

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

**Note:** Revisions to the draft are in **red** and questions for public comment are in **green**. Industry Advisory Committee written comments submitted Oct. 22 are in **blue**.

**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.

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.

**Comment [AMN1]:** The Subgroup will discuss combination products and Mix and Match once the draft standards are finalized.

“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

**§ 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.

**IAC Comments Oct. 22, 2014**

We strongly recommend that you re-consider leaving the preamble alone, as it was in the GTL standards, and not delete the yellow highlighted text below.

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 concepts set forth below, the 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 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.

The group carriers developing the GTL standards had significant concerns that since this was the first set of "group" standards for the IIPRC and group is so different from individual, and they wanted to clearly convey in the standards that there needs to be a basic understanding /agreement that variability and flexibility is needed to accommodate employer requests, and recognizing that employers have unique requirements and preferences. For these reasons, language highlighted in yellow was included regarding the impact that policyholder/employer plan specifications and company underwriting guidelines will have on what type of benefits are included which would then impact what terms/concepts need to be defined and how.

To set the record straight, the language in this preamble was thoroughly vetted by the regulators just a few years ago and it was deemed acceptable. For decades, what was included in the GTL preamble has been deemed acceptable parameters, reflected in the terms/concepts in use today with the related Explanations of Variable Material. Once the regulators understood the issue, they were OK with the preamble. In fact, some of the yellow highlighted text was their final preferences to several earlier drafts.

We thought it would be helpful to recap some of the GTL discussions:

**Re: First Yellow Highlighted Phrase:** in a manner consistent with the policyholder's plan and the insurance company's underwriting guidelines.

What is meant here is that if the policyholder will provide Total and Presumptive Disability, that the appropriate terms/concepts needed for these benefits will be included and these will be subject to the insurance company underwriting guidelines – so a definition of Total Disability will include the triggers that the underwriting guidelines would permit for a policyholder with x number of employees located in specified work locations and engaged in specified jobs, such as engineers, miners, salespersons, etc.

**Second Highlighted Sentence:** 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.

This just underscores the reality that what is included is what is predominant in today's GDI marketplace but there is no intent to use the standards to *prescribe exactly* how terms/concepts will be filed, and that, although most terms/concepts are common, there may be variations by

policyholder or insurance company preference. This is not to say that the IIPRC won't see any of these terms/concepts but instead see a whole bunch of other terms/concepts. If one reviews the remaining standards, one can see that the terms and concepts are key to the remaining standards and this is because what we have included is fairly common in the way products are developed, filed, sold and issued.

***Third Sentence Highlighted:*** 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.

Maybe this sentence is overkill and not needed, but it was intended to reinforce the fear that someone (IIPRC examiner or state) may presume that the terms/concepts filed need to be exactly as shown in Section 3.

In the past year, the group insurance industry has met with 15 DOI staff who have advised that the volume of variability filed for group insurance is overwhelming, confusing, not organized, not mapped well, and reviewing this is a time consuming process. The comments we frequently get is that when a 10 page policy is filed with a 30 page explanation of variable material this is problematic. In addition, companies are constantly filing updates to the explanation. ACLI and the group companies explained that since the DOI should know how language filed would vary and needs to know all the possibilities, that a 30 page explanation is exactly what has to be filed, as well as updates as needed. If a company brackets the beginning of a page and the end of the page, states complain that they are approving a blank page. And yet when the company details all the variable material, this is also a problem.

This is why industry is "nervous" about "minimum standards". There has to be an understanding, appreciation and acceptance of the fact that group insurance does not work like individual insurance – in group insurance the policyholder/employer dictates what he wants to provide, and the bigger he is the bigger are the demands. While a group insurance company has past experience and can fairly well anticipate what product features are needed in most cases, it is impossible to anticipate all requests – this is why in today's state filings you see many single case filings. The single case filings are a time consuming and thankless process for the insurance companies and DOI staff, but it is what the marketplace demands.

The reality is that concern with variability and flexibility is an everyday reality for the insurance companies, and they wanted to help develop standards that are equal to or better than what exists in some states today with respect to specificity, reflect the dynamics of the GDI marketplace, and allow variability and flexibility not so that employers and insurance companies can have a free for all, but that we end up with standards that serve the needs of the regulators, the policyholders/employers, the third party beneficiaries, and the insurance companies.

