covered Person is confined as an inpatient in a Skilled Nursing Home or Rehabilitation Facility where a daily room and board charge is made;
- (g) a Covered Person is receiving Home Health Care or Hospice Care;
- (h) a Covered Person has an impairment rating above a specified percentage similar to the concept used by Workers' Compensation, as would be specified in the certificate;
- (i) a Covered Person is eligible for or receiving Social Security Disability Insurance;
- (j) a Covered Person is a risk for transmitting a contagious disease. A Covered Person may be capable, physically and mentally, of performing the Substantial and material duties described above, but the ability to perform these duties is restricted by a state licensing board or by another appropriate government authority because the risk of transmission of a contagious disease to others with whom the Covered Person may be in contact. In this situation, the Covered Person will be considered to be Disabled in any month in which the Covered Person has a contagious disease and in which the restrictions stated above prevent the Covered Person from earning more than a stated percentage of his monthly pay as specified in the certificate, such as 80%; or
- (k) other types of Disability approved by the Interstate Insurance Product Regulation Commission.

As used in this section, "contagious disease" means asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), the multi-drug resistant Tuberculosis or other such conditions as defined by the Centers for Disease Control and Prevention.

If applicable, the certificate shall define the terms "Skilled Nursing Home", "Rehabilitation Facility", "Home Health Care" and "Hospice Care" in relation to the level of skill required, the nature of the care and the setting in which care shall be given.

The benefits in triggers (d), (e), (f) and (g) above shall not be advertised, marketed or sold as long-term care insurance and the certificate shall prominently disclose that benefits under the certificate will not be triggered by, or calculated with respect to, occurrence or amount of any long-term care services.

There shall not be a requirement that ~~A a Covered Person shall not be required to~~ be unable to perform “any *Occupation or Specialty* whatsoever”, “any duty”, or “each and every duty” or words of similar import.

An insurance company may require, according to standard medical practice:

- (a) that a *Covered Person* be under the regular care, treatment and/or attendance by a *Physician* to effectively treat and manage the *Covered Person’s Disability*;
- (b) that the regular care, treatment and/or attendance is provided by a *Physician* whose specialty or experience is appropriate for the *Disability*; and
- (c) that the regular care, treatment and/or attendance be appropriate for the *Disability* in conformance with standards medical practice.

If it is determined by standard medical practice that a *Covered Person’s Disability* does not require frequent or regular care, treatment and/or attendance by a *Physician*, then neither will the insurance company.

2/4/15 IIPRC Staff Update following the Public Call 1/13/15: On January 28, the IAC submitted the following revised comments recommending revisions to the definition of “*Disability*” or “*Disabled*”. We would suggest that for clarity, the PSC review the suggested revisions to “*Disability*” or “*Disabled*”, “*Partial Disability*” or “*Residual Disability*” and “*Total Disability*” together.

I am attaching above a substitute attachment to the comments we submitted on 1/22/15. It is important to note that while Total Disability is required to be included, there are variations on whether it is the only Disability benefit payable, if it is the first Disability benefit payable, if it may be bypassed by a less strict benefit trigger, such as Partial/Residual or ADL deficiencies, or if it is payable for a specified period of time and then other triggers may be required for the benefits to continue.

Examples:

If a Total Disability benefit is sold with an additional Disability benefit, such as Partial/Residual, an employer can elect to require that a Covered Person receive a specified period of benefits for Total Disability before the Covered Person can receive Partial/Residual benefits, or an employer can allow a Covered Person to bypass the Total Disability requirements and collect Partial/Residual benefit if he is eligible for these.

An employer may also require that Total Disability benefits be the only benefits available for a specified period, such as 24 months, and after that time period other Disability benefit triggers may be required to continue to receive Disability benefits.

The language we are submitting attempts to cover all of these possibilities.

“Disability” or “Disabled” means that due to Injury or Sickness, a Covered Person meets definition of Partial Disability, Residual Disability or Total Disability, or other types of disability approved by the Interstate Insurance Product Regulation Commission. benefit triggers specified in the certificate.

As stated in §4.N. of these standards, a Disability income certificate shall provide a benefit for at least Total Disability. In addition to the Total Disability benefit, and at the insurance company’s option, a Disability income certificate may or may not provide coverage for any one or more of the other Disability benefit triggers shown below.

If Total Disability and an additional Disability benefit, such as Partial Disability or Residual Disability benefit, are included in the certificate, the certificate shall specify if such additional Disability benefit triggers may only apply after a specified period of Total Disability benefits have been paid under the certificate, or if such benefit triggers shall apply as soon as the Covered Person meets such benefit triggers.

[Note:Today, companies offer both approaches to the employer.]

A certificate may specify that the Total Disability requirements will apply for a specified period of time, after which other benefit triggers shall apply. In this case, the certificate shall specify the period of time for which the Total Disability requirements shall apply and one or more of the other benefit triggers that would apply after the end of the specified period for Total Disability. [For example, a certificate would include a Total Disability benefit with the specified triggers in item (43) for the first 24 months of Total Disability, and specify activities of daily living deficiency or cognitive impairment Disability benefit triggers thereafter.]

The additional Disability benefit triggers are:

- (a) **Partial Disability or Residual Disability;**
- (b) **Presumptive Disability;**
- (c) **a Covered Person is terminally ill with a life expectancy of 12 months or less, as certified by a Physician;**
- (d) **a Covered Person is unable to perform one or two of the following six activities of daily living : bathing, dressing, toileting, transferring, continence or eating;**
- (e) **a Covered Person is cognitively impaired, suffering significant and irreversible deterioration or loss of intellectual capacity, as measured by clinical evidence and standardized tests commonly accepted for use in the medical community;**
- (f) **a Covered Person is confined as an inpatient in a Skilled Nursing Home or Rehabilitation Facility where a daily room and board charge is made;**

- (g) a Covered Person is receiving Home Health Care or Hospice Care;
- (h) a Covered Person has an impairment rating above a specified percentage similar to the concept used by Workers' Compensation, as would be specified in the certificate;
- (i) a Covered Person is eligible for or receiving Social Security Disability Insurance;
- (j) a Covered Person is a risk for transmitting a contagious disease. A Covered Person may be capable, physically and mentally, of performing the Substantial and material duties described above, but the ability to perform these duties is restricted by a state licensing board or by another appropriate government authority because the risk of transmission of a contagious disease to others with whom the Covered Person may be in contact. In this situation, the Covered Person will be considered to be Disabled in any month in which the Covered Person has a contagious disease and in which the restrictions stated above prevent the Covered Person from earning more than a stated percentage of his monthly pay as specified in the certificate, such as 80%; or
- (k) other types of Disability approved by the Interstate Insurance Product Regulation Commission.

As used in this section, "contagious disease" means asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), the multi-drug resistant Tuberculosis or other such conditions as defined by the Centers for Disease Control and Prevention.

If applicable, the certificate shall define the terms "Skilled Nursing Home", "Rehabilitation Facility", "Home Health Care" and "Hospice Care" in relation to the level of skill required, the nature of the care and the setting in which care shall be given.

The benefits in triggers (d), (e), (f) and (g) above shall not be advertised, marketed or sold as long-term care insurance and the certificate shall prominently disclose that benefits under the certificate will not be triggered by, or calculated with respect to, occurrence or amount of any long-term care services.

There shall not be a requirement that A a Covered Person shall not be required to be unable to perform "any Occupation or Specialty whatsoever", "any duty", or "each and every duty" or words of similar import.

An insurance company may require, according to standard medical practice:

- (a) that a Covered Person be under the regular care, treatment and/or attendance by a Physician to effectively treat and manage the Covered Person's Disability;

- (b) that the regular care, treatment and/or attendance is provided by a *Physician* whose specialty or experience is appropriate for the *Disability*; and
- (c) that the regular care, treatment and/or attendance be appropriate for the *Disability* in conformance with standards medical practice.

If it is determined by standard medical practice that a *Covered Person's Disability* does not require frequent or regular care, treatment and/or attendance by a *Physician*, then neither will the insurance company.

2/11/15 IPRC Staff Update following the 2/9/15 PSC Member Call: The PSC agreed to the revisions suggested by the Industry with the exception of the addition of (k). Although similar language exists in some Uniform Standards, IPRC staff applies the standard conservatively and would consult with the PSC if a filing was submitted that went beyond the identified triggers.

- (13) “*Eligible Survivor*” means the *Covered Person's Spouse*, if living; if not living, the *Covered Person's Children*.
- (14) “*Elimination Period*” means, subject to satisfaction of all certificate terms and conditions by the *Covered Person*, the period of time following the onset of *Disability* for which no benefits are payable under the certificate. This period of time will be specified in the certificate. The *Elimination Period* for a long term *Disability* benefits plan may be integrated with the *Benefit Period* of the short term *Disability* benefits plan. For all plans, the *Elimination Period* may be integrated with the period of paid time off, including but not limited to, salary continuation or sick leave available to the *Covered Person*, but shall not require use of accumulated vacation leave. The length of time required to satisfy the *Elimination Period* may, but need not, consist of consecutive units of time. The trigger for the start of an *Elimination Period* shall be commencement of a *Disability* for the *Covered Person* as defined in the certificate. The definition or concept may specify a separate *Elimination Period* for *Injury* and a separate *Elimination Period* for *Sickness*.

1/21/2015 IPRC Staff Update following the Public Call 1/13/15: The IAC provided the following comments for the PSC's consideration, opposing the addition of the phrase “but shall not require use of accumulated vacation leave.”

The proposed change is contradictory to the option currently available in the marketplace as well as language that has been approved for use in many states. The purpose of requiring employees to exhaust their bank of vacation days before DI payments can begin is to eliminate the risk that an employee can begin to receive DI payments intended to be a percentage of pre-disability earnings but end up receiving pre-disability earnings. We have earlier paralleled this to the FLMA which works the same way – an employee has to exhaust vacation days to be eligible for the federal leave benefits. Accordingly, we oppose the proposed change.

2/4/15 IPRC Staff Update following the PSC Member Call 1/27/15: The PSC discussed the Industry comments. Some members expressed the view that this is between the employer and

employee. Others noted that some employers allow for cash payment for unused vacation time and requiring vacation time be exhausted prior to being eligible for disability payments did not seem fair since vacation time is unrelated to a health related benefit. It was suggested that an option that a Covered Person not be able to collect both may be better than specifically requiring vacation time use in lieu of disability benefits. The PSC did not make any change to the recommended changes at this time.

- (15) “**Employee**” means a person defined as such by the policyholder.
- (16) “**Enrollment Form**” means any form used to enroll for insurance benefits under a group policy.
- (17) “**Full-Time**” means *Active Work* on the policyholder’s regular work schedule for the class of *Covered Persons* to which the *Covered Person* belongs. The work schedule must be at least a specified period of time (such as 30 hours a week). ~~In the context of the Disability term/concept, “Full-Time” may merely mean that the Covered Person is capable of working the number of hours defined as “Full-Time” in the certificate.~~
- (18) “**Guaranteed Renewable**” means that the policyholder has the right to continue the policy in force by the timely payment of premiums set forth in the policy. During such period, the insurance company shall not unilaterally make any change in any provision of the policy while the policy is in force, unless required by law.
- (19) “**Hospital**” means an accredited facility supervised by one or more *Physicians* and operated under state and local laws. The facility must have 24-hour nursing services by registered graduate nurses. The facility may specialize in treating alcoholism, drug addiction or chemical dependency or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged, or a facility primarily affording custodial, educational or rehabilitative care.
- (20) “**Injury**” means bodily injury resulting from an accident, independent of disease, and not related to any other cause. The insurance company may indicate that the *Injury* shall be sustained independent of *Sickness*. The definition or concept shall not use words such as “external, violent, visible wounds” or similar words of characterization or description. The definition or concept may state that the *Disability* shall have occurred within a specified period of time (not less than 30 days) of the *Injury*, otherwise the condition shall be considered a *Sickness*.
- (21) “**Job**” means the performance of *Substantial and material duties* routinely performed at a required employer location for wage or profit.
- (22) “**Mental or Nervous Disorder**” shall be no more restrictive than those classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), most current version as of the start of a *Disability*. If the DSM is replaced by the APA, these disorders will be those classified in the diagnostic manual then in use by the APA as of the start of a *Disability*. At the discretion of the insurance company, the definition or concept may refer to: 1. disorders

listed in the DSM, or 2. only certain disorders listed in the DSM. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, the insurance company may substitute a comparable diagnostic manual subject to approval by the Interstate Insurance Product Regulation Commission before use of the comparable diagnostic manual.

Drafting Note: The insurance company shall have the ability to exclude certain DSM disorders from the definition or concept. Inclusion or exclusion of DSM disorders may expand or restrict coverage for the *Covered Person*. When inclusion or exclusion of DSM disorders restricts coverage, such restrictions shall be consistent with the Interstate Insurance Product Regulation Commission standards for the exclusions and limitations sections of the certificate.

- (23) “***Noncontributory Insurance***” means insurance for which the policyholder does not require the *Covered Person* to pay any part of the premium.
- (24) “***Occupation***” means a group of *Jobs* or related *Jobs* in the national economy or marketplace, as appropriate, in which a common list of tasks is performed, or which are related in terms of similar objectives or methodologies and which may be related in terms of materials, products, work actions or worker characteristics.

Drafting Note: If the certificate includes the terms “any *Occupation*,” or similar term, the certificate shall define this term accordingly.

- (25) “***Partial Disability***” or “***Residual Disability***” means that, due to an *Injury or Sickness*, a *Covered Person*:
- (a) is unable to perform the *Substantial and material duties* of the work-related tests prescribed in the terms/concepts of *Regular Job*, *Regular Occupation*, *Regular Specialty*, or any other *Occupation* for which the *Covered Person* is qualified by reason of education, training or experience, as applicable; and
- (b) is in fact engaged in work for wage or profit.

