AGENDA

1. Consider Adoption of its July 27 Minutes—Commissioner Barbara D. Richardson (NV) Attachment One

2. Consider Adoption of its Task Force and Working Group Reports
   —Commissioner Barbara D. Richardson (NV)
   a. Antifraud (D) Task Force—Commissioner Trinidad Navarro (DE) Attachment Two
   b. Market Information Systems (D) Task Force—Director Lori K. Wing-Heier (AK) Attachment Three
   c. Producer Licensing (D) Task Force—Director Larry D. Deiter (SD) Attachment Four
   d. Market Conduct Examination Standards (D) Working Group—Director Bruce R. Ramge (NE) Attachment Five
   e. Market Analysis Procedures (D) Working Group—John Haworth (WA) Attachment Six
   f. Market Conduct Annual Statement Blanks (D) Working Group—Rebecca Rebholz (WI) Attachment Seven
   g. Market Regulation Certification (D) Working Group—John Haworth (WA) Attachment Eight
   h. Privacy Protections (D) Working Group—Cynthia Amann (MO) Attachment Nine
   i. Market Actions (D) Working Group—Ignatius Wheeler (TX)
   j. Advisory Organization Examination Oversight (D) Working Group—Commissioner Doug Ommen (IA)

3. Hear Presentation from Alliance of Health Care Sharing Ministries
   —Nancy Atkins (Executive Vice President of Government Relations, One Share Health)
   —Katy Talento (Executive Director, Alliance of Health Care Sharing Ministries) Attachment Ten

4. Discuss Template for Wavier of Onsite Reviews—Commissioner Barbara D. Richardson (NV) Attachment Eleven
5. Consider Adoption of Standardized Data Requests—Director Bruce R. Ramge (NE)
   - Limited Long-Term Care Examination Standards Chapter
   - Inland Marine In Force Standardized Data Request
   - Inland Marine Claims Standardized Data Request

6. Discuss Any Other Matters Brought Before the Committee—Commissioner Barbara D. Richardson (NV)

7. Adjournment
The Market Regulation and Consumer Affairs (D) Committee met via conference call July 27, 2020. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClaim represented by Jimmy Harris (AR); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron (ID); Robert H. Muriel represented by Erica Weyhenmeyer (IL); Anita G. Fox represented by Michele Riddering (MI); Chlora Lindley-Myers represented by Cynthia Amann (MO); Russell Toal represented by Robert Doucette (NM); Mike Causey represented by Tracy Biehn (NC); Kent Sullivan represented by Doug Slape, Matthew Tarpley, Jamie Walker and Ignatius Wheeler (TX); Michael S. Pieciak represented by Christina Rouleau (VT); and Mark Afable represented by Jo LeDuc and Rebecca Rebholz (WI). Also participating was: Bruce R. Ramge (NE).

1. **Adopted its 2019 Fall National Meeting Minutes**

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the Committee’s Dec. 19, 2019, minutes (see *NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. **Adopted Farmowners SDRs**

Director Ramge said the Market Conduct Examination Standards (D) Working Group adopted on Dec. 18, 2019, a farmowners claims standardized data request (SDR) (Attachment ??) and a farmowners policy in-force SDR (Attachment ??). There were no questions or comments on the SDRs.

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the farmowners claims SDR and the farmowners policy in-force SDR. The motion passed unanimously.

3. **Adopted Revised Market Conduct Annual Statement Blanks**

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met May 28, May 27, May 21 and May 20 and adopted edits to existing Market Conduct Annual Statement (MCAS) lines of business. The Working Group also met June 24 and adopted instructional clarifications needed that related to changes adopted in May. Ms. Rebholz provided the following summary of changes:

- **a. Life and Annuities Data Call and Definitions** (Attachment ??)

Two data elements were added that related to policy surrenders. An interrogatory was added to identify third-party administrators (TPAs) used by the company along with their function. Reporting was added for external replacements of unaffiliated company policies and external replacements of affiliated company policies. Lawsuits data elements were added for consistency across the MCAS lines of business. Reporting for Individual Indexed Fixed Annuities and Individual Other Fixed Annuities. Reporting for Individual Variable Annuities was broken out into Individual Indexed Variable Annuities and Individual Other Variable Annuities.

- **b. Homeowners Data Call and Definitions** (Attachment ??)

Wording for interrogatories related to the explanation of company changes was updated for clarity. Interrogatories were added to report managing general agents (MGAs) and TPAs used by the company. Lawsuits data elements and definitions were updated to be consistent across MCAS lines of business. Policy count data elements were added to the underwriting for the reporting of: 1) dwelling fire policies; 2) homeowner policies; 3) tenant/renter/condo policies; and 4) all other residential property policies.

- **c. Private Passenger Auto Data Call and Definitions** (Attachment ??)

Wording for interrogatories related to the explanation of company changes was updated for clarity. Interrogatories were added to report MGAs and TPAs used by the company. Lawsuits data elements and definitions were updated to be consistent across
MCAS lines of business. An interrogatory was added to report the use of telematics or usage-based data. A data element was added for “claims closed without payment because the amount claimed is below the insured’s deductible.”

d. **Lender-Placed Data Call and Definitions (Attachment ??):**

Separate reporting of Blanket Vendor Single Interest Auto and Blanket Vendor Single Interest Home was added.

Ms. Rebholz said interrogatories I-28 and I-20, which ask for the percentage of lender-placed coverage, were inadvertently included and should be deleted from the Interrogatories for Lender-Placed Auto Insurance and Lender-Place Homeowners Insurance.

Commissioner Clark made a motion, seconded by Mr. Doucette, to adopt the four revised MCAS blanks, with the note deletion from Mr. Rebholz to the Lender-Placed interrogatories. The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
The Antifraud (D) Task Force met Aug. 3, 2020. During this meeting, the Task Force:

1. Adopted its May 20 minutes, which included the following action:
   a. Received state updates concerning COVID-19 from California, Delaware, Florida and Ohio.
   b. Received updates concerning COVID-19 from the Coalition Against Insurance Fraud (CAIF), the Healthcare Fraud Prevention Partnership (HFPP), the National Healthcare Antifraud Association (NHCAA), and the National Insurance Crime Bureau (NICB).

2. Heard reports on antifraud activity specific to the COVID-19 pandemic from California, Florida and Texas. The Task Force also heard reports from the antifraud organization of the CAIF and the NICB.


4. Received an update from the Antifraud Technology (D) Working Group. The Working Group has worked with NAIC staff to update a revised draft of the Antifraud Plan Guideline (#1690) for distribution. The Working Group will distribute the new draft for a public comment period ending Aug. 28.

5. Heard reports on antifraud activity from NAIC staff, the NICB and the CAIF.
MARKET INFORMATION SYSTEMS (D) TASK FORCE
Tuesday, August 4, 2020
4:30 p.m. ET / 3:30 p.m. CT / 2:30 p.m. MT / 1:30 p.m. PT / 12:30 p.m. AK

Meeting Summary Report

The Market Information Systems (D) Task Force met Aug. 4, 2020. During this meeting, the Task Force:

1. Adopted its 2019 Fall National Meeting minutes.

2. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met July 22 and July 8 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, and took the following action:
   a. Reviewed the outstanding Uniform System Enhancement Request (USER) forms.
      i. USER Form 10072 was completed. This USER form requested the ability for companies to submit new filings for prior years once the Market Conduct Annual Statement (MCAS) has been closed for submission of the current year.
      ii. USER Form 10051 is in progress. This USER form requests implementation of the Market Action Tracking System (MATS) web service in State Based Systems (SBS) to provide automated submission of information to the MATS.
      iii. USER Form 10080 is in progress. This USER form requests that the Regulatory Information Retrieval System (RIRS) be updated to display data retention policies and terminology related to action dates. This request consists of seven components—one is complete; one is currently being implemented; one is in detailed analysis; one is pending RIRS subject matter expert (SME) input; and the Working Group agreed that the final component will not be addressed.
      iv. USER Form 10053 is still in detailed analysis. This USER form calls for a review of RIRS codes by the RIRS Code Review Working Group to clarify definitions for consistent usage and provision of recommendations for revisions. The RIRS SME group is updating the RIRS proposal to address questions and concerns received from the Working Group members.
      v. Approved USER Forms 10069B and 10082 to add a Complaints Database System (CDS) subject code of “pandemic” and coverage codes for “lender-placed insurance” and “pet insurance.”