The way we understand the IIPRC filing process, companies can file forms based on the standards and submit an explanation of variable material where a standard is permitted to vary. If a company anticipates the needs to include a definition of "Participant" or "Associate" for use in lieu of "Covered Person", a company would address this intent in the explanation of variable material for "Covered Person". The IIPRC would then use their judgment to determine if this is

within the permitted variability, which it should be. If a company develops a new disability concept, other than Total, Presumptive or Partial/Residual, the IAC would need to request to amend the standards to include the concept. If a company decides to add a new benefit trigger, the IAC industry this would also need to request to update the standards, as was done for accelerated death benefits to add the IRS Section 101(g) chronic illness triggers.

- (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 benefit 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 business closures if the *Covered Person was Actively at Work* on the last scheduled work day preceding such time off.

#### IAC Comments Oct. 22, 2014

We have concerns about the need to deviate from the GTL standards.

It is common in all group coverages to link actively at work and full-time. One term is usually defined by reference to the other, as the GTL and GDI reflect. They go hand in hand. The term “full-time” may be defined to have different hourly requirements for regular employees and part-time employees, different hourly requirements for different full-time eligible classes, different employer locations, etc. Alternatively, an employer may want two separate definitions, one for “full-time” and one for “part-time”. This is all handled in the Explanation of Variable Material that is submitted for “full-time”.

It should be noted that Group Life and Group DI are sometimes sold as a package, and one certificate will be issued to show both coverages. And even if the employer requests 2 separate certificates, it is preferable to have one standard for all group lines since it works exactly the same way – there is no need to change the standards now operational for GTL, and there is no reason to change the GDI term/concept.

We asked how the IIPRC would respond if a company submitted a filing with this Item (1) reading “on a full-time basis” and if the answer is that this would be allowed, then there is no need to make the proposed PSC changes.

#### *Page 2, Item (1), “Actively at Work”, Deletion of “The concept may state”*

There is no statutory or regulatory requirement that this be mandatory, as far as we know. While this may be what most policyholders include, the language here may need to vary to reflect how the policyholder/employer prefers to handle situations like business closures, especially when there are seasonal employees involved.

Our preference is to allow the variability for GTL and GDI.

- (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. 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.

**Note for Public Call: The Subgroup is considering whether the last sentence should reference employees or members of third party administrators, associations, discretionary trusts, etc. rather than the names of the groups.**

#### **IAC Comments Oct 22, 2014**

We recommend that in order to simplify what is shown, that this term/concept be subject to Model #100 Section 4.A.(1) (a) and (b).

Item (a) includes the “all the employees of the employer.

Item (b) defines “employees” to include 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 corporation, proprietorship or partnership is under common control. Also included are retired employees, former employees and directors of a corporate employer, as well as elected or appointed officials if the policy insures employees of a public body.

**10/23/14 - IIPRC Staff Note: The following would include the language found under Section 4. Permitted Groups in Model 100**

(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) “*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 the definition of *Partial Disability*, *Residual Disability* or *Total Disability*, or other types of disability approved by the Interstate Insurance Product Regulation Commission.

~~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.

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

**The Subgroup notes that the Drafting Note below is an informational note that will not appear in the final recommended standards.**

~~**Drafting Note:**~~

~~Although tests for Disability based on a Covered Person's inability to perform the Substantial and material duties 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, are the predominant approach to disability in the marketplace today, the definition of what is a loss has been and continues to be an area of considerable innovation, and the standards need to be flexible to accommodate such innovation.~~

- (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*.

#### IAC Comments Oct 22, 2014

We think the intent here was to say “but *shall* not require the ...” However, some policyholders/employers may want to integrate with paid vacation time. The purpose of disability income insurance is to provide some benefit while disabled, but not provide close to, equal to or greater than pre-disability earnings so that there is some incentive to get back to work. If a person can collect GDI benefits with salary continuation, sick leave and paid vacation time, this would defeat the GDI purpose.

We also advised that, in line with the “purpose” explained above, under the federal FLMA (“family leave act”), a person is required to use up vacation days before clocking FLMA days.

- (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.~~

### IAC Comments Oct 22, 2014

See the comments under *Actively at Work*. Both terms refer to each other.

- (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.

### IAC Comments Oct 22, 2014

We advised that “employer” is used in scope because it is referring to permissible groups as specified in the NAIC Group Health Insurance Standards, Model #100 Section 4.A. As was done if GTL, the preference is to use the term “policyholder” since the entity to which the policy may be issued may be an employer or a single employer trust.

For this reason, it should be noted that on *page 7, item (21) “Job”*, we did not include “policyholder” since the term could have referred to a trust and would then not make sense. We don’t believe that the clarification “employer” is needed.

- (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, some insurance companies may 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*.