~~Although the above benefit triggers are the predominant ones in the marketplace today, and shall be included in the policy and certificate some insurance companies may additionally provide *Partial Disability* or *Residual Disability* benefits on the basis of other triggers, such as situations where the *Covered Person*:~~

~~(c) — is terminally ill with a life expectancy of 12 months or less, as certified by a *Physician*;~~

~~(d) — is unable to perform one or two of the following six activities of daily living: bathing, dressing, toileting, transferring, continence or eating;~~

~~(e) — is cognitively impaired, suffering significant and irreversible deterioration or loss of intellectual capacity, as measured by clinical evidence and standardized tests commonly accepted for use in the medical community;~~

- ~~(f) — is confined as an inpatient in a Skilled Nursing Home or Rehabilitation Facility where a daily room and board charge is made;~~
- ~~(g) — is receiving Home Health Care or Hospice Care;~~
- ~~(h) — has an impairment rating above a specified percentage similar to the concept used by Workers' Compensation, as would be specified in the certificate;~~
- ~~(i) — is eligible for or receiving Social Security Disability Insurance; or~~
- ~~(j) — is a risk for transmitting a contagious disease. A Covered Person may be capable, physically and mentally, of performing the Substantial and material duties described above, but the ability to perform these duties is restricted by a state licensing board or by another appropriate government authority because the risk of transmission of a contagious disease to others with whom the Covered Person may be in contact. In this situation, the Covered Person will be considered to be Partially Disabled or Residually Disabled in any month in which the Covered Person has a contagious disease and in which the restrictions stated above prevent the Covered Person from earning more than a stated percentage of his monthly pay as specified in the certificate, such as 80%.~~

~~As used in this section, "contagious disease" means asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), the multi-drug resistant Tuberculosis or other such conditions as defined by the Centers for Disease Control and Prevention.~~

~~The certificate shall define the terms "Skilled Nursing Home", "Rehabilitation Facility", "Home Health Care" and "Hospice Care" in relation to the level of skill required, the nature of the care and the setting in which care shall be given.~~

~~The benefits in triggers (d), (e), (f) and (g) above shall not be advertised, marketed or sold as long term care insurance and the certificate shall prominently disclose that benefits under the certificate will not be triggered by, or calculated with respect to, occurrence or amount of any long term care services.~~

The certificate may require the *Covered Person* to satisfy a specified earnings loss related test, based on a percentage of the *Covered Person's Pre-Disability Earnings* and/or a work hour related test. Such tests may be in addition to items (a) and (b) above, or may be alternatives to item (a) above.

The certificate may require the *Covered Person* to be *Totally Disabled* for a specified period of time before the *Covered Person* may be considered *Partially Disabled* or *Residually Disabled* under the terms of the certificate. The specified period of time may be less than, equal to or greater than the *Elimination Period*.

12/2/14 - IIPRC Staff Update: The Group DI Subgroup recommends revision to this definition as noted to require (a) and (b) in all policies and certificates, while (c) through (j) would be optional triggers.

2/4/15 IIPRC Staff Update following the Public Call 1/13/15: On January 28, the IAC submitted the following revised comments recommending revisions to the definition of “*Partial Disability*” or “*Residual Disability*.” We would suggest that for clarity, the PSC review the suggested revisions to “*Disability*” or “*Disabled*”, “*Partial Disability*” or “*Residual Disability*” and “*Total Disability*” together.

I am attaching above a substitute attachment to the comments we submitted on 1/22/15. It is important to note that while Total Disability is required to be included, there are variations on whether it is the only Disability benefit payable, if it is the first Disability benefit payable, if it may be bypassed by a less strict benefit trigger, such as Partial/Residual or ADL deficiencies, or if it is payable for a specified period of time and then other triggers may be required for the benefits to continue.

Examples:

If a Total Disability benefit is sold with an additional Disability benefit, such as Partial/Residual, an employer can elect to require that a Covered Person receive a specified period of benefits for Total Disability before the Covered Person can receive Partial/Residual benefits, or an employer can allow a Covered Person to bypass the Total Disability requirements and collect Partial/Residual benefit if he is eligible for these.

An employer may also require that Total Disability benefits be the only benefits available for a specified period, such as 24 months, and after that time period other Disability benefit triggers may be required to continue to receive Disability benefits.

The language we are submitting attempts to cover all of these possibilities.

“***Partial Disability***” or “***Residual Disability***” means that, due to an *Injury or Sickness*, a *Covered Person*:

- (a) is unable to perform the *Substantial and material duties* of the work-related tests prescribed in the terms/concepts of *Regular Job, Regular Occupation, Regular Specialty*, or any other *Occupation* for which the *Covered Person* is qualified by reason of education, training or experience, as applicable; and
- (b) is in fact engaged in work for wage or profit.

~~Although the above benefit triggers are the predominant ones in the marketplace today, and shall be included in the policy and certificate some insurance companies may additionally provide *Partial Disability or Residual Disability* benefits on the basis of other triggers, such as situations where the *Covered Person*:~~

- ~~(c) — is terminally ill with a life expectancy of 12 months or less, as certified by a *Physician*;~~

- ~~(d) — is unable to perform one or two of the following six activities of daily living : bathing, dressing, toileting, transferring, continence or eating;~~
- ~~(e) — is cognitively impaired, suffering significant and irreversible deterioration or loss of intellectual capacity, as measured by clinical evidence and standardized tests commonly accepted for use in the medical community;~~
- ~~(f) — is confined as an inpatient in a *Skilled Nursing Home or Rehabilitation Facility* where a daily room and board charge is made;~~
- ~~(g) — is receiving *Home Health Care or Hospice Care*;~~
- ~~(h) — has an impairment rating above a specified percentage similar to the concept used by *Workers' Compensation*, as would be specified in the certificate;~~
- ~~(i) — is eligible for or receiving *Social Security Disability Insurance*; or~~
- ~~(j) — is a risk for transmitting a contagious disease. A *Covered Person* may be capable, physically and mentally, of performing the *Substantial and material duties* described above, but the ability to perform these duties is restricted by a state licensing board or by another appropriate government authority because the risk of transmission of a contagious disease to others with whom the *Covered Person* may be in contact. In this situation, the *Covered Person* will be considered to be *Partially Disabled or Residually Disabled* in any month in which the *Covered Person* has a contagious disease and in which the restrictions stated above prevent the *Covered Person* from earning more than a stated percentage of his monthly pay as specified in the certificate, such as 80%.~~

~~As used in this section, "contagious disease" means asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), the multi-drug resistant Tuberculosis or other such conditions as defined by the Centers for Disease Control and Prevention.~~

~~The certificate shall define the terms "*Skilled Nursing Home*", "*Rehabilitation Facility*", "*Home Health Care*" and "*Hospice Care*" in relation to the level of skill required, the nature of the care and the setting in which care shall be given.~~

~~The benefits in triggers (d), (e), (f) and (g) above shall not be advertised, marketed or sold as long term care insurance and the certificate shall prominently disclose that benefits under the certificate will not be triggered by, or calculated with respect to, occurrence or amount of any long term care services.~~

The certificate may require the *Covered Person* to satisfy a specified earnings loss related test, based on a percentage of the *Covered Person's Pre-Disability Earnings* and/or a work hour related test. Such tests may be in addition to items (a) and (b) above, or may be alternatives to item (a) above.

The certificate may require the *Covered Person* to be *Totally Disabled* for a specified period of time before the *Covered Person* may be considered *Partially Disabled* or *Residually Disabled* under the terms of the certificate. The specified period of time may be less than, equal to or greater than the *Elimination Period*.

2/11/15 IIPRC Staff Update following the 2/9/15 PSC Member Call: The PSC agreed to the recommended changes.

- (26) “**Physician**” means a person legally licensed to practice medicine or psychology and acting within the scope of his or her license, or a health care practitioner who is legally licensed, and is acting within the scope of his or her license, to treat an *Injury* or *Sickness* causing *Disability*. The definition or concept may exclude the *Covered Person*, any person related to the *Covered Person* by blood or marriage, any person who shares a significant business interest with the *Covered Person*, or any person who is a *Covered Person’s* partner in a legally sanctioned civil union, domestic partnership, marriage or other family or domestic relations law.
- (27) “**Policy Anniversary**” means the specified period of time (such as one year) following the effective date of the policy, and each subsequent period.
- (28) “**Policy Month**” The first policy month begins on the effective date of the policy. Subsequent policy months will begin on the same day of each subsequent calendar month.

~~(29) “**Post Disability Earnings**” means certain income earned or received by the *Covered Person* after the onset of *Disability*. The certificate shall identify the various income sources and/or components that are to be considered *Post Disability Earnings*.~~

(3029) “**Pre-Disability Earnings**” means certain income earned or received by the *Covered Person* from the policyholder before the onset of *Disability*. The certificate shall identify the various income sources and/or components that are to be considered *Pre-Disability Earnings*. The certificate shall also identify the date on which, or the periods of time for which, the various income sources and/or components are to be determined (such as the last day the *Covered Person* was *Actively at Work*, the end of the last full month that the *Covered Person* was *Actively at Work* before the onset of *Disability*, a policy anniversary, an average of the prior three calendar years, etc.).

Drafting Note: In the case of a particular policy, the specific components of *Pre-Disability Earnings* are negotiated between the policyholder and the insurance company. An example of this term/concept that could work for many *Full-Time Employees* would be basic wages or salary as of the last day worked prior to the onset of a *Disability*, not including bonuses, overtime pay, or commissions, except that an average of commissions received during the prior full calendar year will be included. Where variable compensation such as bonuses, commissions, or overtime pay are included, it is common to calculate an average over a stated prior period of time for the purposes both of benefit calculation and premium payment. For principals of a partnership or proprietorship, examples of sources which may be included would be (1) a monthly average of

the amount reported as ordinary income on Schedule K-1 of IRS Partnership Return of Income Form 1065 for the prior full calendar year, (2) the *Covered Person's* share of the business net profit and contributions to a pension and/or profit-sharing plan made by the business on behalf of the *Covered Person*, (3) gross income on the prior year's W-2, or (4) draw or salary received during a stated period of time. Examples are limited only by the complexity of the businesses' compensation arrangements. Items often excluded might include capital gains, dividends, interest, rent, royalties, annuities, other investment income, deferred compensation plan income or other forms of income realized from sources not requiring the *Covered Person's* performance of actual services. Many of these need not be specifically mentioned, because the certificate will specify that it is concerned only with income from the policyholder, for instance, and many of these items will not be earned or received from the policyholder.

(3130) "**Preexisting Condition**" means a condition for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a specified period of time (such as 1 to 12 months, but not to exceed 24 months) preceding the effective date of the coverage of the *Covered Person*, or a condition, whether diagnosed or not, for which a *Covered Person* received medical advice, consultation, diagnostic testing or treatment, or took or was prescribed drugs or medications within a specified period of time (such as 1 to 12 months, but not to exceed 24 months) preceding the effective date of the coverage of the *Covered Person*. The term "coverage of the *Covered Person*" as used in this definition or concept refers to initial coverage amounts and it may also refer to coverage increase amounts. In the case of coverage increase amounts, the time periods in this definition or concept run anew from the effective dates of the increased coverage amounts and apply anew only to the coverage increases.

10/28/14 - IIPRC Staff Update: The PSC had no further revisions to this definition.

(3231) "**Premium**" means the amount the policyholder or *Covered Person* shall pay to the insurance company for the insurance provided under the policy as applicable with respect to *Contributory and Noncontributory insurance requirements under the policy. For direct billing situations under the policy, the *Covered Person* shall pay the required *Premium* to the insurance company. In all other situations, the policyholder shall pay to the insurance company the amount the policyholder is required to pay and the amounts the *Covered Persons* are required to pay which are collected through payroll deduction.*

12/2/14 - IIPRC Staff Update: The Group DI Subgroup agreed with the industry suggestion to revise this definition so the §4 provision on Unpaid Premium would reflect that only premiums owed by a *Covered Person* can be deducted from the *Covered Person's* claim payment.

(3332) "**Presumptive Disability**" means that, due to an *Injury* or *Sickness*, a *Covered Person* suffers a total and permanent loss of one or more of the following body functions:

- (a) speech;
- (b) hearing;
- (c) sight; or
- (d) use of a limb.

Total and permanent loss of any one of these body functions shall be sufficient to trigger any benefits based upon *Presumptive Disability*.

Although the above benefit triggers are the predominant ones in the marketplace today, some insurance companies may provide *Presumptive Disability* benefits on the basis of other triggers, such as situations where the *Covered Person* is a risk for transmitting a contagious disease. A *Covered Person* may be capable, physically and mentally, of performing the material duties of his or her own *Occupation*, but the ability to perform these duties is restricted by a state licensing board or by another appropriate government authority because the risk of transmission of a contagious disease to others with whom the *Covered Person* may be in contact. In this situation, the *Covered Person* will be considered to have a *Presumptive Disability* in any month in which the *Covered Person* has a contagious disease and in which the restrictions stated above prevent the *Covered Person* from earning more than a stated percentage of his monthly pay as specified in the certificate, such as 80%.

As used in this section, "contagious disease" means asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), the multi-drug resistant Tuberculosis, and other such conditions as defined by the Centers for Disease Control and Prevention.

The satisfaction of the *Presumptive Disability* tests pre-empts any other *Disability* tests specified in the certificate. This is usually the case for a specified period of time depending on the type of loss for which the *Presumptive Disability* benefits are payable under the certificate.

- | (3433) “**Proof of Loss**” means written evidence satisfactory to the insurance company that a *Covered Person* has satisfied the conditions and requirements for any benefit described in the certificate. The *Proof of Loss* shall establish:
 - (a) The nature and extent of the loss or condition;
 - (b) The insurance company’s obligation to pay the claim; and
 - (c) The claimant’s right to receive payment.

- | (3534) “**Recurrent Disability**” means a *Disability* that occurs within a specified period of time immediately following a prior period of *Disability* and which is due to the same or related cause applicable to the prior period of *Disability*. For example, the specified period of time to be shown in the certificate for short term disability plans may be for a period up to 60 days, and for long-term disability plans for a period up to 12 months.

- | (3635) “**Regular Job**” means the job that a *Covered Person* was performing on the day before *Disability* begins.