3. Adopted USER Forms 10069B and 10082 to add a CDS subject code of “pandemic” and coverage codes for “lender-placed insurance” and “pet insurance.”

4. Heard a presentation on the use of artificial intelligence (AI) in market information.
2020 Summer National Meeting  
Virtual Meeting  

PRODUCER LICENSING (D) TASK FORCE  
Monday, August 3, 2020  
2:00 – 3:00 p.m. ET / 1:00 – 2:00 p.m. CT / 12:00 – 1:00 p.m. MT / 11:00 a.m. – 12:00 p.m. PT  

Meeting Summary Report  

The Producer Licensing (D) Task Force met Aug. 3, 2020. During this meeting, the Task Force:  

1. Adopted its May 6 minutes, which included the following action:  
   a. Adopted its 2019 Fall National Meeting minutes.  
   b. Discussed producer licensing issues arising from COVID-19, which included a review of suggested practices for the issuance of temporary producer licenses and state implementation of online, proctored examinations.  
   c. Discussed uniform and reciprocal licensing of independent adjusters.  

2. Discussed producer licensing issues arising from COVID-19. This discussion primarily focused the state implementation of online, proctored examinations. It was reported that 15 states have implemented online, proctored examinations. State insurance regulators generally indicated that approximately 50–60% of all examinations are now online, proctored examinations. Industry representatives encouraged additional state implementation of online, proctored examinations. Industry all requested that states continue to work with industry to convert temporary licenses to permanent licenses. Examination vendors reported that they continue to work with the states to implement online examinations. The examination vendors said they can generally implement online examinations for a state in less than 60 days, and it could be as short as one week.  

3. Received an update from the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group. The activity of these working groups has been on hold during the COVID-19 crisis, but they will resume their work in the second half of 2020.  

4. Received a report from the National Insurance Producer Registry (NIPR) Board of Directors. Since the onset of the COVID-19 crisis, 48 states have issued over 100 separate bulletins regarding producer licensing. Thirty-three bulletins specifically address license renewal extensions, and 30 states issued bulletins offering temporary licensing. These bulletins and state changes required NIPR to complete significant coding work to move the states’ license expiration dates and provide an electronic solution for a new temporary producer license class through NIPR. NIPR has also been developing enhancements to its Attachment Warehouse product, which allows insurance producers and other licensees to upload licensing related documents for review by state insurance regulators.
Conference Call

MARKET CONDUCT EXAMINATION STANDARDS (D) WORKING GROUP
July 23, 2020 / March 4, 2020 / December 18, 2019

Summary Report


1. During its July 23, 2020, call, the Working Group:
   a. Adopted its March 4, 2020, minutes.
   b. Welcomed one new member state, Illinois, and new state insurance regulator representation for New Mexico and Ohio.
   c. Adopted new examination standards addressing limited long-term care insurance (LTCl), for inclusion in the Market Regulation Handbook (Handbook). The new examiner guidance is based on the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643).

2. During its March 4, 2020, call, the Working Group:
   a. Adopted its Dec. 18, 2019, minutes.
   b. Welcomed one new member state, North Carolina, and new state insurance regulator representation for Nevada, Oklahoma and Oregon.
   c. Discussed its 2020 charges and potential tasks.
   d. Discussed draft examination standards addressing limited LTCI for inclusion in the Handbook.
   e. Discussed a new draft inland marine in force policies standardized data request and a new draft inland marine claims standardized data request for inclusion in the reference documents of the Handbook.

3. During its Dec. 18, 2019, call, the Working Group:
   b. Discussed a new chapter addressing limited LTCI for inclusion in the Handbook. The new examiner guidance is based on Model #642 and Model #643.
MARKET ANALYSIS PROCEDURES (D) WORKING GROUP
Thursday, July 30, 2020
2:00 p.m. ET / 1:00 p.m. CT / 12:00 p.m. MT / 11:00 a.m. PT

Meeting Summary Report

The Market Analysis Procedures (D) Working Group met July 30, 2020. During this meeting, the Working Group:

1. Adopted its March 23 minutes, which included the following action:
   a. Adopted its Feb. 20 minutes, which included the following action:
      i. Adopted its Jan. 30 minutes, which included the following action:
         1. Adopted its 2019 Fall National Meeting minutes.
         2. Discussed revisions to the MCAS Best Practices Guide.
         3. Discussed a proposal to add travel insurance as the next line of business in the Market Conduct Annual Statement (MCAS).
      ii. Discussed revisions to the MCAS Best Practices Guide.
      iii. Discussed a proposal to add travel insurance as the next line of business in the MCAS.
      iv. Discussed Private Flood Insurance MCAS scorecard ratios.
   b. Discussed revisions to the MCAS Best Practices Guide. When the revisions are completed, the drafting group will move on to other MCAS documents.
   c. Discussed potential MCAS filing issues arising from work adjustments due to COVID-19. The Working Group agreed to a blanket extension of all lines of business due dates of 60 days. NAIC staff will send each jurisdiction’s MCAS contact a confirming email regarding the extension of the due date.
   d. Adopted travel insurance as the next line of business in MCAS.

2. Discussed the revisions to the MCAS Best Practices Guide. The updates to date were reviewed, and the drafting group will resume its work on the revisions.

3. Discussed the Market Analysis Framework and asked for comments to be reviewed by the Working Group at its next meeting.

4. Adopted scorecard ratios for the Private Flood MCAS Blank. The ratios closely match the Homeowners and Private Passenger Auto scorecard ratios with the addition of a ratio to measure lawsuits closed with consideration for the consumer.

5. Discussed the MCAS Attestation process. No changes to the current process were made.

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MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP

Friday, July 31, 2020
11:30 p.m. ET / 10:30 p.m. CT / 9:30 p.m. MT / 8:30 a.m. PT

Meeting Summary Report

The Market Conduct Annual Statement Blanks (D) Working Group met July 31, 2020. During this meeting, the Working Group:

1. Adopted its June 24 minutes, which included the following action:
   a. Adopted its May 28, May 27, May 21 and May 20 minutes.
   b. Discussed and approved Market Conduct Annual Statement (MCAS) data call and definitions clarifications needed following adoption of edits to the life, annuity, homeowners and private passenger auto MCAS lines of business. This included:
      i. Discussed possibility of adding the National Producer Number (NPN) to the required information when reporting third party administrators (TPAs) and managing general agents (MGAs).
      ii. Adopted clarification to the definition of individual indexed variable annuity.
      iii. Discussed clarifications needed for newly adopted homeowners MCAS underwriting data elements.

2. Discussed homeowners MCAS clarifications related to newly added underwriting data elements.

3. Discussed MCAS updates previously tabled for further discussion. This included:
   a. Discussed life and annuity MCAS reporting of NPN for TPAs within the interrogatories, and home and auto MCAS reporting of NPN for TPAs and MGAs within the interrogatories.
   b. Discussed possible reporting of accelerated underwriting within the life MCAS.
   c. Discussed placement options for the complaints and lawsuit data elements within the home and auto MCAS.
   d. Discussed possible homeowner MCAS claims reporting of digital claims settlements and other than digital claims settlements in the dwelling and personal property coverage types.

