

REPORT OF MARKET CONDUCT EXAMINATION

Guarantee Trust Life Insurance Company, NAIC # 64211
1275 Milwaukee Ave
Glenview, IL 60025

Guarantee Trust Group
NAIC Group #687

ETS# KS023-M34

AS OF

December 31, 2008

BY

KANSAS INSURANCE DEPARTMENT

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Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

Dear Commissioner Praeger:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

Guarantee Trust Life Ins. Co.
1275 Milwaukee Ave
Glenview, IL 60025
NAIC # 64211

Hereafter referred to as “GTL” or the “Company” and the following report of such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, FLMI, ARM, AR
Market Conduct Supervisor

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of GTL was conducted pursuant to, but not limited to, K.S.A. 40-222. The Kansas Insurance Department (KID) reviewed operations/management, complaints, marketing and sales and claims to determine if the Company was in compliance with applicable statutes, regulations and bulletins of the State of Kansas.

The audit was conducted according to the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2007 (MRH). The exam team utilized the standards and tests recommended in the Handbook and its tolerances of 7% was used for claim procedures and 10% was used for all other categories. The examination report is written by test rather than by exception. This means all standards used are described and results indicated. Not all standards listed in the MRH were used in this exam, and therefore the reader will notice gaps in the numbering of these standards throughout the report.

The examination included reviewing several samples of the Company's complaint files from January 1, 2004 thru December 31, 2008, policyholder files from January 1, 2004 thru December 31, 2008, and claim files for the year of 2008.

Interrogatories were submitted to the Company prior to the on-site segment of the examination, and the Company provided written responses. The responses received addressed the issues requested.

The examination included, but was not limited to the following:

OPERATIONS/MANAGEMENT

History and Profile
Prior Market Conduct Examination Reports
Fines and/or Penalties
Company Operations and Management
Certificates of Authority
Internal Audit Procedures
TPA

COMPLAINT HANDLING

Record Keeping
Timely Response

MARKETING/SALES

Marketing & Advertising Materials
Agent's Materials

AGENCY

Agent Appointments
Agency Management

POLICYHOLDER SERVICE/UNDERWRITING & RATING

Policy Forms and Filings

Policy Issuance

Individual Policies

Group & Association Business

List of all LTC policies that were part of the Illinois consent order and KID agreement

CLAIMS

Claim Processing

Timeliness and Accuracy of Claim Payment

Proper Maintenance of Claim Files

EXECUTIVE SUMMARY

The KID performed a market conduct examination of GTL. The period of examination was January 1, 2004 through December 31, 2008. Lines of business reviewed include accident and health, life insurance, and long-term care (LTC) insurance. The examiners reviewed the Companies' operations/management policies, marketing and sales, complaint files and claim files at the Company's administrative office in Glenview, IL.

The reason the market conduct exam was conducted was due to an issue uncovered through complaints where the company had incorrectly increased premiums on LTC policies. To summarize, in 2004 GTL began selling LTC policies with a rate guarantee for a five-year term to Kansas consumers. There were two riders that were sold as part of the policy (Return of Premium (ROP) and Spousal Enhancement (SE)). The rate actually charged was not on file with KID. In 2005 GTL informed Kansas consumers who had purchased said policies that an increase in premium was assessed as a result of a computer miscalculation on the riders. They gave customers the option at that time to remove the riders and receive a full refund. As of December 2005, if they chose to keep the riders, GTL would correct the rates and the premiums would increase.

The Illinois Department of Insurance had issued a consent order against GTL that the "Company shall revert to the original, at issue, premium rates of its long term care policies and riders...until the expiration of the initial rate guarantee period...and shall refund...any additional premium moneys received as a result of the changing the amount of premiums prior to the expiration of the initial rate guarantee period. For all policies that remain in force, any required refund or premium credit shall be made no later than the expiration of the initial rate guarantee period." KID also entered into an agreement with GTL where they would not charge the new rate as of 2005 and then refund the overcharged amount at the end of the five year guaranteed period. Another option the Company was giving policyholders was to convert to a new LTC policy (while returning all premiums paid for the ROP and Compound Inflation Protection (CIP) riders as well as the amount overpaid for the SE rider).

There were a number of complaints in which the Company did not calculate the premium returns properly and regarding agents using high pressure sales practices to convert existing LTC policies to the newer LTC policy offered by GTL. The market conduct exam was conducted to determine compliance with the terms the agreement between the Company and KID, the IL DOI consent order, as well as to determine if refund calculations were made correctly.

LIST OF RECOMMENDATIONS

Marketing and Sales Recommendations

A. General

There were twenty-seven (27) total complaints closed at KID against the Company in 2008. Of those complaints, fourteen (14) had reasons related to marketing and sales. The following is a breakdown of the specific reasons for the marketing and sales complaints:

<u>No.</u>	<u>Reason</u>
9	High Pressure Sales Tactics
2	Agent Handling
2	Misleading Advertising
1	Misrepresentation

- GTL needs to take a more proactive approach to training and monitoring their agents. Within 60 days the Company should provide KID with an oversight plan for more stringent controls over the entities (TPA's, GA's and marketing groups) that market and sell their products.