- | (3736) “**Regular Occupation**” means the *Occupation* that a *Covered Person* was routinely performing on the day before *Disability* begins.
- | (3837) “**Regular Specialty**” means the *Specialty* that a *Covered Person* was performing on the day before *Disability* begins.
- | (3938) “**Rehabilitation**” means a plan that is geared toward aiding a *Covered Person* to better perform his or her *Occupation* or any *Occupation* for which he or she is fitted by reason of education, training or experience.
- | (4039) “**Sickness**” means illness, disease, or complications of pregnancy. If *Disabilities* caused by pregnancy are to be covered under the policy, then *Disability* benefits for a pregnancy will be paid on the same basis as for a *Sickness*.
- | (4140) “**Specialty**” means a general *Specialty* or sub-*Specialty* recognized by the American Board of Medical Specialties, the American Bar Association, the state where the *Covered Person’s* certificate is issued for delivery, or any other state, as applicable/appropriate.
- | (4241) “**Spouse**” means the *Covered Person’s* lawful *Spouse* and any other person required to be covered as the *Covered Person’s Spouse* under the civil union, domestic partnership, marriage or other family or domestic relations laws, including the case law, of the state where the policy is delivered or issued for delivery.

If the policy and certificate are delivered or issued for delivery in different states, the certificate shall, if required, comply with the applicable marriage laws, including marriage case law, of the state where the certificate is delivered or issued for delivery and, if required, with the applicable domestic partnership and civil union laws of such state, with respect to coverage available for marital relationships, domestic partnerships, or civil unions.

- (a) The term “*Spouse*” may be modified as required by applicable federal law;
- (b) The term “*Spouse*” may also be modified to include any person who is in a domestic partnership, civil union or similar relationship whether or not such relationship is legally recognized provided that an insurable interest exists;
- (c) Nothing in this definition shall be construed as requiring any insurance company to provide coverage or benefits to any person who is in a domestic partnership, civil union, or similar relationship, or marriage or to their families in a state where such relationships are not legally recognized or the providing of such coverage is not required;
- (d) For purposes of determining who may become a *Covered Person*, the term “*Spouse*” may exclude any person who:

- (i) Is on full-time active duty in the armed forces of any country or subdivision of any country;
 - (ii) Legally resides outside the United States, its territories or possessions, or Canada; or
 - (iii) Is insured under the policy as an *Employee*; and
- (e) If the certificate contains exclusions (i) or (ii) above, the certificate shall include a provision notifying the Covered Person of their right to end *Spouse* coverage during the period that the *Spouse* is on full-time active duty in the armed forces of any country or subdivision of any country, or the period that the *Spouse* legally resides outside the United States, its territories or possessions, or Canada. The provision shall also include:
- (i) The procedure for requesting an end of coverage;
 - (ii) An explanation of when such coverage will end;
 - (iii) A statement that premiums for the *Spouse* coverage will not be required once coverage is ended and that any collected, unearned premiums will be refunded; and
 - (iv) An explanation of the procedure required to reenroll the *Spouse* once full-time active military duty ends, or once the *Spouse* resumes residence in the United States, its territories or possessions, or Canada. The procedure shall not be less favorable than the following:
 - (A) If re-enrollment for *Spouse* coverage is made within 31 days of the date full-time active military duty ends, or the date the *Spouse* resumes residence in the United States, its territories or possessions, or Canada, the amount of *Spouse* coverage applied for shall be equal to the lesser of the amount that was in effect on the day before coverage ended and the then current maximum amount of *Spouse* coverage available under the plan. Such coverage will take effect as of the date of application, provided that on that date the *Spouse* is not hospitalized, confined at home under a physician's care, or receiving or applying to receive disability benefits from any source. If the *Spouse* is hospitalized, confined to home under a physician's care, or is receiving or applying to receive disability benefits from any source on such date, such *Spouse* coverage will take effect on the date the *Spouse* is no longer hospitalized, confined or receiving or applying for disability benefits; or

- (B) If re-enrollment for *Spouse* coverage is made more than 31 days after the date that full-time active military duty ends, or the date the *Spouse* resumes residence in the United States, its territories or possessions, or Canada, the *Spouse* will be required to submit evidence of insurability satisfactory to the insurance company, and the *Spouse* coverage approved by the insurance company will take effect on the date specified by the insurance company.

| (4342) “**Substantial and material duties**” means the important tasks, functions and operations generally required by the policyholder, or in the national economy or marketplace, as applicable, from those engaged in a *Job*, *Occupation* or *Specialty* that cannot be reasonably omitted or modified. This term may include the *Covered Person’s* ability to work on a regular work schedule for a specified number of hours.

| (4443) “**Total Disability**” means that, due to an *Injury* or *Sickness*, a *Covered Person*:

- (a) is unable to perform the *Substantial and material duties* of the work-related tests prescribed in the terms /concepts of *Regular Job*, *Regular Occupation*, *Regular Specialty* or any gainful *Occupation* for which the *Covered Person* is qualified by reason of education, training or experience, as applicable; and
- (b) is not in fact engaged in any *Job* for wage or profit.

~~Although the above benefit triggers are the predominant ones in the marketplace today and shall be included in the policy and certificate, some insurance companies may additionally provide *Partial Disability* or *Residual Disability* benefits on the basis of other triggers, such as situations where the *Covered Person*:~~

~~(e) is terminally ill with a life expectancy of 12 months or less, as certified by a *Physician*;~~

~~(d) is unable to perform one or two of the following six activities of daily living:
bathing,
dressing, toileting, transferring, continence or eating;~~

~~(e) is cognitively impaired, suffering significant and irreversible deterioration or loss of intellectual capacity, as measured by clinical evidence and standardized tests commonly accepted for use in the medical community;~~

~~(f) is confined as an inpatient in a *Skilled Nursing Home* or *Rehabilitation Facility* where a daily room and board charge is made;~~

~~(g) is receiving *Home Health Care* or *Hospice Care*;~~

~~(h) has an impairment rating above a specified percentage similar to the concept used by *Workers’ Compensation*, as would be specified in the certificate;~~

- ~~(i) is eligible for or receiving Social Security Disability Insurance; or~~
- ~~(j) is a risk for transmitting a contagious disease. A Covered Person may be capable, physically and mentally, of performing the Substantial and material duties described above, but the ability to perform these duties is restricted by a state licensing board or by another appropriate government authority because the risk of transmission of a contagious disease to others with whom the Covered Person may be in contact. In this situation, the Covered Person will be considered to be Partially Disabled or Residually Disabled in any month in which the Covered Person has a contagious disease and in which the restrictions stated above prevent the Covered Person from earning more than a stated percentage of his monthly pay as specified in the certificate, such as 80%.~~

~~As used in this section, "contagious disease" means asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), the multi drug resistant Tuberculosis or other such conditions as defined by the Centers for Disease Control and Prevention.~~

~~The certificate shall define the terms "Skilled Nursing Home", "Rehabilitation Facility", "Home Health Care" and "Hospice Care" in relation to the level of skill required, the nature of the care and the setting in which care shall be given.~~

~~The benefits in triggers (d), (e), (f) and (g) above shall not be advertised, marketed or sold as long term care insurance and the certificate shall prominently disclose that benefits under the certificate will not be triggered by, or calculated with respect to, occurrence or amount of any long term care services.~~

12/2/14 - IIPRC Staff Update: The Group DI Subgroup recommends revision to this definition as noted to require (a) and (b) in all policies and certificates, while (c) through (j) would be optional triggers.

2/4/15 IIPRC Staff Update following the Public Call 1/13/15: On January 28, the IAC submitted the following revised comments recommending revisions to the definition of "Total Disability." We would suggest that for clarity, the PSC review the suggested revisions to "Disability" or "Disabled", "Partial Disability" or "Residual Disability" and "Total Disability" together.

I am attaching above a substitute attachment to the comments we submitted on 1/22/15. It is important to note that while Total Disability is required to be included, there are variations on whether it is the only Disability benefit payable, if it is the first Disability benefit payable, if it may be bypassed by a less strict benefit trigger, such as Partial/Residual or ADL deficiencies, or if it is payable for a specified period of time and then other triggers may be required for the benefits to continue.

Examples:

If a Total Disability benefit is sold with an additional Disability benefit, such as Partial/Residual, an employer can elect to require that a Covered Person receive a specified period of benefits for

Total Disability before the Covered Person can receive Partial/Residual benefits, or an employer can allow a Covered Person to bypass the Total Disability requirements and collect Partial/Residual benefit if he is eligible for these.

An employer may also require that Total Disability benefits be the only benefits available for a specified period, such as 24 months, and after that time period other Disability benefit triggers may be required to continue to receive Disability benefits.

The language we are submitting attempts to cover all of these possibilities.

“*Total Disability*” means that, due to an *Injury* or *Sickness*, a *Covered Person*:

- (a) is unable to perform the *Substantial and material duties* of the work-related tests prescribed in the terms /concepts of *Regular Job, Regular Occupation, Regular Specialty* or any gainful *Occupation* for which the *Covered Person* is qualified by reason of education, training or experience, as applicable; and
- (b) is not in fact engaged in any *Job* for wage or profit.

~~Although the above benefit triggers are the predominant ones in the marketplace today and shall be included in the policy and certificate, some insurance companies may additionally provide Partial Disability or Residual Disability benefits on the basis of other triggers, such as situations where the Covered Person:~~

- ~~(c) is terminally ill with a life expectancy of 12 months or less, as certified by a *Physician*;~~
- ~~(d) is unable to perform one or two of the following six activities of daily living : bathing, dressing, toileting, transferring, continence or eating;~~
- ~~(e) is cognitively impaired, suffering significant and irreversible deterioration or loss of intellectual capacity, as measured by clinical evidence and standardized tests commonly accepted for use in the medical community;~~
- ~~(f) is confined as an inpatient in a *Skilled Nursing Home* or *Rehabilitation Facility* where a daily room and board charge is made;~~
- ~~(g) is receiving *Home Health Care* or *Hospice Care*;~~
- ~~(h) has an impairment rating above a specified percentage similar to the concept used by *Workers’ Compensation*, as would be specified in the certificate;~~
- ~~(i) is eligible for or receiving *Social Security Disability Insurance*; or~~
- ~~(j) is a risk for transmitting a contagious disease. A *Covered Person* may be capable, physically and mentally, of performing the *Substantial and material duties* described above, but the ability to perform these duties is restricted by a state licensing board or by another appropriate government authority because the risk of transmission of a~~

~~contagious disease to others with whom the *Covered Person* may be in contact. In this situation, the *Covered Person* will be considered to be *Partially Disabled or Residually Disabled* in any month in which the *Covered Person* has a contagious disease and in which the restrictions stated above prevent the *Covered Person* from earning more than a stated percentage of his monthly pay as specified in the certificate, such as 80%.~~

~~As used in this section, "contagious disease" means asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), the multi drug resistant Tuberculosis or other such conditions as defined by the Centers for Disease Control and Prevention.~~

~~The certificate shall define the terms "*Skilled Nursing Home*", "*Rehabilitation Facility*", "*Home Health Care*" and "*Hospice Care*" in relation to the level of skill required, the nature of the care and the setting in which care shall be given.~~

~~The benefits in triggers (d), (e), (f) and (g) above shall not be advertised, marketed or sold as long term care insurance and the certificate shall prominently disclose that benefits under the certificate will not be triggered by, or calculated with respect to, occurrence or amount of any long term care services.~~

2/11/15 IIPRC Staff Update following the 2/9/15 PSC Member Call: The PSC agreed to the Industry's recommended revisions.

§ 4. REQUIRED PROVISIONS

Each policy or certificate, as applicable, shall contain all of the provisions as set forth below. The company may, at its option, substitute for one or more of the provisions below corresponding provisions of different wording approved by the Interstate Insurance Product Regulation Commission as not less favorable in any respect to the policyholder and/or *Covered Person*.

A. CLAIM PROVISIONS

The policy may or may not include the Claim provisions described below, but the certificate shall include ~~these~~ the Claim provisions described below.

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC suggests the following change to this preamble to be consistent with the language in E. ELIGIBILITY PROVISIONS:

The policy may or may not include the Claim provisions described below; ~~but the certificate shall include these the Claim provisions described below.~~ if the policy does not, the certificate shall include the applicable Claim provisions.

2/4/15 IIPRC Staff Update following the PSC Member Call 1/27/15: After reviewing the Industry recommendation to change the preamble to be consistent with the language in E. ELIGIBILITY PROVISIONS, the PSC decided to make no change. It was noted that the

certificate shall always describe the Claim provisions, and the suggested revision would not achieve that goal.

- (1) **Payment of Benefits.** A provision that t~~The~~ insurance company shall pay benefits at the end of each month, bi-weekly, each week or for a shorter period, as applicable, for which it is liable, after it receives the required *Proof of Loss*. If any amount for which the insurance company is liable is unpaid when *Disability* ends, the insurance company shall pay such amount when it receives the required *Proof of Loss*. The provision shall state that if a claim is paid more than 30 days after a company receives the required *Proof of Loss*, the delayed payment shall be subject to simple interest at the rate of 10% per year beginning with the 31st day after receipt of satisfactory *Proof of Loss*, and ending on the day the claim is paid.

- (2) **To Whom Payable.** A provision that u~~U~~nless otherwise specified in the certificate, the insurance company shall pay all benefits to a *Covered Person*. ~~However, if medical evidence indicates that a legal guardian should be appointed, the insurance company may hold further benefits due until such time as a guardian of a *Covered Person* is appointed and it shall pay benefits to such guardian at that time.~~ The provision shall state that i~~f~~ any amount for which the insurance company is liable remains unpaid when the *Covered Person* dies, the insurance company shall pay such amount in accordance with the payment determination rule(s) specified in the certificate. If there are legal impediments to payment of Disability benefits under the certificate that depend on the actions of parties other than the insurance company, the insurance company may hold further benefits due until such impediments are resolved and sufficient evidence of the same is provided to the insurance company. Legal impediments to payment may include, but are not limited to, the establishment of guardianships and conservatorships, or the appointment and qualification of trustees, executors and administrators, as applicable. Payment shall be made within 30 days of when the insurance company receives sufficient evidence that the legal impediments are resolved. Delayed payment shall be subject to simple interest at the rate of 10% per year beginning with the 31st day after receipt of such evidence and ending on the day the claim is paid

12/2/14 - IIPRC Staff Update: The Group DI Subgroup recommends deleting the language regarding a legal guardian. Review of Model 100 and 171 does not indicate any specific provision. Regulators note that it is the court, not a doctor or insurer who renders a determination about whether a legal guardian should be appointed.