4. Heard and discussed industry concerns with addition of newly adopted data element to collect claims closed without payment below the deductible for the auto MCAS.

1. During its Feb. 20 call, the Working Group:
   a. Adopted its Jan. 30 minutes.
   a. Considered interested party comments regarding cybersecurity requirements and the cost of contractors. No actions were taken on the comments.
   b. Discussed pass/fail metrics for certifying participating jurisdictions. A matrix will be developed and presented to the Working Group for consideration.

2. During its Jan. 30 call, the Working Group:
   a. Adopted its Nov. 20, 2019, minutes.
   b. Adopted numerous suggestions from interested state insurance regulators to improve and clarify the checklist and guidelines.

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The Privacy Protections (D) Working Group met July 30, 2020. During this meeting, the Working Group:

1. Adopted its May 5 minutes, which included the following action:
   a. Adopted its Feb. 19 minutes.
   b. Heard an update on state and federal privacy legislation.
   c. Discussed comments received on the *NAIC Insurance Information and Privacy Protection Model Act* (#670).

2. Received updates on data privacy legislation by NAIC legal staff, which included the following:
   a. Reviewed federal privacy legislation.
   b. Reviewed state data privacy legislation.

3. Heard a presentation that included a comparative analysis and comments from the Blue Cross Blue Shield Association (BCBSA) and Arbor Strategies LLC on behalf of the Health Coalition.

4. Reviewed plans to begin a gap analysis discussion by Working Group members, interested state insurance regulators and interested parties using the *Privacy of Consumer Financial and Health Information Regulation* (#672) as a baseline model.
Overview

• Background on the Alliance
• History and Features of Health Care Sharing Ministries
• Statistics on Size and Reach of HCSMs
• Challenges for HCSMs
• Development of Accreditation Program for Oversight
The Alliance of HCSMs

- Non-profit, non-partisan coordinating body among 7 HCSMs
- Issue advocacy, PR/awareness
- Rebuilding into a membership organization
- HCSMs must have CMS certification and meet standards posted on website
- Moving toward accreditation (with robust standards) as the ticket for membership
Features of Health Care Sharing Ministries

- Religious underpinnings of HCSMs
- HCSMs allow faith-centered people to come together as a community to share each other’s medical expenses
- Each Health Care Sharing Ministry has a statement of religious beliefs that everyone in the community agrees to uphold
- HCSMs are not insurance
- Defined in / exempted from the Affordable Care Act
## Statistics

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<tbody>
<tr>
<td>9</td>
<td>$1.3B</td>
<td>1.5M</td>
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<tr>
<td>9 of the 108 Health Care Sharing Ministries have large, open membership.</td>
<td>$1.3 billion of medical expenses shared by Health Care Sharing Ministries in 2019.</td>
<td>1.5 million Americans are active members of a Health Care Sharing Ministry.</td>
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<tr>
<td>108</td>
<td>100%</td>
<td>50</td>
</tr>
<tr>
<td>HHS has certified 108 Health Care Sharing Ministries as meeting the federal definition.</td>
<td>Health Care Sharing Ministries have historically shared 100% of eligible medical bills.</td>
<td>Members of Health Care Sharing Ministries live in all 50 states.</td>
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Challenges for HCSMs

- Statutory safe harbor language
- Non-profit vs. for-profit operations
- Consumer clarity
Accreditation Model

- Managed independently from HCSMs and the Alliance and governed by independent Board of Directors
- Adopt industry standards
- Conduct audit and review of HCSMs seeking accreditation
- Inform consumers and interested parties of accredited HCSMs
DATE: (Insert Date)

TO: All Insurers Transacting the Business of Insurance in (Inset Name of State)

FROM: (Insert Name of Commissioner, Director or Superintendent)

RE: Waiver of On-Site Review Requirements

Purpose
The purpose of this bulletin is for the Department of Insurance (DOI) to advise all insurance companies regarding compliance with regulatory requirements during the COVID-19 public health emergency. This flexibility is being provided in light of guidance from the Centers for Disease Control and Prevention (CDC) that individuals practice social distancing to the extent possible in order to mitigate their chances of getting or spreading COVID-19. Furthermore, CDC guidance cautions that travel increases individuals’ chances of getting and spreading COVID-19.1 As a result, many companies have suspended or limited business travel to protect the health and safety of their employees and communities. In addition, some state and local governments may require people who have recently traveled to stay home for 14 days.

Waiver of On-Site Review Requirements
Pursuant to (insert reference to applicable state law based on Section 5(C) of the NAIC Managing General Agents Model Act (#225)) insurers are required to, at least semiannually, conduct an on-site review of the underwriting and claims processing operations of a managing general agent.

Pursuant to (insert reference to applicable state law based on Section 7(H) of the NAIC Third Party Administrator Model Act (#1090)) insurers are required to, at least semiannually, conduct a review of the operations of its third-party administrator in cases where an administrator administers benefits for more than one hundred (100) certificate holders, subscribers, claimants, or policyholders on behalf of an insurer, and at least one such review must be conducted on site.

To support the recommendations of the CDC, and in the interest of the public health and safety, the DOI will not require insurers to conduct any on-site reviews of managing general agents or third-party administrators in 20202. For 2020 only, insurers may conduct reviews of managing general agents or third-party administrators through electronic information to satisfy their on-site review obligations under (insert reference to applicable state law based on Section 5(C) of Model #225 and Section 7(H) of Model #1090).

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2 Alternative recommendation: replace “in 2020” with “until further notice”
ATTACHMENT TWELVE: CONDUCTING THE LIMITED LONG-TERM CARE EXAMINATION CHAPTER

This chapter provides a format for conducting limited long-term care insurance examinations. The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This chapter does not apply to qualified limited long-term care insurance contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement limited long-term care insurance. This chapter also does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

ATTACHMENT THIRTEEN: INLAND MARINE IN FORCE STANDARDIZED DATA REQUEST

This is a standardized data request a state may use to determine if a company follows appropriate procedures with respect to the issuance and/or termination of inland marine policies.

ATTACHMENT FOURTEEN: INLAND MARINE CLAIMS STANDARDIZED DATA REQUEST

This is a standardized data request a state may use to determine if a company follows appropriate procedures with respect to the handling of inland marine claims.

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Chapter 26A—Conducting the Limited Long-Term Care Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state’s own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter applies to limited long-term care insurance policies. This chapter does not apply to qualified limited long-term care insurance contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement limited long-term care insurance. This chapter also does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

This chapter provides a format for conducting limited long-term care insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of limited long-term care insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Appeal of Benefit Trigger Adverse Determination
G. Underwriting and Rating
H. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

IIIPRC-Approved Products
When conducting an exam that includes limited long-term care insurance products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (IIIPRC) on behalf of a compacting state, it is important to keep in mind the uniform standards, and not state-specific statutes, rules and regulations, are applicable to the content and approval of the product. The IIIPRC website is www.insurancecompact.org and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIIPRC for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each IIIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIIPRC office should be included when a
compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards). Under the uniform standards, a limited long-term care insurance product approved by the IIPRC can be used in a compacting state’s partnership program provided the company has obtained the necessary approval from the compacting state or made the necessary certification to the compacting state, as applicable. Please note that the company must still comply with a compacting state’s laws for minimum daily benefit amounts, minimum benefit periods and maximum elimination periods when selling a limited long-term care insurance product approved by the IIPRC.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.