**Questions about *Partial Disability* for Public Comment:**

**(Note: Most of these questions are similar to the questions for *total disability*)**

- **Are benefit triggers (a) and (b) always included or is it possible to have one of more of the triggers (c) – (j) alone?**
- **If a policy does not include (a) and (b), what is the justification for such a policy?**
- **Are there states that do not permit Activities of Daily Living as benefit triggers for Disability Income policies?**
- **Is there a need to separately define for short term or long term disability policies?**
- **In (b) of the definition, it refers to “work” an undefined term, while *Total Disability* references *Job*. Should work be defined or should the definition of *Partial Disability* refer to *Job*?**
- **The Individual Disability Income Standard definition of *Partial Disability* references the inability to perform some of the substantial and material duties of *Occupation* while this definition refers to being “unable to perform the *Substantial and material duties* of the work-related tests prescribed...” Please explain this difference.**

**IAC Comments Oct 22, 2014**

***First and Second Bullets:***

Sub-items (a) and (b) are the predominant ones in the marketplace today – note “and” which means that when they appear they will appear together.

Triggers (c) – (j) may be either alternatives to (a) and (b), or may be in addition to these. While potentially (a) through (j) may be included, this is not likely since this may be quite expensive – more potential for a claim. The addition of one or more triggers (c) – (j) are intended to permit a “shortcut” to benefits in that some of these triggers are not as strict as (a) and (b).

***Third Bullet:***

The companies have noted that in the past few years there is a trend for more policyholders/employers asking about the availability of the chronic illness triggers. The market has seen more interest for chronic illness triggers with accelerated death benefits, guaranteed living benefits, waiver of surrender charges, etc. Perhaps this is an outgrowth of coverage in the press regarding the fact that most people are not adequately pre-funding for the care needed for chronic illness.

We advised that a disability benefit will never be issued with only triggers (d), (e), (f) and (g), and if a company wants to sell this type of benefit the industry would have to request to amend the current GDI standards to do this, and it is possible that such a benefit may need to also be subject to all or some of the LTC standards of the IIPRC.

***Fourth Bullet:***

We advised that if a plan has only short term benefits, these would be itemized in the specifications page of the certificate where the applicable benefit details would be specified.

We advised that if a plan has only long term benefits, these would be itemized in the specifications page of the certificate where the applicable benefit details would be specified.

We advised that if a plan has both short and long term benefits, these would be itemized in the specifications page, usually under separate sub-headings of ‘SHORT TERM BENEFIT’ and ‘LONG TERM BENEFITS’.

Since the plan parameters would be specified in the specifications page, there is no need to define what is meant by “short term” or “long term” benefits.

***Fifth Bullet:***

We advised that on page 15, item (44) sub-item (b) should be changed to say “is not engaged in any *work* for wage or profit.”

We noted that the Partial/Residual and Total Disability concepts rely on inability to perform substantial and material duties of the work-related tests prescribed in the terms/concepts Regular Job, Regular Occupation, Regular Specialty, and that substantial and material duties are defined to mean the important tasks, functions and operations generally required...”. Accordingly, we don’t believe that “work” needs to be defined.

***Sixth/Last Bullet:***

There needs to be an understanding that the product works differently from individual and group. The folks who developed the individual standards were not group product experts and the group product experts are not individual DI experts – some companies sell one product and not the other. When the group DI experts reviewed what was done for IDI, they made the changes needed to better reflect how group works. For example, the IDI specified periods shown are from the A&S Model which does not apply to group insurance, so this individual standard is inapplicable to group.

- (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..

Industry Draft of Group DI Policy/Cert (June 2014)

Includes suggested revisions made by the Group Disability Income Subgroup of the Product Standards Committee

(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.~~

#### Questions about Post Disability Earnings for Public Comment:

**The term does not appear to be referenced anywhere within the Standard. Is it needed? If so, the Subgroup would like examples of the income sources and/or components referenced in the definition.**

#### IAC Comments Oct 22, 2014

We confirmed that the term “Post-Disability Earnings” is not needed in these standards.

~~(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.

#### Questions about Preexisting Condition for Public Comment:

**How do insurers determine when a *Covered Person* would seek treatment? How do they determine the conduct of an ordinarily prudent person? As an example, if a *Covered Person* ultimately became seriously ill after having minor symptoms during a time prior to coverage that would not normally require treatment, could an insurer consider this a preexisting condition?**

#### IAC Comments Oct 22, 2014

We advised that the language in question is based on NAIC Model #171, Regulation to Implement the Accident & Sickness Minimum Standards Model Act #170, page 5, Item K

**10/23/14 - IIPRC Staff Note:** The following is the language from Model 171 Accident and Sickness Minimum Standards Regulation Section 5. Policy Definitions K:

“Preexisting condition” shall not be defined more restrictively than the following: Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.