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC proposes adding the following language (adapted from the IIPRC Group Term Life standards on page 17) at the end of item (2):

If there are legal impediments to payment of Disability benefits under the certificate that depend on the actions of parties other than the insurance company, the insurance company may hold further benefits due until such impediments are resolved and sufficient evidence of the same is

provided to the insurance company. Legal impediments to payment may include, but are not limited to, the establishment of guardianships and conservatorships, or the appointment and qualification of trustees, executors and administrators, as applicable.

2/4/15 IIPRC Staff Update following the PSC Member Call 1/27/15: The PSC agreed to the change industry proposed with the addition of language clarifying that upon receipt of evidence of satisfaction of legal impediments, the company must pay the claim within thirty days or interest is owed.

To Whom Payable. ~~A provision that unless otherwise specified in the certificate, the insurance company shall pay all benefits to a *Covered Person*. However, if medical evidence indicates that a legal guardian should be appointed, the insurance company may hold further benefits due until such time as a guardian of a *Covered Person* is appointed and it shall pay benefits to such guardian at that time. The provision shall state that if~~ any amount for which the insurance company is liable remains unpaid when the *Covered Person* dies, the insurance company shall pay such amount in accordance with the payment determination rule(s) specified in the certificate. ~~If there are legal impediments to payment of Disability benefits under the certificate that depend on the actions of parties other than the insurance company, the insurance company may hold further benefits due until such impediments are resolved and sufficient evidence of the same is provided to the insurance company. Legal impediments to payment may include, but are not limited to, the establishment of guardianships and conservatorships, or the appointment and qualification of trustees, executors and administrators, as applicable. Payment shall be made within 30 days of when the insurance company receives sufficient evidence that the legal impediments are resolved. Delayed payment shall be subject to simple interest at the rate of 10% per year beginning with the 31st day after receipt of such evidence and ending on the day the claim is paid.~~

(3) ***Filing a Claim.***

- (a) ~~A provision that if~~ a *Covered Person* wants to file a claim, the *Covered Person* must send the insurance company notice of the claim. ~~The provision shall state that t~~The insurance company must have written notice of any insured loss within 30 days after it occurs, or as soon ~~thereafter~~ as reasonably possible. The *Covered Person* can send the notice to the insurance company's home office, to one of its regional group claims offices, or to one of its agents. The insurance company needs enough information to identify the claimant as a *Covered Person*.
- (b) ~~A provision that w~~Within 15 days after the date of a *Covered Person's* notice, the insurance company will send the *Covered Person* certain claim forms. The forms must be completed and sent to the insurance company's home office or to one of its regional group claims offices. ~~If the *Covered Person* does not receive the claim forms within 15 days, the insurance company will accept a written description of the exact nature and extent of the loss. The provision shall state that if~~ the forms are not furnished by the insurance company within 15 days after the giving of such notice, the *Covered Person* shall be deemed to have complied with the requirements as to proof of loss when the *Covered Person* submits written proof

covering the occurrence, character and extent of the loss for which claim is made.

12/2/14 - IIPRC Staff Update: The Subgroup notes the inserted language is consistent with the IDI language and reflects the language found in Section 8 J of Model 100 covering Group DI.

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC proposes adding the following revision:

A provision that wWithin 15 days after the date of a *Covered Person's* notice, the insurance company will send the *Covered Person* certain claim forms. The forms must be completed and sent to the insurance company's home office or to one of its regional group claims offices. ~~If the *Covered Person* does not receive the claim forms within 15 days, the insurance company will accept a written description of the exact nature and extent of the loss. The provision shall state that~~ if the forms are not furnished by the insurance company within 15 days after the giving of such notice, the *Covered Person* shall be deemed to have complied with the requirements of the policy as to proof of loss when the claimant *Covered Person* submits written proof covering the occurrence, character and extent of the loss for which claim is made.

2/4/15 IIPRC Staff Update following the PSC Member Call 1/27/15: The PSC agreed to the change that Industry proposed.

(4) ***Proof of Loss.***

- (a) A provision that *Proof of Loss* must be given within 90 days after the end of a *Covered Person's Elimination Period* unless it can be shown that it was not reasonably possible to provide such proof within such time frame and *Proof of Loss* is given as soon as reasonably possible. ~~In any event, *Proof of Loss* must be given no later than one year from the time specified unless the *Covered Person* was legally incapacitated. The certificate may state that if *Proof of Loss* is first received by the insurance company more than a specified number of days, such as 180, after the end of the *Elimination Period*, the *Covered Person's Disability* benefit as specified in the certificate may be reduced by a specified percentage, such as 30%.~~ A provision that failure to furnish proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured *Covered Person*, later than one year from the time proof is otherwise required. If a claim reduction is applicable, such reduction shall be specified in the certificate and shall not exceed 30% of the benefit amount otherwise payable.

- (b) A provision that cContinuing *Proof of Loss* must be given as often as the insurance company may reasonably require. The provision may state that cContinuing *Proof of Loss* must be given within a time period not less than 60 days ~~of~~ from the insurance company's request. The insurance company shall not reduce any continuing claim for failure to furnish proof of loss within the time period required; however, benefit payments may be delayed until the required proof is received by the insurance company.

12/2/14 - IIPRC Staff Update: This Subgroup notes that the inserted language is consistent with the language found in Model Law 100 §8 (K) as well as the language in the IDI standards.

~~**Drafting Note:** It should be noted that the passage of time impairs the ability to accurately adjudicate a *Disability* claim or mitigate its severity. Accordingly, some companies may want to include a disincentive to file *Proof of Loss* more than a specified number of days after the end of an *Elimination Period*.~~

- ~~(c) A provision that cContinuing *Proof of Loss* must be given as often as the insurance company may reasonably require. The provision may state that cContinuing *Proof of Loss* must be given within a time period not less than 60 days ~~of~~ from the insurance company's request.~~
- (dc) A provision that a *Covered Person* must provide the insurance company with all of the information it specifies as necessary to determine *Proof of Loss* and decide its liability. This may include but is not limited to medical records, hospital records, pharmacy records, test results, therapy and office notes, mental health progress notes, medical exams and consultations, tax returns, business records, Workers' Compensation records, payroll and attendance records, job descriptions, Social Security award and denial notices, and Social Security earnings records.
- (ed) A provision that a *Covered Person* must also provide the insurance company with a written authorization allowing the sources of medical, vocational, occupational, financial, and governmental information to release documents to the insurance company which enables it to decide its liability. The provision may state that if the *Covered Person* does not provide the insurance company with continuing proof of *Disability* and the items and authorization necessary to allow it to determine its liability, the insurance company will not pay the *Disability* benefits specified in the certificate.

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC submitted the following revised comments after the Public Call:

We suggest that (a) and (b) be combined as new (a). The proposed rewrite for previous (b) needs to change "insured" to say "*Covered Person*".

Based on the PSC's recommended language that includes "or reduce", we seek confirmation that a reduction would be permitted if it was reasonably possible to give proof within the time required. If this is the case, we suggest adding the following at the end of item (a):

"If a claim reduction is applicable, such reduction shall be specified in the certificate and shall not exceed 30% of the benefit amount otherwise payable."

With regard to previous (c) now new (b), there was concern expressed that a delay in giving continuing proof of loss would not result in a reduction. If the PSC shares this concern, you may want to consider adding the following sentence at the end of the item:

"The insurance company shall not reduce any continuing claim for failure to furnish proof of loss within the time period required; however, benefit payments may be delayed until the required proof is received by the insurance company."

Based on the IAC comments, the following are revisions for the PSC's consideration:

(4) ***Proof of Loss.***

- (a) A provision that Proof of Loss must be given within 90 days after the end of a Covered Person's Elimination Period unless it can be shown that it was not reasonably possible to provide such proof within such time frame and Proof of Loss is given as soon as reasonably possible. ~~In any event, Proof of Loss must be given no later than one year from the time specified unless the Covered Person was legally incapacitated. The certificate may state that if Proof of Loss is first received by the insurance company more than a specified number of days, such as 180, after the end of the Elimination Period, the Covered Person's Disability benefit as specified in the certificate may be reduced by a specified percentage, such as 30%. A provision that failure to furnish proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured Covered Person, later than one year from the time proof is otherwise required. **If a claim reduction is applicable, such reduction shall be specified in the certificate and shall not exceed 30% of the benefit amount otherwise payable.**~~
- (~~b~~) A provision that cContinuing Proof of Loss must be given as often as the insurance company may reasonably require. ~~The provision may state that cContinuing Proof of Loss must be given within a time period not less than 60 days of from~~ the insurance company's request. **The insurance company shall not reduce any continuing claim for failure to furnish proof of loss within the time period required; however, benefit payments may be delayed until the required proof is received by the insurance company.**

2/4/15 IIPRC Staff Update following the PSC Member Call 1/27/15: The PSC agreed to the suggested revisions.

- (5) *Procedures for Review of Claim Determinations.* A provision that describes the process for appealing and resolving benefit determinations.

1/28/15 IIPRC Staff Update: As noted under §6 OPTIONAL PROVISIONS H. PROCEDURES FOR REVIEW OF A DENIAL OF A CLAIM, the Subgroup decided since the majority of groups would be subject to ERISA requirements and Subgroup members could think of no reason a policy or certificate should fail to explain appeal rights, that it would be beneficial to make this a required provision, using language similar to that found in the Individual Disability Income Uniform Standards as follows:

- (5) *Procedures for Review of Claim Determinations.* A provision that describes the process for appealing and resolving benefit determinations.

2/4/15 IIPRC Staff Update following the 2/3/15 Subgroup call: The Subgroup agreed to the recommended revisions.

- (56) ***Right to Examine, Test or Interview.*** A provision that tThe insurance company may ask a *Covered Person* to be examined or tested as often as it requires at any time it chooses. The insurance company may require a *Covered Person* to be interviewed by its authorized representative. The provision shall state that the insurance company will pay third party charges for any exam, test or interview which it requires. The provision may state that if a *Covered Person* fails to attend or fully participate, the insurance company will not pay the *Disability* benefits specified in the certificate.
- (67) ***Limit on Legal Action.*** A provision that nNo action at law or in equity may be brought to recover under the policy until at least 60 days after a *Covered Person* files *Proof of Loss*. The provision shall state that nNo action can be brought after the applicable statute of limitations has expired, but, in any case, not after 3 years from the date of loss.

~~**Drafting Note:** It should be noted that the passage of time impairs the ability to accurately adjudicate a *Disability* claim. Accordingly, it is recommended that the above 60 days and 3 year limits be the standard despite the few state variations that extend these timeframes.~~

- (78) ***Unpaid Premium.*** A provision that uUpon the payment of a claim under a certificate, any *Premium* then due by a *Covered Person* and unpaid may be deducted from the *Covered Person's* claim payment.

12/9/14 - IIPRC Staff Update: The PSC notes that not all insurance companies include a provision regarding Unpaid Premiums and questions why this is included as a Required Provision rather than Optional Provision.

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC submitted the following comment in response to the PSC's question:

While we agree that not all companies include this, we note that some companies do this and accordingly the *Covered Person* has the right to know this. We proposed this as “required” to raise the bar.

B. CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

- (1) The policy and certificate shall state that each was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. The policy and certificate shall also state that any provision of the policy and certificate that on the provision’s effective date is in conflict with the applicable Interstate Insurance Product Regulation Commission standards for this product type in effect as of the provision’s effective date of Commission policy and certificate approval is hereby amended to conform to the Interstate Insurance Product Regulation Commission standards in effect as of the provision’s effective date of Commission policy and certificate approval ~~for this product type as of the provision’s effective date.~~

12/9/14 - IIPRC Staff Update: Changes are to conform to provision changes previously adopted through the 5 Year review Process with other Uniform Standards

C. CONTRIBUTIONS

- (1) The policy shall include a provision stating that, with regard to *Contributory* insurance, the maximum amount that a *Covered Person* may be required to contribute to the cost of such insurance shall not exceed the premium charged for the amounts of such insurance.

D. DATA NEEDED

- (1) The policy shall include a provision requiring the policyholder to provide the insurance company with all the data needed to compute premiums and administer the terms of the policy.
- (2) The provision shall give the insurance company the right to examine the policyholder insurance data at any time.
- (3) The provision shall state that if the insurance company or the policyholder makes a clerical error in keeping the data, the premiums and/or benefits will be adjusted according to the correct data. An error will not end insurance validly in effect, nor will it continue insurance validly ended.

E. ELIGIBILITY PROVISIONS

The policy may or may not include the Eligibility provisions described below; if the policy does not, the certificate shall include the applicable Eligibility provisions. If a certificate is issued on a named basis, the certificate shall include the date a *Covered Person’s* insurance will end. If a

certificate will be issued on a no-name basis, the certificate shall include the Eligibility provisions described below.

- (1) The policy or certificate, as applicable, shall contain eligibility provisions describing the eligibility requirements applicable to *Covered Persons* under the policy, including, but not limited to:
 - (a) ***Eligible Classes.*** The provision shall describe the eligible classes for *Covered Persons*;
 - (b) ***Date Persons Are Eligible for Insurance.*** The provision shall describe how this date is determined and specify any waiting period requirements. The waiting period may be defined as a period of continuous membership in an eligible class that a person must wait before the person becomes eligible for insurance (such as 30 days). The period begins on the date the person enters an eligible class and ends on the date the person completes the waiting period. The provision may describe requirements for situations where the person was previously employed with the policyholder;
 - (c) ***Enrollment Process.*** The provision shall specify the process required for enrolling for *Contributory* insurance if such insurance is included under the policy. Eligible persons may be required to complete an *Enrollment Form*. Previous *Enrollment Forms* obtained by the policyholder may be accepted by the insurance company. The provision shall also specify if evidence of insurability satisfactory to the insurance company is required and these requirements will be described in the evidence of insurability provision. The provision may also state that the person will be required to authorize payroll deductions for such insurance;

Drafting Note: The enrollment process described above refers to a “may” process because industry anticipates that the U.S. Department of Labor may in the future issue guidance on an “auto-enroll” procedure where, at the option of the employer, eligible employees will be automatically enrolled and have the option to opt out at a later date. The “auto enroll” feasibility is currently under discussion and it is not known if or when guidance will be issued.