Apply to: All limited long-term care companies
Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of reports and certifications made by the entity

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Each insurer shall file with the insurance commissioner, prior to offering group limited long-term care insurance to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory limited long-term care insurance requirements substantially similar to those adopted in the state of issue (Model #643 Section 20 & Model 642 Section 5). (Note: Section 20 of the Limited Long-Term Care Model Regulation (#643) requires an evidentiary filing only from discretionary groups.

Each insurer should file with the insurance commissioner a copy of any limited long-term care insurance advertising intended for use in the state—whether through written, radio or television medium—for review or approval to the extent required by state law. All advertisements should be retained for at least three years from the date of first use.

Determine if replacement/lapse reporting is submitted by the entity as required. Items to be reported are:

- Top 10 percent of producers with the highest percentage of replacements and lapses; and
- Number of lapsed policies as a percentage of annual sales and policies in force at the end of the previous calendar year.

Determine that the entity complies with filing and certification requirements set forth by statutes, rules and regulations for associations endorsing or selling limited long-term care insurance. Generally, these requirements are imposed on an association group meeting the definition of a professional/trade/occupational association found in Section 4E(2) of the Limited Long-Term Care Insurance Model Act (#642).
Ensure that the insurer has filed all requested advertising with the insurance department regarding association sold or endorsed limited long-term care insurance, as may be requested by the insurance department. Any such advertising must disclose:

- The specific nature and amount of compensation that the association receives from the endorsement or sale of the policy or certificate to its members; and
- A brief description of the process under which the policies and the issuing insurer were selected.

Determine that the entity submits suitability and rescission information as required by applicable statutes, rules and regulations.

Determine the regulated entity has proper procedures in place to ensure its producers are properly trained and that the training meets the minimum standards established by the applicable laws and regulations.

Insurers subject to the *Limited Long-Term Care Insurance Model Act* (#642) shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A of the *Long-Term Care Insurance Model Act* (#640) and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of limited long-term care, including Medicaid, in a state. These records shall be maintained in accordance with state record retention requirements and shall be made available to the commissioner upon request. Pursuant to Model#642, Section 9 – Producer Training Requirements are optional.

Most states have a limited long-term care partnership policy forms certification process in order for limited long-term care partnership forms to be sold in their state.
B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
### Standard 1

The entity has suitability standards for its products, where required by applicable statutes, rules and regulations.

<table>
<thead>
<tr>
<th><strong>Apply to:</strong></th>
<th>All limited long-term care products</th>
</tr>
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<tr>
<td><strong>Priority:</strong></td>
<td>Recommended</td>
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</table>

#### Documents to be Reviewed

- [ ] Applicable statutes, rules and regulations
- [ ] Producer records
- [ ] Training materials
- [ ] Procedure manuals
- [ ] Underwriting/Policy files

**Others Reviewed**

- [ ] __________________________________________
- [ ] __________________________________________

#### NAIC Model References

- *Limited Long-Term Care Insurance Model Act (#642)*
- *Limited Long-Term Care Insurance Model Regulation (#643)*

#### Review Procedures and Criteria

Determine whether the entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have the entity run a policyholder history to identify the number of policies sold to those individuals.

Determine if entity guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine if the entity has developed and uses suitability standards and procedures to determine whether the purchase or replacement of limited long-term care insurance is appropriate for the needs of the applicant. Suitability standards and procedures should include:

- Consideration of the advantages and disadvantages of insurant to meet the needs of the applicant; and
- Discussion with applicants of how the benefits and costs of limited long-term care insurance compare with long-term care insurance.
- Agent training in its suitability standards and procedures
- Maintain a copy of suitability standards and procedures and make them available for inspection upon request by the commissioner.
If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent. Either the applicant’s returned letter or a record of the alternate method of verification shall be made a part of the applicant’s file.

Note: Pursuant to Section 25H of the Limited Long-Term Care Insurance Model Regulation (#643), suitability standards do not apply to life insurance policies or riders that accelerate benefits for limited long-term care as defined in the Limited Long-Term Care Model Act, Section (# 642), Section 4(D).

Determine if the insurer is reporting suitability information to the insurance commissioner as required by applicable statutes, rules and regulations.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used by the entity.

Ensure the entity maintains a written statement specifying the standards of suitability used by the insurer and provides the standards to its producers, and that both follow the standards. The standards should specify that no recommendation should be made and/or no policy issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant (based on information known to the insurer or producer making the recommendation).
STANDARDS
MARKETING AND SALES

Standard 2
Policy forms provide required disclosure material regarding standards for benefit triggers.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Claim procedure/Underwriting manuals

_____ Claim files

_____ Policy forms

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ensure the policy conditions the payment of benefits on a determination of the insured’s ability to perform activities of daily living (ADLs) and cognitive impairment.

Ensure that the policy contains the definition of ADLs, cognitive impairment and other key terms as required by statutes, rules and regulations.

Determine that the eligibility for payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the ADLs or the presence of cognitive impairment. Ensure that payment of benefits is not more restrictive than those allowed by statutes, rules and regulations.

Ensure that the policy contains a clear description of the process for appealing and resolving benefit determinations.


STANDARDS
MARKETING AND SALES

Standard 3
Marketing for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIIPRC) uniform standards for products approved by the IIIPRC)

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Required reports filed with the insurance department

_____ Marketing materials filed with the insurance department

_____ Underwriting files or other files containing proof of issuance of outline of coverage

_____ Review state statutes, rules and regulations to determine if state limited long-term care requirements apply to annuity products with a limited long-term care element. If so, then the applicable Annuity Disclosure Model Regulation (#245) would apply

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Life Insurance Disclosure Model Regulation (#580)
Life Insurance Illustrations Model Regulation (#582)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity uses applications for limited long-term care insurance policies or certificates containing clear and unambiguous questions designed to ascertain the health condition of the applicant. (In most cases, application forms should have been reviewed by the insurance department’s rates and forms division.)

Verify that the entity complies with right to return/“free look” requirements.

Verify that the outline of coverage is delivered to the applicant at time of initial solicitation through means that prominently directs the attention of the recipient to the document and its purpose.
Verify that at the time of policy delivery the insurer has delivered a policy summary for an individual life insurance policy that provides limited long-term care benefits within the policy or by rider. In the case of direct response solicitations, verify that the insurer has delivered the policy summary upon the applicant’s request, but regardless of request has made delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, ensure that the summary also includes:

- An explanation of how the limited long-term care benefit interacts with other components of the policy;
- Any exclusions, reductions and limitations on benefits of limited long-term care; and
- A statement that any limited long-term care inflation protection option required by the applicable state’s statutes, rules and regulations regarding inflation protection option requirements comparable to Section 13 of the Limited Long-Term Care Insurance Model Regulation (#643) is not available under this policy.

In addition to the above, if applicable to the policy type, ensure that the summary includes the following:

- A disclosure of the effects of exercising other rights under the policy; and
- A disclosure of guarantees related to limited long-term care costs of insurance charges.

The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with the applicable state’s basic illustration requirements comparable to Sections 7 and 8 of the Life Insurance Illustrations Model Regulation (#582) or into the life insurance policy summary, which is required to be delivered in accordance with the applicable state’s life insurance policy summary requirements comparable to Section 5 of the Life Insurance Disclosure Model Regulation (#580).