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

(312) “**Premium**” means the amount the policyholder shall pay to the insurance company for the insurance provided under the policy.

(323) “*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.

#### Questions about *Presumptive Disability* for Public Comment:

- Was the intent to make the *Presumptive Disability* benefit additional to the regular disability benefit?
- Is there a reason the term cannot be defined as it is in the Individual Disability Income Uniform Standards?

#### IAC Comments Oct 22, 2014

The companies advised that in group insurance, the *Presumptive* benefit is a shortcut to disability benefits under the certificate in those cases where someone meets the triggers – more easy to

meet this trigger since there is no work test and it removes a burden of proof of disability. Benefits are usually for the same amounts and durations as Total Disability.

- | (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.

**Question about Recurrent Disability for Public Comment:**

**Is there a reason the term cannot be defined as it is in the Individual Disability Income Uniform Standards?**

**IAC Comments Oct 22, 2014**

As stated earlier, the product works differently from individual and group. The folks who developed the individual standards were not group product experts and the group product experts are not individual DI experts – some companies sell one product and not the other. The individual DI definition/concept was subject to the A&S Model whereas the group definition/concept is not.

- | (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*.

**The Subgroup notes that the Drafting Note below is an informational note that will not appear in the final recommended standards.**

~~*Drafting Note:* The industry preference is not to equate “pregnancy” with “sickness”, since pregnant women are not considered “sick”. However, industry concedes that under state and federal law the policyholder is required to treat *Disabilities* caused by pregnancy on the same basis as *Disabilities* caused by a *Sickness*, so unless the policyholder elects to self insure *Disabilities* caused by pregnancy, *Disabilities* caused by pregnancy shall be covered under the policyholder’s policy on the same basis as those caused by *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.

**Question about Substantial and material duties for Public Comment:**

**Is the reference to the national economy or marketplace in this definition intended to supersede how the policyholder defines Regular Job, Regular Occupation and Regular Specialty?**

**IAC Comments Oct 22, 2014**

We responded as follows (more information than was provided on 10/21 is also included):

For the Job and Specialty test, the duties required by the policyholder/employer would be considered the substantial and material duties. However, for Occupation, “the national economy or marketplace” does make sense and should supersede the specific tasks required by a particular policyholder/employer. Otherwise, there is not a distinction between job and occupation. This is why we included “as applicable”.

Occupation is typically defined as a group of jobs that share similar characteristics. However, each particular policyholder/employer may require those jobs to be performed slightly differently. To determine which tasks are important to all the jobs in an occupation, and therefore substantial and material duties, a national economy or marketplace standard is standard in the industry. The national economy or marketplace standard is used because the vocational resources that analyze occupational duties collect data about occupations on a national level. For example, a receptionist in a particular medical office may be expected to spend a small part of the day filing documents. A receptionist in a law office might have no filing duties. To determine whether filing is a material duty of a receptionist, the industry typically uses vocational resources like the Department of Labor's Dictionary of Occupational Titles (DOT) or Occupational Information Network (O\*Net). These resources have analyzed jobs on a national level or marketplace and provide information about the types of skills, tasks and demands are common to all of the jobs in that occupation on a nationwide basis.

(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, some insurance companies may 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.

**Questions about *Total Disability* for Public Comment:**

**(Note: These questions are similar to the questions for *partial disability*)**

- **Are benefit triggers (a) and (b) always included or is it possible to have one or more of the triggers (c) – (j) alone?**
- **If a policy does not include (a) and (b), what is the justification for such a policy?**
- **Are there states that do not permit Activities of Daily Living as benefit triggers for Disability Income policies?**
- **Is there a need to separately define for short term or long term disability policies?**

**IAC Comments Oct 22, 2014**

See the first four bullet comments on *Partial Disability*. Note: We advised that on page 15, item (44) *Total Disability* sub-item (b) should be changed to say “is not engaged in any *work* for wage or profit.”

**Additional Question about § 3. TERMS AND CONCEPTS for Public Comment:**

**The Standard appears to be designed for both short term and long term disability policies. Is there a need to include definitions of these terms?**

**IAC Comments Oct 22, 2014**

We advised that if a plan has only short term benefits, these would be itemized in the specifications page of the certificate where the applicable benefit details would be specified.

We advised that if a plan has only long term benefits, these would be itemized in the specifications page of the certificate where the applicable benefit details would be specified.

We advised that if a plan has both short and long term benefits, these would be itemized in the specifications page, usually under separate sub-headings of ‘SHORT TERM BENEFIT’ and ‘LONG TERM BENEFITS’.

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Since the plan parameters would be specified in the specifications page, there is no need to define what is meant by “short term” or “long term” benefits