- (d) ***Date A Person’s Insurance Takes Effect.*** The provision shall describe the rules for the date a *Covered Person’s Noncontributory* and/ or *Contributory* insurance takes effect, as applicable. The cover page or first page, or specifications page, of the policy or certificate shall specify which insurance benefits are *Contributory* and which are *Noncontributory*. The provision may state that:
 - (i) If the *Covered Person* is not *Actively at Work* on the date insurance would otherwise take effect, insurance will take effect on the day he resumes *Active Work*. ~~If so stated, T~~he provision ~~may shall~~ also state that if the day insurance would normally take effect is not a regular scheduled work day for the *Covered Person*, insurance will take effect on that day if the *Covered Person* is able to do his or her *Regular Job* on that day; or

1/21/15 IPRC Staff Update following the Public Call 1/13/15: The IAC submitted the following comment in opposition to this change:

First, the lead-in for (i) and (ii) states “The provision *may* state that.” Accordingly, changing the “may” to a “shall” is conflicting. Second, this represents another difference from Group Term Life and a consistency issue as discussed above. This is a group issue, not specific to DI, and represents a rewrite of group standards previously adopted.

2/11/15 IPRC Staff Update following the 2/9/15 PSC call: The PSC concluded that if a provision is included that states that coverage does not take effect until the *Covered Person* resumes *Active Work*, it is an important consumer protection to require that if the day insurance would take effect is not a regularly scheduled work day, insurance will take effect if the *Covered Person* is able to do his or her *Regular Job* on that day. The PSC added language to address the potential conflicting language and will consider whether conforming changes should be made to the Group Term Life Uniform Standards.

- (ii) If evidence of insurability satisfactory to the insurance company was required for a *Covered Person's* insurance amount, such amount shall take effect on the later of the date the *Covered Person* satisfies all applicable eligibility requirements or the date the insurance company approves the evidence of insurability required for such amount; and
- (e) ***Date A Covered Person's Insurance Ends.*** The provision shall describe how and when insurance may end for a *Covered Person*. The provisions shall also state that if the policy ends, this shall not affect a claim otherwise payable under the certificate.

F. ENTIRE CONTRACT

- (1) ***Policy Entire Contract Provision.*** The provision shall state that the policy, the policyholder's application, the certificates, and any riders, endorsements or amendments to the policy and to the certificates shall constitute the entire contract. No document may be included by reference.
- (2) ***Certificate Entire Contract Provision.*** The provision shall state that the insurance for *Covered Persons* is provided under a contract of group ~~term~~ insurance with the policyholder, and that the entire contract with the policyholder includes the policy, the policyholder's application, the certificates, statement of insurability, and any riders, amendments or endorsements to the policy and to the certificates. No document may be included by reference.

G. EFFECTIVE DATE OF THE POLICY

- (1) The policy shall include a provision stating when the policy will take effect.

- (2) If the policy is issued as a replacement of a policy previously issued by the insurance company to the policyholder, the provision shall state the fact of the replacement, as well as the policy number and effective date of such previously issued policy.

H. EVIDENCE OF INSURABILITY

- (1) The certificate shall include a provision describing the evidence of insurability requirements, if any. If evidence of insurability will be required, the provision shall identify the applicable evidence requirements, such as those:
 - (a) Specified in the respective eligibility provisions;
 - (b) For amounts for a *Covered Person* exceeding a specified amount (such as \$5,000 of monthly income for *Employees*);
 - (c) For increases in amounts that exceed a specified amount; and
 - (d) For *Contributory* amounts if a *Covered Person* was hospitalized within a specified period (such as 90 days) preceding the date the person enrolled for coverage or applied for an increase in coverage.
- (2) The cost of providing such evidence shall be borne by the insurance company.

I. GRACE PERIOD

- (1) The policy shall include a grace period provision and describe the conditions of the provision.
 - (a) The provision shall state that each *Premium* due after the effective date of the policy may be paid up to a specified period not less than 31 days after its *Premium* due date (the “grace period”);
 - (b) The provision shall state that the insurance provided under the policy shall stay in effect during the grace period, unless the policyholder has given the insurance company advance written notice of intent to end insurance under the policy in accordance with the terms of the policy;
 - (c) The provision shall state that if the *Premium* is not paid by the due date, the insurance company shall give written notification to the policyholder that if the *Premium* is not paid by the end of the grace period, the policy will end on the last day of the grace period. If the insurance company fails to give such written notice, the insurance provided under the policy will continue in effect until the date such notice is given;

- (d) The provision shall state that the policyholder shall be liable to the insurance company for the payment of a pro rata *Premium* for the time the policy was in force during such grace period;
 - (e) The provision shall state that if the policyholder replaces the policy with another group policy but does not give the insurance company written notice of intent to end the policy, the grace period provisions of the policy and certificate will apply;
 - (f) The policy shall state that *Premiums* shall be paid for any grace period, any extension of such period, and any period for which insurance under this policy was in effect and *Premium* was not paid; and
 - (g) If the *Covered Person* is paying *Premiums* directly to the insurance company, the grace period provision shall be included in the certificate.
- (2) The provision may allow ~~that at the request of the policyholder,~~ the insurance company ~~to~~ may extend the grace period by giving written notice of such intent to the policyholder. Such notice shall specify the date the policy will end if the *Premium* remains unpaid.

J. INCONTESTABILITY

~~Drafting Note: Model 180-1 refers to this provision as Time Limit on Certain Defenses, and companies use this title and Incontestability interchangeably in approved forms today, so we suggest that the Interstate Insurance Product Regulation Commission allow either title to be used at the option of the insurance company.~~

12/2/14 - IIPRC Staff Update: The Subgroup questioned whether the terms Incontestability and Time Limit on Certain Defenses are used interchangeably. They note that the Individually Disability Income Uniform Standards allow for either an Incontestable provision or a Time Limit for Certain Defenses under §3 POLICY PROVISIONS C. Required Provisions (8) Misstatements in the Application, as well as a separate provision (19) Time Limit for Certain Defenses Other Than Misstatements in the Application. Model Law 100 does not specifically address the provision by name, rather it requires “A provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue. Absent a showing of intentional fraud, no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person’s lifetime nor unless the statement is contained in a written instrument signed by the person making the statement. However, no such provision shall preclude the assertion at any time of defenses based upon the person’s ineligibility for coverage under the policy or upon other provisions in the policy.”

- (1) The policy shall include an incontestability provision for statements made by the policyholder and the certificate shall include an incontestability provision for statements made by *Covered Persons*.

- (a) ***Policy Incontestability Provision.*** The provision shall state that:
- (i) Any statement made by the policyholder shall be considered a representation and not a warranty;
 - (ii) The insurance company shall not use such statements to avoid insurance, reduce benefits or defend a claim unless it is included in a written application which has been made a part of the policy;
 - (iii) The insurance company shall not use such statement to contest disability income insurance after it has been in force for two years from its effective date, or date of last reinstatement, if applicable. However, fraud in the procurement of the policy may be contestable when permitted by applicable law in the state where the policy is delivered or issued for delivery; and
 - (iv) The statement on which the contest is based shall be material to the risk accepted or the hazard assumed by the insurance company; and
- (b) ***Certificate Incontestability Provision.*** The provision shall state that:
- (i) Any statement made by a *Covered Person* shall be considered a representation and not a warranty;
 - (ii) The insurance company shall not use such statements to avoid insurance, reduce benefits or defend a claim unless it is included in a written statement of insurability which has been signed by the *Covered Person* and a copy of such statement of insurability has been given to the *Covered Person* or to the *Covered Person's Beneficiary Eligible Survivor or personal representative, as applicable*;

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC submitted the following comment:

Item (1)(b) Certificate Incontestability provisions, sub-item (ii.) We have no definition for “Beneficiary” but we do have one for “Eligible Survivor” which may be designated for the Incidental Benefits. We have checked what companies have filed/approved and based on this suggest changing to say “or to the Covered Person’s Eligible Survivor or personal representative, as applicable.”

Based on the IAC comment, the following revision is submitted for the PSC’s consideration:

- (b) ***Certificate Incontestability Provision.*** The provision shall state that:
- (i) Any statement made by a *Covered Person* shall be considered a representation and not a warranty;
 - (ii) The insurance company shall not use such statements to avoid insurance, reduce benefits or defend a claim unless it is included in a written statement of insurability which has

been signed by the *Covered Person* and a copy of such statement of insurability has been given to the *Covered Person* or to the *Covered Person's* **Beneficiary Eligible Survivor or personal representative, as applicable**;

2/11/15 IIPRC Staff Update following the 2/9/15 PSC call: The PSC agreed with the Industry's recommended revisions.

- (iii) The insurance company shall not use a *Covered Person's* statement which relates to insurability to contest disability income insurance, after it has been in force for two years during the *Covered Person's* life. In addition, the insurance company will not use such statement to contest an increase or benefit addition to such insurance, or reinstatement of insurance, if applicable, after the increase, benefit or reinstatement, as applicable, has been in force for two years during the *Covered Person's* life. However, fraud in the procurement of coverage under the policy may be contestable when permitted by applicable law in the state where the certificate is delivered or issued for delivery; and
- (iv) The statement on which the contest is based shall be material to the risk accepted or the hazard assumed by the insurance company.

K. MISSTATEMENT OF A COVERED PERSON'S AGE

The certificate shall include a provision for misstatement of a *Covered Person's* age stating that the correct age shall be used to determine if insurance is in effect and, as appropriate, adjust the *Premium* and/or benefits. The insurance company may terminate coverage and refund premiums if the correct age at the time of issue is outside the issue age ranges for the plan in question.

L. PARTICIPATING POLICY

- (1) The policy shall include a provision stating whether the policy is participating or non-participating. If the policy is participating in the divisible surplus of the insurance company, then the following shall apply:
 - (a) The conditions of the participation shall be included in the policy;
 - (b) The policy shall provide that the insurance company shall annually ascertain and apportion any divisible surplus, beginning not later than the third year;
 - (c) The policy shall provide that the policyholder may receive any dividend payment in cash or as a reduction in premium payments. Other dividend options may be provided in the policy;
 - (d) Any dividend or cash payments shall be based on the actual experience of the policyholder, or of a class of policyholders, or a combination of such experience.

Such amounts shall also be based upon an objective formula which is set forth explicitly in writing, is actuarially sound, is uniformly applied and is approved by the insurance company's board of directors.

- (e) Any dividend or cash payments may be applied to reduce the policyholder's part of the cost of the policy, except that the excess, if any, of the *Covered Person's* aggregate contributions for coverage under the policy over the net cost of coverage shall be applied by the policyholder for the sole benefit of the *Covered Persons*.
- (f) The policy shall provide for an automatic dividend option if more than one dividend option is provided. If the policy provides for more than one dividend option, the policy shall identify the automatic option;
- (g) Any additional supplemental benefits attached to a participating policy, whether or not considered in determining surplus earnings, may not be specially labeled or described as non-participating; and
- (h) The policy shall state that any dividend accumulations and the cash value of any paid up dividend additions shall be paid to the policyholder when the policy ends.

M. PAYMENT OF *PREMIUM*

- (1) The policy shall contain provisions specifying the requirements for payment of *Premium*, including:
 - (a) A provision stating that the policy is issued in return for the payment by the policyholder of required *Premiums* in United States dollars;
 - (b) A provision specifying where *Premium* payments are to be sent, such as to the home office of the insurance company or to a designated administrative office or address;
 - (c) A provision stating that the first *Premium* is due on and shall be paid by the policy's effective date, or by the end of a specified policy period;
 - (d) A provision specifying the *Premium* mode and due dates for later *Premiums*, such as monthly, quarterly, semi-annually or annually in advance, or in arrears, as applicable;
 - (e) A provision stating that the *Premium* due on any premium due date is determined by the total amount of insurance provided by the policy on such date, multiplied by the appropriate *Premium* rate(s) which are in effect subject to any *Premium* adjustment, if applicable;
 - (f) A provision stating that the insurance company may use any reasonable method to compute *Premiums* due under the policy;

- (g) A provision stating how *Premium* will be computed for changes in insurance. For example, for a monthly *Premium* due date, if insurance takes effect after the first of the month, premium may be charged from the first day of the next month;
 - (h) A provision specifying the insurance company's right to change *Premium* rates for changes which materially affect the risk assumed for the insurance provided under the policy, such as:
 - (i) When the policy is changed by a rider, endorsement or amendment;
 - (ii) When a class of eligible persons is added to or deleted from the policy for any reason, including corporate restructuring, acquisitions, spin-off or similar situations;
 - (iii) When a policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from the policy for any reason, including corporate restructuring, acquisitions, spin-off or similar situations;
 - (iv) There is a significant change in the geographic distribution of *Covered Persons*;
 - (v) When applicable law or Interstate Insurance Product Regulation Commission standard requires a change in:
 - (A) The insurance provided by the policy; and/or
 - (B) The class of persons eligible under the policy; or
 - (vi) When a *Premium* due date coincides with or next follows:
 - (A) A change greater than a specified percentage in the number of *Covered Persons* , such as 20%, since the later of the policy effective date and the last date *Premium* rates were changed; or
 - (B) A change greater than a specified percentage (such as 20%) in the amount of insurance provided under the policy since the later of the policy effective date and the last date *Premium* rates were changed; and
 - (i) The policy may include any other payment of *Premium* provisions approved by the Interstate Insurance Product Regulation Commission.
- (2) The provision may also allow the insurance company to change *Premium* rates:

- (a) On any date on or after the first *Policy Anniversary*, unless there is a specified rate guarantee included in the policy. If the provision allows the insurance company to change *Premium* rates on any date on or after the first *Policy Anniversary*, the provision shall provide that if the insurance company changes *Premium* rates, the insurance company shall give written notice to the policyholder of at least 31 days in advance of such change; and
 - (b) On any other date agreed to by the insurance company and the policyholder.
- (3) The provision shall state that new *Premium* rates will apply only to *Premiums* due on or after the rate change takes effect.
 - (4) If no *Premium* is due for a *Covered Person* who is entitled to receive group *Disability* income benefits under the certificate, the provision shall so state.