Verify that the entity complies with records maintenance and reporting requirements:

- Entity must maintain records for each producer of that producer’s amount of replacement sales as a percentage of the producer’s total annual sales and the amount of lapses of limited long-term care insurance policies sold by the producer as a percentage of the producer’s total annual sales;
- Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements;
- Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year; and
- Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year.
## STANDARDS
### MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 4</th>
<th>All advertising and sales materials are in compliance with applicable statutes, rules and regulations.</th>
</tr>
</thead>
</table>

| Apply to: | All limited long-term care products |
| Priority: | Essential |

### Documents to be Reviewed

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for advertisements approved by the IIPRC)
- All company advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials
- Policy forms, including any required buyer’s guides, outline of coverage, limited long-term care insurance personal worksheets and disclosure forms as they coincide with advertising and sales materials
- Producer’s own advertising and sales materials

### Others Reviewed

- ___________________________
- ___________________________

### NAIC Model References

- *Limited Long-Term Care Insurance Model Act (#642)*
- *Limited Long-Term Care Insurance Model Regulation (#643)*
- *Unfair Trade Practices Act (#880)*

### Review Procedures and Criteria

Evaluate the company’s system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either at least three years from the date the advertisement was first used or later if required by state statutes, rules and regulations.
Review advertising materials in conjunction with the appropriate policy form. Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead prospective buyers to believe that they are purchasing an investment or savings plan. Problematic terminology may include the following terms: investment, investment plan, founder’s plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences;
- Use terms such as “non-medical” or “no medical examination required,” if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is a fact. Enrollment periods may not be described in terms such as “special” or “limited” when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in the advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact; and
- Misrepresent any policy as being shares of stock.
Materials should:

- Clearly disclose the name and address of the insurer;
- If using a trade name, disclose the name of the insurer, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to the policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed; and
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact. Any proprietary relationship or payment for the testimonial must be disclosed.

Determine if the company approves producer sales materials and advertising. Ensure that copies of sales material other than company-approved materials, if permitted, are maintained in a central file. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer’s capacity as an insurance producer. Improper terms may include “financial planner,” “investment advisor,” “financial consultant” or “financial counseling,” if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Review the use of the words “free,” “no cost,” “without cost,” “no additional cost,” “at no extra cost” or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy, unless it is a fact. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a limited long-term care insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

Determine that company procedures and materials relative to limited long-term care products comply with right to return/“free look” requirements.

Review the company and producer’s Internet sites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised products are (or are not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?
• For the review of Internet advertisements:
  • Run an inquiry with the company’s name;
  • Review the company’s home page;
  • Identify all lines of business referenced on the company’s home page;
  • Research the ability to request more information about a particular product and verify that the information provided is accurate; and
  • Review the company’s procedures related to producers’ advertising on the Internet and ensure that the company requires prior approval of the producers’ web pages, if the company name is used.
STANDARDS
MARKETING AND SALES

Standard 5
Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products
Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ Replacement register
_____ Policy/Underwriting file
_____ Loan and surrender files, if applicable

Others Reviewed

_____ __________________________
_____ __________________________

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Review policy/underwriting files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm applicant’s receipt of replacement notice.

Review replacement disclosure forms for completeness and signatures as required.
STANDARDS
MARKETING AND SALES

Standard 6
Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

____ Applicable statutes, rules and regulations
____ Replacement register
____ Policy/Underwriting file
____ Agency correspondence file/Agency bulletins
____ Agency procedural manual
____ Claim files
____ Agency sales/Lapse records
____ Company systems manual

Others Reviewed

____ ________________________________
____ ________________________________

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the company has advised its producers of its replacement policy.

Determine if the company has separate commission schedules for replacement business, pursuant to applicable state statutes, rules and regulations. Note: Some states limit the compensation payable on replacement business to no more than that payable on renewal policies.

Determine if the company has provided timely notice to the existing insurers of the replacement.

Examine the company system of identifying undisclosed replacements for effectiveness.

Determine if the company has the capacity to produce the data required by replacement regulation to assess producer replacement activity.
Determine if the company has issued letters in a timely manner to policyholders advising of the effects of preexisting conditions on covered benefits.

Review policy/underwriting files to determine if the company is retaining required records for required time frames.

Examine company procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the company provides required credit for preexisting conditions or probationary periods on replacements.
D. Producer Licensing

Use the Producer Licensing Standard 2 that is provided in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
POLICYHOLDER SERVICE

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy renewals are applied consistently and in accordance with policy provisions.</td>
</tr>
</tbody>
</table>

Apply to:  All limited long-term care products

Priority:  Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- Underwriting/Policy file
- Underwriting/Administrative procedure manuals

Others Reviewed

- ________________
- ________________

NAIC Model References

*Limited Long-Term Care Insurance Model Regulation (#643)*

Review Procedures and Criteria

Review renewal business to determine if the entity’s procedures for handling renewals are in accordance with applicable statutes, rules and regulations.

Ensure that individual policies or certificates do not contain renewal provisions other than “guaranteed renewable” or “noncancellable,” and that these terms are adequately defined in the policy or certificate.

Review the underwriting/policy file to determine if premium notices were sent in a timely and accurate manner.

Review mailroom records for billings sent by the entity to ensure they were sent in a timely manner.
### STANDARD 2
**Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.**

<table>
<thead>
<tr>
<th>Apply to:</th>
<th>All limited long-term care products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority:</td>
<td>Essential</td>
</tr>
</tbody>
</table>

#### Documents to be Reviewed

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- Underwriting/Administrative files

Others Reviewed

- _________________________________________
- _________________________________________

#### NAIC Model References

- *Limited Long-Term Care Insurance Model Act* (#642)
- *Limited Long-Term Care Insurance Model Regulation* (#643)

#### Review Procedures and Criteria

Determine if the required notification of lapse or termination is sent to the proper addressee(s), within the required time frames and that the required information is provided, per applicable statutes, rules and regulations.

Ensure that the entity receives designation of a person(s), other than the insured, to receive notice of lapse or termination of the policy or certificate for nonpayment of premiums or a written waiver by the insured not to designate an additional person(s) to receive notice.

Ensure that the insurer notifies existing insureds of their right to change their written designation at least once every two years, or as specified by state statutes, rules and regulations.

Verify that nonforfeiture and reinstatement provisions were applied consistently and in a non-discriminatory manner. Nonforfeiture provisions upon lapse and reinstatements should be applied per policy provisions and in accordance with applicable statutes, rules and regulations.

Ensure that the policy includes a provision that provides for reinstatement of coverage in the event of lapse, if the entity has provided evidence that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option should be made available to the insured for a period of 5 months after the date of termination.
# STANDARDS
## POLICYHOLDER SERVICE

### Standard 3

**Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.**

<table>
<thead>
<tr>
<th>Apply to:</th>
<th>All limited long-term care products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority:</td>
<td>Essential</td>
</tr>
</tbody>
</table>

### Documents to be Reviewed

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- Underwriting/Administrative file
- Entity procedures manual

### Others Reviewed

- _________________________________________
- _________________________________________

### NAIC Model References

*Limited Long-Term Care Insurance Model Act (#642)*

*Limited Long-Term Care Insurance Model Regulation (#643)*

### Review Procedures and Criteria

Determine if the entity offers applicants the opportunity to purchase a limited long-term care policy that includes a nonforfeiture benefit, as required by applicable statutes, rules and regulations.

If the applicant declines the nonforfeiture benefit, ensure that the entity provides a contingent benefit upon lapse of the policy for a specified period following a substantial increase in premium rates, as required and defined by applicable statutes, rules and regulations.

Ensure that a policy offered with nonforfeiture benefits contains the same coverage elements, eligibility, benefit triggers and benefit length as a policy without the nonforfeiture benefit.

Determine if the entity provides notice as required by applicable statutes, rules and regulations prior to the due date of the premium reflecting a substantial premium increase.