N. REQUIRED TOTAL DISABILITY BENEFIT

- (1) A *Disability* income policy or certificate shall provide a benefit for at least *Total Disability*. *Disability* income certificates providing benefits only for *Partial*, *Residual* or *Presumptive Disabilities* or any disabilities less than *Total Disability* shall not be approved by the Interstate Insurance Product Regulation Commission. At the insurance company's option, a *Disability* income policy or certificate may or may not provide coverage for *Disabilities* in addition to a required benefit for *Total Disability*.

O. SUSPENSION OF COVERAGE WHILE IN MILITARY SERVICE

- (1) If the certificate does not provide for continuation of insurance when a *Covered Person* enters military service, the certificate shall state that if a *Covered Person* enters military service, the *Covered Person* shall be entitled to have their coverage suspended and reinstated in accordance with the requirements of the federal Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, as amended.

P. TERMINATION OF INSURANCE UNDER THE POLICY

- (1) The policy shall include a provision stating how and when insurance may end under the policy.
 - (a) The provision may state that the policyholder may end the policy by giving a specified period of at least 31 days of advance written notice to the insurance company. In this case, the policy shall end on the later of:
 - (i) The date stated in the written notice; or
 - (ii) The date the insurance company receives the notice;

- (b) The provision may state that the insurance company may end the policy for specified reasons, including:
- (i) On the date *Premium* is not paid when due, subject to the grace period provisions of the policy;
 - (ii) On any *Premium* due date, by giving the policyholder ~~a specified period~~ (such as no less than 31 days) of advance written notice if less than:
 - (A) A specified percentage (such as 75%) of persons eligible under the policy are insured for *Contributory* insurance;
 - (B) 100% of persons eligible under the policy are insured for *Noncontributory* insurance; or
 - (C) A specified number of *Covered Persons* (such as 100) are insured under the policy;
 - (iii) Upon a determination that there is a significant change in the group size, or the occupations or ages of the eligible *Covered Persons* as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the policyholder and/or its *Employees*;
 - (iv) On any *Premium* due date, by giving the policyholder a specified period (such as 31 days) of advance written notice if the policyholder fails to provide information on a timely basis or perform any obligations required by this policy and applicable law; and
 - (v) On any *Policy Anniversary*, except during any rate guarantee period, by giving the policyholder a specified period (such as 31 days) of advance written notice; and
- ~~(e) — The form may include any other specified reasons approved by the Interstate Insurance Product Regulation Commission.~~
- (2) The provision shall state that if the policy ends, written notice of this shall be given to all *Covered Persons* as soon as reasonably possible. This provision shall specify whether the insurance company or policyholder is responsible for giving notice.
- (3) The provision shall state that if the policy ends, all *Premiums* due shall be paid.
- (4) The provision shall state that if the insurance company accepts *Premium* after the date the policy ends, such acceptance shall not act to reinstate the policy. The insurance company shall refund any unearned *Premium* as soon as reasonably possible, but in no event later than 30 days following receipt of the unearned Premium. Delayed refund of any unearned Premium shall be subject to simple interest at the rate of 10% per year beginning with the

31st day after receipt of the unearned Premium and ending on the day the premium refund is issued.

1/21/15 IIPRC Staff Update following the Public Call 1/13/15: The IAC submitted the following comments:

Item (1)(a). There is no explanation given for the proposed deletion. This represents another difference from Group Term Life and a consistency issue as discussed above. This is a group issue, not specific to DI, and represents a rewrite of standards previously adopted. Why would it not make good business sense to require a policyholder to give no less than a 31 days' notice when this is required of the insurance company in (b)(ii)? We oppose the deletion.

Item (1)(c). Another change from Group Term Life standards – why is this necessary?

Item (4). We agree with the addition of “as soon as reasonably possible” but oppose a specific time frame. Including a specific time frame is a slippery slope for arguing that if the refund is made after 30 days that this would constitute a reinstatement of coverage. Note DATA NEEDED item (3) on page 22. Also note that the REINSTATEMENT provision on page 25, which has not yet been reviewed, is a “may” provision, as it is for Group Term Life, and only addresses the grace period lapsing for nonpayment of premium. We respectfully request that the 30 days deadline be deleted.

2/11/15 IIPRC Staff Update following the 2/9/15 PSC call: The PSC agreed to require the same 31 day time period for the policyholder to provide notice of intent to terminate coverage to allow processing time for the insurance company and to allow time for the policyholder to notify *Covered Persons*. With respect to (1)(c), the PSC notes that although similar language exists in some Uniform Standards, IIPRC staff applies the standard conservatively and would consult with the PSC if a filing was submitted that went beyond the identified reasons for termination. The PSC decided to retain the 30 day time period in (4) to assure timely return of unearned premiums. The PSC added language requiring interest for delayed return of premium to make it clear that delayed return of premium does not reinstate coverage.

§ 5. REHABILITATION PROVISIONS

Drafting Note: (Explanatory note to be deleted with final recommendations for adoption)

~~The primary role of Disability insurance generally remains to provide income replacement benefits to those who have lost the ability to provide financially for themselves, and their families if any, as a result of Illness or Injury. The most recent thirty five years in the group insurance market have however expanded the value proposition traditionally offered by the industry to include a significant focus on Employee productivity and return to work. The business owners who sponsor and often pay for Disability plans certainly want to provide financial security to those workers genuinely incapable of work, but they are also committed to improving the productivity of their work forces and providing plans that both actively address the obstacles in the way of return to work and that are structured to ensure that those who can work, do, with whatever assistance is needed. Because of this focus, which differs from the more~~

~~directly self-interested focus of purchasers of individual disability insurance, group Disability provisions often include features which are different from those found in individual policies. One area in which such differences are seen is the area of rehabilitation provisions.~~

~~Also impacting group Disability insurance rehabilitation provisions and related provisions is a concept from personal injury law (also found in property and casualty law and in the common law in connection with breach of contract cases), namely that an individual who has suffered a loss has a responsibility to take reasonable steps to mitigate the loss.~~

~~We are recommending a separate section in the standards for the rehabilitation benefits for the following reasons:~~

~~1. many modern group rehabilitation provisions or related provisions contain both “carrots” and “sticks”, and therefore are neither an unalloyed limitation or exclusion provision nor an unalloyed benefit provision as we are using that term; and~~

~~2. the importance of rehabilitation and return to work efforts in our industry’s current value proposition merits independent treatment in any case.~~

(1) A certificate may include a rehabilitation provision. If included, the provision may include either vocational rehabilitation, medical rehabilitation, or both. Services offered by or through the insurance company may include, but are not limited to:

- (a) assistance in designing a viable rehabilitation plan;
- (b) coordination of physical and medical rehabilitation services;
- (c) financial and business planning assistance;
- (d) vocational evaluation and transferable skills analyses;
- (e) career counseling and retraining;
- (f) labor market surveys and job placement services; and /or
- (g) evaluation of necessary worksite modifications and adaptive or durable medical equipment.

(2) If the certificate includes a rehabilitation provision, the following rehabilitation provisions apply:

(a) The certificate shall state that the decision whether to offer such services to the Covered Person or not, and if so, which services, shall be made by the insurance company.

IIPRC Staff Update 1/6/15: The Subgroup agreed that as originally drafted, this provision may seem to require all certificates to include this statement even if the policy does not offer rehabilitation services. It is the Subgroup’s belief that the intent is to clarify that the decision in each individual case of whether the *Covered Person* is eligible (and to what extent) for rehabilitation benefits is made by the insurance company, so suggest the revision for clarity, along with reformatting to add the following provisions under (2).

- (3b) The certificate may state ~~that the insurance company may also agree to fund, directly or indirectly, most or all of the extent to which the insurance company is paying~~ the expenses associated with a rehabilitation plan in which a *Covered Person* is participating. ~~in good faith. If the insurance company requires the Covered Person to pay any expenses associated with a rehabilitation plan, the Covered Person's participation in the rehabilitation plan shall be voluntary.~~
- (4c) The certificate may state that the insurance company may also provide additional inducements to encourage participation in a plan. For example, it may increase the basic benefit payment for the duration during which a *Covered Person* is participating ~~in good faith~~ in a rehabilitation plan, or it may agree to continue payments for a time even after a *Covered Person* has recovered if the *Covered Person* has not yet found work.
- (5d) The certificate shall state that nonparticipation in a rehabilitation plan shall not affect the insurance company's determination of whether a *Covered Person* is *Disabled*. However, unless the insurance company requires the covered person to pay any expenses associated with a rehabilitation as described in (b) above, an insurance company may include a provision indicating that failure to participate in a rehabilitation plan, without good cause (where "good cause" means a medical reason documented by the Covered Person's treating physician preventing implementation of the rehabilitation plan), may result in the reduction or cessation of the *Covered Person's* right to *Disability* benefits, in a manner specified in the certificate.
- (6e) The certificate may also include a provision stating that vocational services may be offered to *Spouses of Disabled Covered Persons*. If included, the provision shall describe the services offered and the terms and conditions for receiving benefits for such services under the certificate. Subject to the policy terms and conditions, vocational services provided to Spouses of Disabled Covered Persons will not impact the Disability benefits provided to the Covered Person.

1/6/14 - IIPRC Staff Update: On 12/16/14, the Subgroup discussed the rehabilitation provisions and expressed concern with the lack of parameters in the draft provisions found in §5(3) and (5)(now formatted as 5(2)(b) and (d)) in areas such as the potential for a *Covered Person* to be responsible for expenses associated with rehabilitation and to face reduction or cessation of benefits for failure to participate in a program the *Covered Person* cannot afford. Some members also requested that the standards to include approval by the treating physician for participation in rehabilitation. The term "good faith" was considered vague and subject to interpretation, and the subgroup agreed to eliminate this qualifier. In §5(6 (now 5(2)(e))), the subgroup agreed to add a provision stating that rehabilitation services for the spouse do not impact the disability benefits for the *Disabled Covered Person* to assure that the *Disabled Covered Person* continues to receive benefits. Alternative language in this subsection is intended to balance the employer's desire to return the *Covered Person* to work with the *Covered Person's* ability to have the treating physician involved in the process and to not lose benefits

based on inability to pay for rehabilitation services if required. The Subgroup agreed to the revisions.

2/11/15 IPRC Staff Update following the 2/9/15 PSC member call: The PSC questioned whether the language made it clear that (d) would not apply if the covered person was required to pay for the plan and added the following language:

(~~5~~d) The certificate shall state that nonparticipation in a rehabilitation plan shall not affect the insurance company's determination of whether a *Covered Person* is *Disabled*. However, unless the insurance company requires the covered person to pay any expenses associated with a rehabilitation as described in (b) above, an insurance company may include a provision indicating that failure to participate in a rehabilitation plan, without good cause (where "good cause" means a medical reason documented by the *Covered Person's* treating physician preventing implementation of the rehabilitation plan), may result in the reduction or cessation of the *Covered Person's* right to *Disability* benefits, in a manner specified in the certificate.

§ 6. OPTIONAL PROVISIONS

The Interstate Insurance Product Regulation Commission may approve the following optional provisions if the provisions meet the standards as set forth below. The insurance company may, at its option, use a provision of different wording approved by the Interstate Insurance Product Regulation Commission that is not less favorable in any respect to the *Covered Person*. The insurance company may include in the certificate one or more of these optional provisions.

A. ARBITRATION

- (1) An arbitration provision may be included in the policy or certificate. If included, the provision shall permit only voluntary post-dispute binding arbitration. With respect to such a provision, the following guidelines apply:
 - (a) Arbitration shall be conducted in accordance with the rules of the American Arbitration Association ("AAA"), before a panel of 3 neutral arbitrators who are knowledgeable in the field of disability income insurance and appointed from a panel list provided by AAA.
 - (b) Arbitration shall be held in the city or county where the policyholder is located or where the Covered Person lives.
 - (c) The cost of arbitration shall be paid by the insurance company, to include any deposits or administrative fee required to commence a dispute in arbitration, as well as any other fee including an arbitrator's fee.
 - (d) Where there is an inconsistency between these guidelines and AAA rules, these guidelines control.

B. ASSIGNMENT OF BENEFITS

- (1) The certificate may include a provision allowing the *Covered Person* whose claim for benefits has been approved to assign the benefits payable under the certificate.

C. AUTHORITY

- (1) The policy and certificate may state that the policyholder has delegated to the insurance company and agrees that the insurance company ~~has discretionary authority~~ reserves the right to make an initial determine determination regarding eligibility for participation or benefits and ~~to interpret the~~ terms of the policy and certificate.

1/6/15 IIPRC Staff Update: The Subgroup expressed concerns that this provision could allow Discretionary Clauses and questioned if it could allow sole discretion to the insurer to interpret benefits or the terms of the policy and certificate. They agreed to delete the Authority provision and ask the Industry why this is needed and why it does not conflict with the Discretionary Clauses provision found in § 8 PROHIBITED LIMITATIONS AND EXCLUSIONS.

1/15/15 IIPRC Staff Update: IIPRC staff asked the industry about this provision and received the following response:

The Discretionary Clauses (in §8 Prohibited Limitations and Exclusions) is establishing what can't be said (Prohibited Provisions). The AUTHORITY approach is a more positive one for what authority *may* be delegated (this is an Optional Provision). Both are consistent with each other.

The prohibited Provision will not show up in a policy/certificate, so a company/employer may want to include the AUTHORITY provision to establish guidelines.

IIPRC staff suggests that the Subgroup consider the following language to assure consistency between the two provisions:

Subject to the provisions of §8 Prohibited Limitations and Exclusions (2) Discretionary Clauses, ~~t~~The policy and certificate may state that the policyholder has delegated to the insurance company and agrees that the insurance company has discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy and certificate.

1/28/2015 IIPRC Staff Update: Upon review of the Industry response and recommended revisions, the Subgroup expressed concerns with using the language "has discretionary authority". A Subgroup member offered language from state regulation. The members agreed to review language on the next call that retains the provision without reference to discretionary authority.

IIPRC staff suggests that the Subgroup consider the following language:

The policy and certificate may state that the policyholder has delegated to the insurance company and agrees that the insurance company ~~has discretionary authority~~ reserves the right to determine eligibility for participation or benefits and to make an initial interpret interpretation as to the terms of the policy and certificate.

2/4/15 IIPRC Staff Update following the 2/3/15 Subgroup call: The Subgroup agreed to the recommended revisions.

2/11/15 IIPRC Staff Update following the 2/9/2015 PSC Member call: The PSC recommended further revisions to clarify that the initial determination is for eligibility, benefits and the terms of the policy and certificate.

The policy and certificate may state that the policyholder has delegated to the insurance company and agrees that the insurance company ~~has discretionary authority~~ reserves the right to make an initial ~~determine~~ determination regarding eligibility for participation or benefits and to make an initial interpret interpretation as to the terms of the policy and certificate.

D. CONTINUATION OF GROUP DISABILITY INCOME INSURANCE

- (1) The policy may allow for continuation of insurance if group *Disability* income insurance would otherwise end, at the option of the insurance company. If continuation is provided, the continuation shall be provided on a uniform basis precluding individual selection. The provisions describing the continuation may be included in the policy but shall be included in the certificate. The provisions may also be added to the policy or the certificate by rider, endorsement or amendment. The provisions shall also specify the premium requirements for continuation.
- (2) Continuation of insurance may be provided for situations specified in the certificate. The situations may include, but are not limited to, the following:
 - (a) while the *Covered Person* is *Disabled*, up to the maximum *Benefit Period* specified in the certificate;
 - (b) ~~while the Covered Person is during on~~ a family and medical leave as permitted by the federal Family and Medical Leave Act of 1993 (FMLA) or any similar state law; or
 - (c) for *Covered Persons* who cease *Active Work* in an eligible class, continuation of insurance will be provided for the situations specified in the certificate. The situations may include, but are not limited to, the following:
 - (i) Due to *Injury* or *Sickness* covered under the certificate, up to the period specified in the certificate (such as 12 months);
 - (ii) Due to *Injury* or *Sickness* not covered under the certificate, up to the period specified in the certificate (such as the end of the calendar month following the cessation of *Active Work*);

- (iii) Due to part-time work, temporary layoff or strike, up to the period specified in the certificate (such as 12 months);
 - (iv) Due to a policyholder approved leave of absence, up to the period specified in the certificate (such as 12 months); or
 - (v) Due to military service, up to the period specified in the certificate (such as for the period of service not to exceed 5 years).
- (3) The provisions shall state that at the end of a continuation period, if the *Covered Person* resumes *Active Work* in an eligible class, the *Covered Person's* insurance will continue under the policy. If the *Covered Person* does not resume *Active Work* in an eligible class, insurance will end in accordance with the *Date a Covered Person's Insurance Ends* provision.

1/6/15 IIPRC Staff Update: Language was added to (b) for consistency in formatting.

E. CONVERSION OF GROUP DISABILITY INCOME INSURANCE

Drafting Note:

In today's marketplace, companies are providing conversion to an individual policy, or under another group policy that has been issued specifically for, and limited to, providing conversion coverage for *Covered Persons* whose coverage ends under an employer's plan. Companies have advised that these group conversion policies are approved for use in all Compacting States. Companies have also advised that they may provide one option or the other, but never both. Accordingly, we are recommending standards that address both conversion options on an optional basis.

It should be noted that under traditional group *Disability* income plans, companies may provide either a conversion option or a portability option. However, the industry prefers to provide as much flexibility as possible and is recommending that the standards also accommodate a plan that may provide conversion and portability options. It is important to note that under group *Disability* income plans, conversion and portability provide different benefits. Conversion may result in amounts of insurance which are less than what the *Covered Person* was insured under the employer's plan. Portability allows a *Covered Person* to "port" the same coverage that was in effect on the day coverage ended under the employer's plan.

- (1) The policy may allow for conversion of group *Disability* income insurance that ends under the policy, at the option of the insurance company. If conversion is provided, conversion shall be provided on a uniform basis precluding individual selection. The provisions describing such conversion may be included in the policy but shall be included in the certificate. The provisions may also be added to the policy or the certificate by rider, endorsement or amendment. At the option of the insurance company, the provisions give *Covered Persons* who are eligible either the right to buy an individual policy of *Disability* income insurance from the insurance company, or become covered under

another group policy that has been issued by the insurance company specifically for, and limited to, providing *Disability* conversion coverage (“conversion coverage”).

- (a) The provisions shall specify if conversion coverage will be provided under an individual policy of *Disability* income insurance issued by the insurance company, or if coverage will be provided under another group policy that has been issued by the insurance company specifically for, and limited to, providing *Disability* conversion coverage;
- (b) The provisions may state that, for maximum benefit amounts less than a specified amount stated in the certificate (such as \$4,000), evidence of insurability satisfactory to the insurance company is not required if a *Covered Person* applies for the conversion coverage and pays the required *Premium* and the insurance company receives such application and *Premium* during the specified conversion period of at least 31 calendar days after the date on which group *Disability* income insurance ends. For a maximum benefit amount equal to or in excess of a specified amount in the certificate (such as \$4,000), evidence of insurability satisfactory to the insurance company may be required;
- (c) The provisions shall describe the situations which may entitle a *Covered Person* to convert if the *Covered Person's* group *Disability* income insurance ends and the *Covered Person* had been insured under the group *Disability* policy for a period of time specified in the certificate (such as 12 months). The situations may include, but are not limited to, the following:
 - (i) The *Covered Person's* employment ends;
 - (ii) The *Covered Person's* continuation of insurance, if any, ends; or
 - (iii) The *Covered Person's* portability coverage, if any, ends;
- (d) The provisions shall describe situations which would not entitle a *Covered Person* to convert. The situations may include, but are not limited to, the following:
 - (i) The policy ends;
 - (ii) The policy is changed to end *Disability* income insurance for the eligible class to which the *Covered Person* belongs;
 - (iii) The *Covered Person* is *Disabled*;
 - (iv) The *Covered Person's* group *Disability* income insurance ended due to nonpayment of *Premium*;
 - (v) The *Covered Person* applies for the conversion coverage after the expiration of the conversion period;

- (vi) The *Covered Person* retires;
 - (vii) The *Covered Person* becomes insured under another group *Disability* insurance policy within 31 days after insurance ends under this group *Disability* insurance policy; or
 - (viii) The *Covered Person* has attained an age specified in the certificate (such as age 70 or older) on the date group *Disability* income insurance ends; and
- (e) The following conversion provisions shall apply:
- (i) The provisions shall state that, if evidence of insurability satisfactory to the insurance company is not required, the insurance company must receive the completed application and required *Premium* within a specified period of at least 31 days after insurance ends (the “conversion period”). If evidence of insurability satisfactory to the insurance company is required, the insurance company must receive a completed application and the required evidence of insurability within the conversion period;
 - (ii) If conversion is offered to an individual *Disability* income insurance policy, the provisions shall state that:
 - (A) The conversion policy may be any form then customarily offered by the insurance company;
 - (B) The *Premiums* for the conversion policy shall be based on the insurance company’s rates then in use for the form, the amount of insurance to which the *Covered Person* becomes eligible to convert, and the *Covered Person’s* class of risk and attained age when insurance ended;
 - (C) The conversion policy may be issued without any additional benefits, whether or not such benefits were in effect on the date insurance ended; and
 - (D) The conversion policy will take effect on the first say after the day that coverage ended; and
 - (iii) If conversion is offered under another group policy, the provisions shall state that:
 - (A) A new certificate will be issued under the group policy;

- (B) The new certificate will describe the benefits provided;
- (C) The *Premiums* for the new certificate shall be based on the insurance company's rates then in use for the group conversion policy, the amount of insurance to which the *Covered Person* becomes eligible to convert, and the *Covered Person's* amount of insurance and attained age when insurance ended;
- (D) The new certificate may be issued without any additional benefits, whether or not such benefits were in effect on the date insurance ended;
- (E) The application for conversion may include a schedule of *Premiums* and payment instructions, or such schedule and instructions will be included in the application kit; and
- (F) For converted amounts of insurance that were not subject to evidence of insurability satisfactory to the insurance company, the new certificate shall take effect on first day after the day that coverage ended under the certificate. For converted amounts of insurance that were subject to evidence of insurability satisfactory to the insurance company, the new certificate shall take effect on the later of (i) the date the insurance company approved the evidence of insurability, or (ii) the first day after the day that coverage ended under the certificate.

F. POLICY AND CERTIFICATE CHANGES

- (1) The policy may include a provision which states that the terms and provisions of the policy and certificate may be changed, at any time, without the consent of the *Covered Persons* or anyone else with a beneficial interest in it. If the policy contains such a provision, the provision shall also be included in the certificate.
 - (a) This provision shall state that the insurance company may issue riders, endorsements or amendments to effect such changes, and these forms are subject to prior approval by the Interstate Insurance Product Regulation Commission;
 - (b) This provision shall state that the insurance company shall only make changes that are consistent with Interstate Insurance Product Regulation Commission standards;
 - (c) This provision shall state that a rider, endorsement or amendment shall not affect the insurance provided under certificates until the effective date of the change, unless retroactivity is required by the Interstate Insurance Product Regulation Commission;

- (d) This provision shall state that a change or waiver of the terms and provisions of the policy and certificate shall be evidenced by a rider, endorsement or amendment signed by an officer of the insurance company;
 - (e) This provision may further state that a sales representative, or other employee of the insurance company, who is not an officer of the insurance company does not have the insurance company's authority to approve such changes or waivers; and
 - (f) This provision shall state that a copy of the rider, endorsement or amendment shall be provided to the policyholder for attachment to the policy, and shall also be provided to the *Certificateholder* for attachment to the certificate if the change affects the certificate.
- (2) Any rider, endorsement or amendment added to the policy after the date of issue that diminishes rights, benefits or coverage in the policy shall require signed acceptance by the policyholder.

G. PORTABILITY OF GROUP *DISABILITY* INCOME INSURANCE

- (1) The policy may allow for portability of group *Disability* income insurance that ends under the policy, at the option of the insurance company (portability). If portability coverage is provided, portability shall be provided on a uniform basis precluding individual selection. The provisions describing such coverage may be included in the policy but shall be included in the certificate. The provisions may also be added to such policy or certificate by rider, endorsement or amendment.
- (a) The provisions shall specify if portability coverage will be provided under the same group policy in a separate class or if coverage will be provided under another group policy that has been issued by the insurance company specifically for, and limited to, providing portability coverage for *Covered Persons* whose coverage ends under an employer's plan;
 - (b) The provisions shall state that the portability coverage is available if the certificate is in effect at the time of the event giving rise to a *Covered Person's* eligibility to port coverage, and that portability coverage shall only be available for amounts of group *Disability* income insurance for which no application to convert is pending or has been approved;
 - (c) The provisions shall specify the maximum amount of group *Disability* income insurance that may be available under the portability option, and the amount ported shall not exceed the *Disability* income insurance amount that was provided under the certificate before the coverage ended or the maximum amount specified in the certificate;
 - (d) The provisions may state that, for maximum benefit amounts less than a specified amount stated in the certificate (such as \$4,000), evidence of insurability

satisfactory to the insurance company is not required if a *Covered Person* applies for the portability coverage and pays the required *Premium* and the insurance company receives such application and *Premium* during the specified portability period of at least 31 calendar days after the date on which group *Disability* income insurance ends. For maximum benefit amount equal to or in excess of a specified amount in the certificate (such as \$4,000), evidence of insurability satisfactory to the insurance company may be required;

- (e) The provisions shall describe the situations which may entitle a *Covered Person* to port if the *Covered Person's* group *Disability* income insurance ends and the *Covered Person* had been insured under the group *Disability* policy for a period of time specified in the certificate (such as 12 months). The situations may include, but are not limited to, the following:
 - (i) The *Covered Person's* employment ends; or
 - (ii) The *Covered Person's* continuation of insurance, if any, ends;
- (f) The provisions shall describe situations which would not entitle a *Covered Person* to port. The situations may include, but are not limited to, the following:
 - (i) The policy ends;
 - (ii) The policy is changed to end *Disability* income insurance for the eligible class to which the *Covered Person* belongs;
 - (iii) The *Covered Person* is *Disabled*;
 - (iv) The *Covered Person's* group *Disability* income insurance ended due to nonpayment of *Premium*;
 - (v) The *Covered Person* applies for the portability coverage after the expiration of the portability period;
 - (vi) The *Covered Person* retires;
 - (vii) The *Covered Person* becomes insured under another group *Disability* insurance policy within 31 days after insurance ends under this group *Disability* insurance policy; or
 - (viii) The *Covered Person* has attained an age specified in the certificate (such as age 70 or older) on the date group *Disability* income insurance ends;
- (g) The provisions shall specify the *Premium* payment requirements, such as who has the responsibility to pay the *Premium*, the frequency for such payment, etc.;

- (h) If portability coverage is to be provided under another group policy, the provisions shall state that:
 - (i) A new certificate will be issued under that group policy;
 - (ii) The new certificate will describe the benefits provided; and
 - (iii) The new certificate may include a conversion provision that provides for the *Covered Person's* right to convert if portability coverage ends at any time;
- (i) If portability coverage is to be provided under the same group policy in a separate class, the certificate may include a conversion provision that provides for the *Covered Person's* right to convert if portability coverage ends at any time; and
- (j) The application for portability coverage may include a schedule of *Premiums* and payment instructions, or such schedule and instructions will be included in the application kit; and.
- (k) For ported amounts of insurance not subject to evidence of insurability satisfactory to the insurance company, the new certificate shall take effect on first day after the day that coverage ended under the certificate. For ported amounts of insurance subject to evidence of insurability satisfactory to the insurance company, the new certificate shall take effect on the later of (i) the date the insurance company approved the evidence of insurability, or (ii) the first day after the day that coverage ended under the certificate.