Ensure that the entity offers the proper nonforfeiture benefit and nonforfeiture credit, as required by applicable statutes, rules and regulations.

Determine if the policy contains the proper time frames for nonforfeiture benefit and the contingent benefit upon lapse, as required by applicable statutes, rules and regulations.

Determine if the correct nonforfeiture option is provided in case of policy lapse.
Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to nonforfeiture values, refer to applicable statutes, rules and regulations regarding the calculation of nonforfeiture values.

Review the entity’s procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Ensure that the entity notifies policyowners of material changes to any nonforfeiture benefits in accordance with applicable statutes, rules and regulations.
STANDARDS
POLICYHOLDER SERVICE

Standard 4
Policyholder service for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedures manuals

_____ Procedure manuals

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity offers nonforfeiture benefits.
F. Appeal of Benefit Trigger Adverse Determination

Use the standard set forth below.
STANDARDS
APPEAL OF BENEFIT TRIGGER ADVERSE DETERMINATION

Standard 1
Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.

Apply to: All limited long-term care insurers

Priority: Essential

Documents to be Reviewed

_____ Company’s written procedures explaining administration of appeals process and template denial letters

_____ Internal company procedures which describe the appeals process

_____ Applicable statutes, rules and regulations

_____ Request copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ask insurer how it describes its appeal procedures to the insured.

Ask for copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective.

In the event the insurer has determined that the benefit trigger of a limited long-term care insurance policy has not been met, verify that the insurer has provided a clear, written notice to the insured and the insured’s authorized representative, if applicable, of all of the following:

- The reason that the insurer determined that the insured’s benefit trigger had not been met;
- The insured’s right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request within 120 calendar days of receipt of the notice; and
- The insured’s right, after exhaustion of the insurer’s internal appeal process, to have the benefit trigger determination to contact their state insurance department and their State Health Insurance Program (SHIP) office.

Ensure that the individual or individuals making the internal appeal decision are not the same individual or individuals who made the initial benefit determination.
Verify that the insurer, within 30 calendar days of the insurer’s receipt of all necessary information upon which a final determination can be made, has completed and sent written notice of the internal appeal decision to the insured and the insured’s authorized representative, if applicable.

If the insurer’s original determination is upheld upon internal appeal, ensure that the notice of the internal appeal decision describes any additional internal appeal rights offered by the insurer.

If the insurer’s original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their state insurance department and their State Health Insurance Program (SHIP) office, pursuant to applicable state statutes, rules and regulations.

Verify that if any new or additional information not previously provided to the insurer is submitted by the insured or the insured’s authorized representative, the insurer either (1) considers and affirms or (2) overturns its benefit trigger determination.

If the insurer overturns its benefit trigger determination, verify that the insurer has provided notice to the insured and the insured’s authorized representative, if applicable, and the commissioner of its decision.
G. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- Rating practices;
- Underwriting practices;
- Use of correct and properly filed and approved forms and endorsements;
- Termination practices;
- Unfair discrimination;
- Use of proper disclosures, outlines of coverage and delivery receipts;
- Reinsurance; and
- Marketing and sales materials.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Individual and group issued and renewed policy files;
- Policy summaries;
- Replacement and conservation materials;
- Documentation of required disclosures and delivery receipts;
- Individual and group canceled policy files and certificates;
- Documentation of premium refund upon election of “free look” period;
- Recessions occurring prior to a claim;
- Policy forms, endorsements and applications, along with appropriate filings;
- Producer licensing information;
- Producer compensation agreements, where applicable;
- Premium statements and billing statements;
- Group trust arrangements, where applicable;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;
- Reinsurer policies/treaties; and
- Reinsurer guidelines and manuals.

For the purposes of this chapter, “underwriting file” means the file or files containing the new business application, renewal application, certificates or evidences of coverage, including binders, rate calculation sheets, billings, medical information, credit information, inspection or interview reports, all underwriting information obtained or developed, policy summary page, endorsements, cancellation or reinstatement notices, correspondence and any other documentation supporting selection, classification, rating or termination of the policy.
In selecting samples for testing, individual policies should generally not be combined with group policies. Because these two areas are generally not homogeneous, any conclusions or inferences made from the results of sampling may not be valid if combined. The examiner should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies, endorsements and premium statements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice of the examination.

Next, determine the entity’s policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain that the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner’s responses should maximize objectivity; the examiner should avoid replacing examiner judgment for entity judgment.

a. Rating Practices

It is necessary to determine if the entity is in compliance with rating systems that have been filed with and, in some cases, approved by the insurance department. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the entity’s own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by an entity might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that an entity is engaged in unfair competitive practices. Inconsistent application of rates or classifications can result in unfair discrimination.

If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the use of improperly worded, vague or obsolete rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

Occasionally, the examiner may need to review loss statistics to determine if premiums are fair and reasonable in relation to the associated claims experience. When possible, the examination team should make use of audit software to verify the correct application of specific rating components and the consistent use of rates. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

The rating practices for renewal policies and newly issued policies should be reviewed. The examination team should also review premium notices and billing statements. The examiner should ensure the proper application of rate increases or rate decreases.

The examiner should also ensure that the underwriting files contain sufficient information to support the rates that have been developed.
b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the entity’s underwriting manuals, underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and entity minutes that may furnish evidence of anti-competitive behavior may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the entity’s compliance with its own manuals and guidelines. The examiner should confirm that the entity’s underwriters and producers consistently apply the entity guidelines for all business selected or rejected. The examination team should verify that the entity has correctly classified insured individuals.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the entity’s management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of the business. Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each applicable field office.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to the insurance department’s counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Termination Practices

The examination team should review the entity’s policy cancellation and reinstatement practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the entity’s own rules, guidelines and policy provisions.

Cancellation and lapsed policy processing should include a formal notice to the insured, including secondary addressees, where elected by the insured. Adherence to policy provisions for renewal language and for applicable grace periods should be reviewed.

The examination team should verify that premium refunds upon election of “free look” provisions are handled correctly, uniformly and in a timely manner.

The examination team should review reinstatement offers and determine what the entity’s practice is for offering reinstatement. In addition, the examination team should be mindful of billing practices that may encourage policy lapses.
e. Unfair Discrimination

The examination team should be mindful of entity underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional, yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

f. Use of Proper Disclosures, Buyer’s Guides and Outlines of Coverage

The examination team should review the entity’s use of required disclosure forms, buyer’s guides, policy summaries, replacement notices, “free look” periods and outlines of coverage. In addition to the use of such required items, the examiner may wish to verify that the above items contain the correct content and are in the correct format.

g. Reinsurance

Most state statutes include a feature that for many lines of business the entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files.

Adherence to the requirement is easy to test, but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It also may reflect on the care that the entity’s management places on its selection of business, and represent a danger to the financial health of the entity. Errors in this area should be forwarded to the appropriate state financial examiners. Any tests of this type must be coordinated with the state’s financial examiners.

h. Marketing and Sales Materials

It is recommended that a review of all forms and materials be conducted by reviewing the marketing and sales standards simultaneously during the underwriting and rating review.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the entity’s underwriting activities. The sequence of the standards listed here does not indicate priority of the various standards.
STANDARDS
UNDERWRITING AND RATING

Standard 1
All mandated definitions and requirements for group limited long-term care insurance are followed in accordance with applicable statutes, rules and regulations.

Apply to: All group limited long-term care products

Priority: Essential

Documents to be Reviewed

____ Applicable statutes, rules and regulations
____ Underwriting files
____ Rating/Quote information provided electronically
____ Marketing materials
____ Correspondence to producers

Others Reviewed

____ ________________________________
____ ________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

If a group policy is issued to an employer or labor organization or association, determine if the group meets the required criteria to qualify the association or organization as a bona fide organization established for the benefits of its members.