~~H. PROCEDURES FOR REVIEW OF A DENIAL OF A CLAIM~~

- ~~(1) The policy may include a provision for review of denial of a claim. If a *Covered Person* wants a review of a denial of claim, the certificate shall include a provision that the *Covered Person* must request, in writing, a review of the denial of claim within a specified number of days after the *Covered Person* receives notice of the denial. The number of days shall be specified in the certificate.~~
- ~~(2) The policy shall include a provision that a *Covered Person* has the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to the *Covered Person's* claim for benefits, and the *Covered Person* may submit written comments, documents, records and other information relating to the claim for benefits.~~
- ~~(3) The policy shall include a provision that the insurance company will review a *Covered Person's* claim after receiving the *Covered Person's* request and send the *Covered Person* a notice of its decision within a specified number of days after the insurance company receives the request, or within another specified period of days if special circumstances require an extension. The number of days shall be specified in the certificate. The insurance company will state the reasons for its decision and refer the~~

~~Covered Person to the relevant provisions of the policy. The insurance company will also advise the Covered Person of the Covered Person's further appeal rights, if any.~~

Drafting Note:

~~If the policy is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the policyholder shall provide the applicable claims review procedures to Employees. Upon request from the policyholder, the insurance company may include such procedures in the back of the certificate or the procedures may be included as a separate document issued with the certificate. The procedure for review may be included in certificates issued under policies subject to ERISA, as well as policies not subject to ERISA. Because policies subject to ERISA will have to comply with ERISA requirements and policies not subject to ERISA may have other requirements, the number of days referred to in the above standards is not specified in the standard. If included for certificates issued under policies subject to ERISA, the number of days will reflect the current ERISA requirements.~~

1/6/14 - IIPRC Staff Update: The Subgroup questioned whether the provision should be required for policies that are not subject to ERISA. Members were asked to research whether their respective jurisdictions have such a requirement and IIPRC staff will survey other member states and update the Subgroup on their findings.

1/28/15 IIPRC Staff Update: The Subgroup decided since the majority of groups would be subject to ERISA requirements and Subgroup members could think of no reason a policy or certificate should fail to explain appeal rights, that it would be beneficial to make this a required provision, using less detailed language similar to that found in the Individual Disability Income Uniform Standards. The Subgroup did not believe the drafting note was required, since the note informational for insurance companies, not related to a standard for form review. The new provision is added under § 4. REQUIRED PROVISIONS A. CLAIM PROVISIONS (5) *Procedures for Review of Claim Determinations.*

2/4/15 IIPRC Staff Update following the 2/3/15 Subgroup call: The Subgroup agreed to the recommended revisions.

2/11/15 IIPRC Staff Update following the 2/9/15 PSC member call: The PSC agreed to the recommended revisions.

I. REINSTATEMENT

- (1) The policy may include a provision regarding reinstatement of the policy in the event the grace period has elapsed for nonpayment of *Premiums*. If included, the provision shall describe the conditions of the reinstatement of the policy.

J. SUBROGATION RIGHTS

- (1) The policy may include a provision that if the insurance company has paid or will pay group *Disability* income benefits under the certificate in connection with a *Disability* which a *Covered Person* suffered because of an act or omission of a third party, the

insurance company reserves any and all rights of recovery available to the insurance company under applicable law in the state where the policy is delivered or issued for delivery that the *Covered Person* has against the third party to the extent necessary to protect the insurance company's interest. The insurance company has the right to bring legal action against the third party on the *Covered Person's* behalf to recover ~~its~~ payments made by the insurance company. The *Covered Person* must agree to furnish all information and documents that are necessary to secure those rights to the insurance company. The insurance company will pay for any expenses connected with its pursuit of subrogation or recovery. The insurance company shall not deduct anticipated recovery from a third party from benefits paid to the *Covered Person*. Subject to limitations under applicable law in the state where the policy is delivered or issued for delivery, ~~if~~ a *Covered Person* makes any recovery of amounts from the third party, the amount of the *Covered Person's* recovery which is subject to the insurance company's subrogation interest must be paid to the insurance company.

1/6/15 - IIPRC Staff Update: The Subgroup discussed whether state specific prohibitions or limitations on Subrogation were significant enough that the provision should include qualifying language referencing applicable state law. Members were asked to research whether there were any subrogation limitations in their respective jurisdictions and IIPRC staff will survey other member states and update the Subgroup. If the members decide to add qualifying language, the following is suggested for consideration:

The policy may include a provision that ~~if~~ the insurance company has paid or will pay group *Disability* income benefits under the certificate in connection with a *Disability* which a *Covered Person* suffered because of an act or omission of a third party, the insurance company reserves any and all rights of recovery available to the insurance company under applicable law in the state where the policy is delivered or issued for delivery that the *Covered Person* has against the third party to the extent necessary to protect the insurance company's interest. The insurance company has the right to bring legal action against the third party on the *Covered Person's* behalf to recover its payments. The *Covered Person* must agree to furnish all information and documents that are necessary to secure those rights to the insurance company. The insurance company will pay for any expenses connected with its pursuit of subrogation or recovery.

Subject to limitations under applicable law in the state where the policy is delivered or issued for delivery, ~~if~~ a *Covered Person* makes any recovery of amounts from the third party, the amount of the *Covered Person's* recovery which is subject to the insurance company's subrogation interest must be paid to the insurance company.

1/28/15 IIPRC Staff Update: On the January 20th call, the Subgroup discussed the provision and agreed to review language with the IIPRC suggested revision and additional language prohibiting the insurance company from reducing benefits based on anticipated subrogation recovery. The following is suggested language for consideration:

The policy may include a provision that ~~if~~ the insurance company has paid or will pay group *Disability* income benefits under the certificate in connection with a *Disability* which a *Covered Person* suffered because of an act or omission of a third party, the insurance company reserves any and all rights of recovery available to the insurance company under applicable law in the state

where the policy is delivered or issued for delivery that the *Covered Person* has against the third party to the extent necessary to protect the insurance company's interest. The insurance company has the right to bring legal action against the third party on the *Covered Person's* behalf to recover ~~its~~ payments made by the insurance company. The *Covered Person* must agree to furnish all information and documents that are necessary to secure those rights to the insurance company. The insurance company will pay for any expenses connected with its pursuit of subrogation or recovery. The insurance company shall not deduct anticipated recovery from a third party from benefits paid to the *Covered Person*.

Subject to limitations under applicable law in the state where the policy is delivered or issued for delivery, ~~if~~ a *Covered Person* makes any recovery of amounts from the third party, the amount of the *Covered Person's* recovery which is subject to the insurance company's subrogation interest must be paid to the insurance company.

2/4/15 IIPRC Staff Update following the 2/3/15 Subgroup call: The Subgroup agreed to the recommended revisions.

2/11/15 IIPRC Staff Update following the 2/9/15 PSC member call: The PSC agreed to the recommended revisions.

§4. A. CLAIMS PROVISIONS, *New Item (5) Procedures for Review of Claim Determination, Page 40*

§6. OPTIONAL PROVISIONS, *Item H. Procedures For review of a Denial of a Claim (Proposed Deletion, Pages 64-65)*

Item (5) addresses all claim determinations. We are advised that the PSC prefers to include this since it was included in the IDI standards. However, the language was taken from IDI standards Item (11)(b) on pages 18-19 and only addresses facility of payment determinations, and only those where appeals or a resolution is needed – meaning that payment of any indemnity under the policy to an estate or a beneficiary deemed by the company to be equitably entitled to such payment may be challenged, and the company needs to describe how it would do so.

Additionally, there are no specific standards, so is it anticipated that companies may include whatever procedures they want? What standards will the IIPRC examiners use to determine if the language filed is acceptable?

We advise that no other IIPRC product standards address a claim determinations process for a good reason – while one could argue that there is “one process”, the process for each claim is determined by the claim specifics such as type of disability involved, type of injury or sickness involved, timelines involved, information required, etc. Initial claim determinations would require a different process than the process required for determination of ongoing claims.

For the reasons stated above, we respectfully oppose the inclusion of this standard.

*Sub-section H was reflecting the ERISA requirement which is only applicable to **adverse claim determinations, and not all determinations, and the ERISA requirements.*** The language we proposed made no reference to ERISA and this was intentional. This sub-section was included so that employers subject to ERISA can elect to include this in the certificate, or any employer may also do so (raising the bar), which is why ERISA is not mentioned. The other option for employers is to include this in the ERISA required Summary Plan Description (SPD). Employers comply with the SPD requirements in various ways: they may incorporate the SPD requirements in the back of a certificate following the filed provisions, or they may issue a separate SPD to be issued with the certificate. Some employers have elected to include the ERISA claim denial information in the certificate for all employees, which is why the sub-section was located in the Optional Provisions section. By removing this sub-section, the PSC has eliminated the employer options.

As an alternative to including this as an OPTIONAL PROVISION, the PSC may consider including this as a “may” in the Claim provisions section.

While the PSC would like to have the ERISA requirements applied to all employers, the federal law does not require this. It should be noted that the ERISA requirements are quite specific as to what constitutes such determinations. Not all employers are subject to ERISA and they may not want the language included since it is not a requirement for them. This is why the language needs to be optional/variable.

We urge the PSC to reconsider reinstating the deletion and including it in a way that allows the employer and the insurance company to decide what is required/appropriate, as applicable.

§5. REHABILITATION PROVISIONS

Item (2)(a) at bottom of page 53

The PSC has added a leading sentence to (2) which presumes that rehabilitation benefits will be provided, so (2)(a) should just say:

“The certificate shall specify which rehabilitation services are offered by or through the insurance company.”

This language is consistent with item (1).

Item (2) (b) and (d) on page 54

In the last sentence of (b) and the second sentence of (d), we are concerned about the reference to “any expenses”. If a company has a rehabilitation plan that requires a Covered Person to complete an Excel training course, the company would typically pay for course tuition, but would not pay for mileage, meals, paper, pens, etc. If a company had a rehabilitation plan requiring a Covered Person to apply for a certain number of jobs per week, the company would pay for the job coach to help draft a resume, but would not pay the internet access costs, or printer ink and postage costs for submitting the resumes. We believe that these are “diminimus” expenses that should not justify classifying a rehabilitation plan as “voluntary”.

We believe that some type of a “qualifier” is needed for “any expenses”. We could add an out of pocket dollar maximum for the Covered Person as a delineator for “voluntary”, but it would be difficult to set an amount that would be fair/appropriate for each Covered Person, and the maximum would apply for each plan component? Monthly? For the entire plan?

We respectfully request that the PSC consider this issue further.

Item (2) (d) on page 54, “treating physician”

We respectfully advise that companies cannot agree to be bound by the opinion of the Covered Person’s treating physician. Companies want and need the ability to determine good cause like they determine any other medical issue relating to disability. While the treating physician’s opinion would certainly be considered, it cannot be binding on the company. If a company reaches a contrary conclusion, it will explain why it disagrees with the treating physician and give the physician the opportunity to appeal.

§6. OPTIONAL PROVISIONS

C. AUTHORITY, Item (1), Page 56-57

While we understand what the PSC intended with “the initial”, we respectfully point out that with regard to any disability, companies would be making initial *and periodic ongoing* determinations for the disability for the duration of the disability. As proposed, the language could and will be interpreted by others to mean that a policyholder does not have the right to delegate “periodic ongoing” determinations. Additionally, we believe that the process of making a determination may, and often does, require an interpretation of the terms of the policy and certificate.

We request consideration of the following substitute language:

“The policy and certificate.....the insurance company reserves the right to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the policy and certificate for the purpose of administering the terms of the policy and certificate.”

J. SUBROGATION RIGHTS, Item (1), Pages 65-67

We have no issues with the addition of “applicable laws” since we agree that any subrogation would be subject to state laws for any right of recovery. That being the case, we presume that “deducting anticipated recovery” is also addressed by such state recovery laws, and our preference is that, if this sentence is needed, the language be changed to say:

“The insurance company may only deduct anticipated recovery from a third party from benefits paid to a Covered Person if applicable law in the state where the policy is issued for delivery permit such deduction.”

Ms. Anne Marie Narcini ,

The Product Standards Committee should not recommend adoption of a standard that permits group disability income insurance policies to deny or limit benefits otherwise payable based on the insured's "anticipated" recovery from third party tortfeasors:

1) A contractual provision allowing offset of disability income benefits against anticipated recovery from third party tortfeasors is not permitted under the law governing subrogation. Subrogation is an equitable doctrine created, in most states, by the courts.

The right of subrogation arises only when an insurer makes a payment on a loss which is the responsibility of another party/tortfeasor. The insurer is subrogated to the claim of the insured against the responsible tortfeasor in order to prevent double recovery for the loss. Subrogation law does not give rise to a right of offset for anticipated recovery for three reasons:

If payment is offset, i.e. not made, there is no right of subrogation; subrogation law grants the right to the insured's claim against the third party tortfeasor, not a right of offset; and, most important, a right of offset against anticipated recovery from a third party tortfeasor is inequitable for too many reasons to fully list here.

2) A contractual right to offset anticipated recovery from a third party tortfeasor places the insured in the inequitable position of disputing the highly uncertain outcome of the claim for loss of income. It also defeats the purpose of disability income insurance by leaving the insured with reduced or no benefits for years or even decades of litigation. It requires the insured to fund the litigation of the claim against the third party tortfeasor and requires speculative resolution of multiple areas of dispute, including whether the insured will be "Made Whole" with respect to all elements of the insured's claim (such as for medical costs, pain and suffering and the cost of prosecuting the claim) aside from the amount of the claim for loss of income.

3) The Industry Advisory Committee suggested that a right of offset for anticipated recovery from a third party tortfeasor is contemplated under the Industry Advisory Committee draft Section 9. We disagree. Section 9 appears to contemplate reduction based on the insured's first party rights to benefits under either a contractual or statutory benefit scheme. We note in particular that the Covered Person under Section 9 must be either eligible for or be entitled to the benefits on timely application. In each case the term used does not lend itself to a tort claim requiring litigation.

Items listed in Section 9 (2) that suggest to the contrary, such as Section 9 (2) (g), (n) and (o) should be revised or deleted.

Fred Nepple, Consumer Representative
Brendan Bridgeland, Center for Insurance Research Consumer Representative
Sonja Larkin-Thorne, Consumer Representative

(Note: This email is forwarded today to assure it is timely. Additional Consumer Representatives may join this email by separate communications.)