Determine if all group limited long-term care policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group limited long-term care policy standard provisions that are applicable in the examining jurisdiction are incorporated into the group policy. These provisions include, but are not limited to, grace periods, periods of incontestability, required copies of applications, deemers of representations and not warranties, medical or other evidence of insurability, provision for a certificate of insurance and conversion to an individual policy in the event of termination or total disability.
STANDARDS
UNDERWRITING AND RATING

Standard 2
Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All applications

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and inflation protection options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Determine if the application complies with applicable statutes, rules and regulations regarding form and content.
STANDARDS
UNDERWRITING AND RATING

Standard 3
The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Applications and related disclosure and consent forms

_____ Health questionnaires for applicants

_____ Medical underwriting guidelines

_____ Entity guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

_____ ________________________________

_____ ________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ensure the entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional.

Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test, and should be a part of the underwriting file. Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

Questions may ask if the applicant has been diagnosed with AIDS or ARC, if they are designed to establish the existence of the condition, but are not to be used as a proxy to establish sexual orientation of the applicant.
Ensure the entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant’s sexual orientation a factor in the determination of insurability.

Review a sample of underwriting files for denied applications in order to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the entity guidelines (e.g., based on the amount of insurance).

Neither the marital status, the living arrangements, the occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant’s sexual orientation.
STANDARDS
UNDERWRITING AND RATING

Standard 4
Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

____ Underwriting/Administration file

____ Policies, riders, amendments, endorsements, applications and certificates of coverage

Others Reviewed

____ ______________________________

____ ______________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the policy contains the required terms and definition of such terms per applicable statutes, rules and regulations, including, but not limited to:

- Guaranteed renewable and noncancellable;
- Activities of daily living, acute condition, adult day care, bathing, cognitive impairment, continence, dressing, eating, hands-on assistance, home health care services, Medicare, mental or nervous disorder, personal care, skilled nursing care, toileting and transferring. In addition, coverage specific to limited long-term care benefits may include non-skilled nursing care by providers of service, including but not limited to skilled nursing facility, extended care facility, convalescent nursing home, personal care facility, specialized care providers, assisted living facility, and home care agency; and
- Reasonable and customary/usual and customary.

Determine if riders and endorsements added after the original date of issue, at reinstatement or renewal that reduce or eliminate benefits or coverage (except as requested by the insured) require signed acceptance by the insured.

Ensure that the entity has not established a new waiting period in the event existing coverage is converted or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the individual or group policyholder.
Ensure that the entity does not apply preexisting condition provisions more restrictive than “…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person,” unless the insurance commissioner has extended limitation periods.

A limited long-term care insurance policy or certificate, other than a policy or certificate issued to a defined group, may not exclude coverage for a loss or confinement that is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

A limited long-term care insurance policy or certificate may not exclude or use riders or waivers to exclude, limit or reduce benefits for specifically named or described preexisting conditions or physical conditions beyond the defined waiting period.

Determine if the policy meets the requirements under applicable statutes, rules and regulations with regard to prior hospitalization/institutionalization. The policy may not:

- Condition eligibility of any benefits on a prior hospitalization requirement, or, in the case of benefits provided in an institutional care setting, on the receipt of a higher level of institutional care;
- Condition eligibility for benefits (other than waiver of premium, post-confinement, post-acute care or recuperative benefits) on a prior institutionalization requirement;
- Condition eligibility of non-institutional benefits based on the prior receipt of institutional care on a prior institutional stay of more than 30 days; and
- Condition the receipt of benefits following institutionalization upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge.

A policy or rider containing post-confinement, post-acute care or recuperative benefit shall contain in a separate paragraph titled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.

Determine if the policy contains any limitations regarding preexisting conditions, and, if so, ensure that they are outlined in a separate paragraph titled “Preexisting Condition Limitations.”

Ensure that the policy measures the need for limited long-term care on the activities of daily living (ADLs) and cognitive impairment, and that they are described—along with any additional benefit triggers, benefits and entity-required certification of functional dependency—in a separate paragraph titled “Eligibility for the Payment of Benefits.”

If a limited long-term care policy provides benefits for home health care or community care services, ensure that it meets the required minimum standards required by applicable statutes, rules and regulations.
## STANDARDS
### UNDERWRITING AND RATING

<table>
<thead>
<tr>
<th>Standard 5</th>
<th><strong>Underwriting and rating for limited long-term care products complies with applicable statutes, rules and regulations.</strong></th>
</tr>
</thead>
</table>

**Apply to:** All group limited long-term care products  

**Priority:** Essential  

**Documents to be Reviewed**

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)  
- Policy contract  
- Notice of cancellation/nonrenewal  
- Insurance department approval of forms  
- Underwriter’s file or notes on a system log  
- Insured’s request (if applicable)  
- Entity cancellation/nonrenewal guidelines  
- Certificate of mailing  

Others Reviewed

-  
-  

**NAIC Model References**

- Limited Long-Term Care Insurance Model Act (#642)  
- Limited Long-Term Care Insurance Model Regulation (#643)

**Review Procedures and Criteria**

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and applicable statutes, rules and regulations.

Review entity procedures for cancellation/nonrenewal to determine if the entity is following its own guidelines.

Review cancellation and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the forms, if necessary, were approved by the insurance department.
In addition to other applicable review procedures, verify the following:

- The entity has not cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;
- The entity has not established a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
- The entity does not provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; and
- The entity does not apply preexisting condition provisions more restrictive than “…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person,” unless limitation periods have been extended by the insurance commissioner.

Verify that standards for incontestability periods are no more restrictive than as follows:

- Within 6 months, misrepresentations must be material;
- Within 2 years and more than 6 months, misrepresentation must be material and pertain to the condition for which benefits are sought; and
- After 2 years, benefits are contestable only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured’s health.

Verify that the entity’s underwriting practices reflect minimum requirements related to guaranteed renewability, noncancellability and continuation or conversion.

Replacement of a group limited long-term care policy with another group limited long-term care policy shall offer coverage to all persons covered under the previous group policy on its date of termination, with no preexisting condition exclusions that would have been covered on the prior policy and shall not vary or otherwise depend on the individual’s health or disability status, claim experience or use of limited long-term care services.

Verify that the entity provides notice to the designated person, in addition to the applicant, for termination of a policy or certificate for nonpayment of premium.

Verify that the entity allows for reinstatement of coverage in the event of lapse if provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

Verify that prior to issuance of a limited long-term care policy or certificate to an applicant age 80 or older, the insurer obtains one of the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician’s statement; or
- Copies of medical records.

Verify that the entity delivers a copy of the completed application or enrollment form (whichever is applicable) to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

Verify that the entity maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. The entity shall annually furnish this information to the insurance commissioner in the format prescribed by applicable statutes, rules and regulations.

Verify that the premium charged does not increase due to increase of age beyond 65 or the duration the insured has been covered under the policy.
STANDARDS
UNDERWRITING AND RATING

Standard 6
The company’s underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Apply to: All limited long-term care products
Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ New business application
_____ All underwriting information obtained
_____ Company underwriting guidelines and bulletins
_____ Declination procedures
_____ Agency agreements and correspondence with producers
_____ Riders or extensions of coverage
_____ Interoffice memoranda and company minutes
_____ Policy specifications page
_____ Underwriter’s file or notes on a system log

Others Reviewed

_____ ___________________________________________
_____ ___________________________________________

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Limited Long-Term Care Insurance Model Act (#642)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness (#888)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper
Review Procedures and Criteria

Ensure the file documentation adequately supports the decisions made:

- The application should be complete and signed;
- Determine when, and under what conditions the company requires motor vehicle reports, inspection reports, credit reports, Medical Information Bureau (MIB) or other medical physician reports or other underwriting information to confirm exposure or premium basis;
- Determine if the file contains the necessary information to support the classification, rating and selection decision made; and
- Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable statutes, rules and regulations.

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state’s definition of unfair discrimination.

Determine if the company is following its underwriting guidelines, and that the guidelines conform to applicable statutes, rules and regulations, including, but not limited to:

- The insurer shall obtain one of the following prior to issuance of a policy or certificate to an applicant aged 80 or older:
  - A report of physical examination;
  - An assessment of functional capacity;
  - An attending physician’s statement; or
  - Copies of medical records.
- All applications for limited long-term care, except policies issued on a guaranteed-issue basis, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant; and
- If an application for limited long-term care coverage contains a question regarding whether the applicant has had medication prescribed by a physician, the company shall also ask the applicant to list the medication.

Determine if the company underwriting guidelines have been filed, where applicable.

Review interoffice memoranda for evidence of anti-competitive behavior, collusive practices or improper replacement tactics.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each office being examined.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination. Companies may not permit discrimination between individuals of the same class and equal health status.

Ensure that underwriting requirements are not applied in an unfairly discriminatory manner.

Review guaranteed-issue criteria to ensure correct handling.

Review policy provisions for skilled nursing care to ensure that no restrictions are placed on the proper level of care; i.e., the company does not provide only skilled nursing care or does not provide more coverage for skilled care in a facility than coverage for lower levels of care.

Verify that the questions on applications are sufficiently clear and applicable to the coverage being requested.

Verify that Medical Information Bureau (MIB) information is not used as the sole basis for an underwriting decision.
Companies may not refuse to insure, continue to insure or limit coverage based on:

- Sex;
- Marital status;
- Race;
- Religion;
- National origin;
- Physical or mental impairment (except where based on sound actuarial principles or actual or reasonably anticipated experience);
- Blindness or partial blindness only* (however, all other conditions, including the underlying cause of the blindness or partial blindness, are subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person); and
- Abuse status.

*Note: Review individual state statutes, rules and regulations that may provide that an insurer may not refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness.

Many jurisdictions have enacted legislation regarding subjects of abuse. Examiners should be familiar with their statutes, rules and regulations in this area.

Examine new business applications for the required fraud statement.
H. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
### Standards

#### Claims

**Standard 1**

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<tr>
<th>Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.</th>
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</table>

**Apply to:** All limited long-term care products  
**Priority:** Essential

### Documents to beReviewed

- [ ] Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- [ ] Company claim procedure manuals
- [ ] Claim training manuals
- [ ] Internal company claim audit reports
- [ ] Insured’s requests (if applicable)
- [ ] Claim bulletins and procedure manuals
- [ ] Company claim forms manual
- [ ] Claim files

### Others Reviewed

- [ ] _________________________________________
- [ ] _________________________________________

### NAIC Model References

- Insurance Fraud Prevention Model Act (#680)
- Limited Long-Term Care Insurance Model Act (#642)
- Unfair Claims Settlement Practices Act (#880)
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
- Limited Long-Term Care Insurance Model Regulation (#643)

### Review Procedures and Criteria

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether standards comply with state statutes. Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner.

Determine if claim handling meets applicable statutes, rules and regulations, including:
- Correct payees and addresses; and
- Correct benefit amounts.
Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

If a claim under a limited long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

- Provide a written explanation of the reasons for the denial; and
- Make available all information directly related to the denial.

Determine if the insurer is in compliance with proper payment of “clean claims,” as defined in applicable state statutes, rules and regulations. Verify that the insurer pays clean claims within 30 business days after receipt of a clean claim. For claims that do not fall within the category of a clean claim, verify that the insurer has sent a written notice acknowledging the date of receipt of the claim and containing one of the following provisions within 30 business days:

- The insurer has declined to pay all or part of the claim and the specific reason(s) for denial; or
- That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

Verify that the insurer has paid clean claims within 30 business days after receipt of all requested additional information, or has sent a written notice that the insurer has declined to pay all or part of the claim within 30 days. The notice should specify the specific reason(s) for denial.

If, upon review of insurer clean claim payment practices, an examiner determines that an insurer has failed to comply with clean claim requirements, verify that the insurer has paid interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the receipt of the claim or, in the event the insurer has requested additional information, upon receipt of all requested additional information.

Verify that the insurer has included interest payable in any late reimbursement without requiring the individual who filed the original claim to make any additional claim for such interest.

It is an unfair practice to settle, or attempt to settle, a claim on the basis of an application that was materially altered without the consent of the insured.

Confirm that a monthly report is issued to the policyholder whenever limited long-term care benefits are issued through acceleration of death benefit provisions of a life insurance product.

Confirm that mandatory nonforfeiture benefits are offered.

Determine that eligibility for the payment of benefits is based on a deficiency in the ability to perform not more than 3 of the activities of daily living (ADLs) or the presence of cognitive impairment.

Ensure that determination of deficiency is not more restrictive than:

- Requiring the hands-on assistance of another person to perform the prescribed ADLs; and
- For a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

Ensure that licensed or certified professionals, such as physicians, nurses or social workers, perform assessments of ADLs and cognitive impairment.
POLICY IN FORCE STANDARDIZED DATA REQUEST
Property/Casualty Line of Business
Inland Marine

Contents: This file should be downloaded from the company system(s) and contain one record for each inland marine policy issued in [applicable state] which was in force at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of inland marine policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state(s) licensing information to ensure proper producer licensure

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<tr>
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<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
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<td>Total policy premium amount (sum of all premium for the policy, involving all premium, fees, etc.)</td>
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<td>InceptDt</td>
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<td>Inception date of the policy [MM/DD/YYYY]</td>
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<td>EffDt</td>
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<tr>
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<td>D</td>
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<td>Date policy was paid to before cancellation [MM/DD/YYYY]</td>
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<tr>
<td>CanTerDt</td>
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<td>D</td>
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<td>Date policy cancelled/terminated [MM/DD/YYYY]</td>
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<tr>
<td>CanReqDt</td>
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<td>D</td>
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<td>Date cancellation requested, if applicable [MM/DD/YYYY]</td>
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<td>Who cancelled the coverage C=Consumer or I=Insurer</td>
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<td>Reason for cancellation/termination of coverage (i.e., lapse, underwriting reasons, change of risk, nonpayment) If codes are used, provide a list of codes along with their meanings</td>
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<tr>
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<td>Date the cancellation/termination notice was mailed [MM/DD/YYYY]</td>
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<td>Date premium refund mailed [MM/DD/YYYY]</td>
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<td>Refund method (i.e. 90%, prorata, etc.) If codes are used, provide a list of codes along with their meanings</td>
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<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
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W:\National Meetings\2020\Summer\Cmte\D\Inland_Marine_In_Force_07_23_20.docx
CLAIMS STANDARDIZED DATA REQUEST  
Property & Casualty Line of Business  
Inland Marine

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of inland marine claims within the scope of the examination.

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper adjuster licensure.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Start</th>
<th>Length</th>
<th>Type</th>
<th>Decimals</th>
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<td>Cause of loss (water, hail, theft, fire, etc.)</td>
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<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
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<td>Date of company appraisal</td>
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<td>NtcInvDt</td>
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<td>D</td>
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<td>Date of written notice to insured regarding incomplete investigation [MM/DD/YYYY]</td>
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</table>

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