B. Critical Provider Program

GTL's Critical Provider Product Brochure does not clearly define the type of policy being advertised; this is in violation of the life advertising regulation, K.A.R. 40-9-118 Section 5, (5). The cover page of the brochure has to clearly and prominently describe the type of policy advertised.

The Company markets a 10 and 20 year term life policy under the banner of their "Critical Provider Program". Included in this program is a Critical and Terminal Illness Benefit Rider. Their Critical Provider Product Brochure is in violation of the Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b). The brochure did not have the phrase, "accelerated benefit" or words of similar import in its title. The Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b) requires an accelerated benefit form approved in Kansas to include the phrase, "accelerated benefit" or words of similar import in its title.

Examiner Note: The Company has since revised the brochure for this product.

The cover letter sent to a new customer with the policy appears misleading and is a violation of K.S.A. 40-2404 (1)(a)&(e). The first point made in the letter talks about lump sum cash benefits being paid out for critical or terminal illness or being confined to a nursing home and using the money for paying health insurance deductibles or medical expenses etc. This gives the impression that it is a health policy. It isn't until the third paragraph that the letter indicates that they are actually buying a life insurance policy. The letter does not indicate to the consumer that they are actually buying a term life insurance policy with a rider that provides some accelerated benefits.

Examiner Note: The Company has already revised this cover letter.

The application for the Critical Provider Product is in violation of K.A.R. 40-2-20(b) as well as K.S.A. 40-2404 (1) (a)&(e). It does not clearly indicate it is a term life policy with “accelerated benefit”. It includes the term “Full Critical Illness Coverage,” which appears to be misleading and suggestive of health coverage.

- Within 30 days the Company shall provide KID a revised application for this product.

The Company was accepting applications for their critical provider program that were not filed with KID. This is a violation of K.S.A. 40-442 and K.S.A. 40-443.

- The Company should implement procedures to better monitor applications being submitted for coverage to ensure the applications being used are adequate.

C. Cancer Policy Outline of Coverage

- GTL needs to revise their outline of coverage cancer form to come into compliance with K.A.R. 40-4-23(b)(3)(A)(E)&(F). The following areas need addressed:
 1. The outline of coverage needs to include a designation for the date, name and signature of the insurance agent or the name of the employee of the insurer, if no agent is involved, who assumes responsibility for the outline.
 2. The outline of coverage form needs to disclose policy provisions relating to the cancellation of coverage.
 3. The outline of coverage form needs to disclose policy premiums

Examiner Note: The Company has already re-filed this form.

D. Individual Products - Advertising forms for Student Blanket Coverage

- There are several advertising forms for student blanket coverage that need updated to be in compliance with provisions within K.A.R. 40-9-100. Within 30 days, the Company needs to provide evidence that the following documents have been revised:
 1. Six student blanket coverage advertising forms need to be revised and have a form number to identify the brochure per K.A.R. 40-9-100 Guideline 2-B.
 2. Two brochures are in violation of K.A.R. 40-9-100 Guideline Section 11 and need to be revised removing any disparaging comparisons and statements of non-comparable policies.
 3. One brochure needs to be revised to indicate the source of the statistics quoted in the material per K.A R. 40-9-100 Guideline 9-B.

E. Association Business

1. In five different situations a particular Association’s marketer incorrectly used enrollment forms which reflected a carrier other than GTL. Kansas does not require filings for out-of-state based association business and the individual certificates issued to Kansas members for those associations are not subject to Kansas statutes and regulations. The agreement to provide 24-hour

accident insurance to members of the Association is between Guarantee Trust Life and the Association itself. It is the master application between these parties and not the Association enrollment form which forms the basis of the insurance contract.

- The Company needs to implement more stringent monitoring procedures on marketers for this product or require more documentation when policies are written.

2. In reviewing the association membership form there was only one dollar amount shown. The application for the blanket sickness and accident insurance must be separate from the association membership application. The insurance premium must be clearly visible to the insured, not co-mingled with the association dues per K.S.A. 40-2215(a).

- Within 30 days, the Company should provide confirmation that the membership form as been revised to separate insurance premium form the association dues.

Claims Recommendations

1. Both the Company and their TPA, First Agency, need to review their procedures to insure if a claim cannot be processed within 30 days as clean claim because of lack of documentation, they must send notification and include what additional information is necessary in order to consider the claim for payment per K.S.A. 40-2442 (a).

Company Response: First Agency has been advised to revise its procedure when it receives notice of claim without the medical bills. Going forward, it will include (within the receipt of claim notification) a sentence requesting the medical bills to be sent so that the claim may be considered for payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.

2. The Company and their TPA, First Agency, need to revise their procedures to notify the claimants when the full amount of the claim was paid per K.A.R. 40-1-34, Section 8(a).

Company Response: The Company's home office claim management staff is in the process of working with First Agency to revise its current procedures so that in all situations a claimant will be notified on the status of claim payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.

3. The EOB's use a number code with a few words to explain the reason for the denial. The specific policy provision, condition or exclusion usually is not referenced by policy page number, section or paragraph. Many of the denials on the EOB's sent to the claimant were vague. This is a violation of K.A.R. 40-1-34, Section 8(a).

Company Response: The Company provided an electronic communication sent from GTL's Claim Department manager to Claim Department supervisors addressing the use of EOB remark codes and to use more specific description for a claim denial.

The Company plans to convert to a new Claims Processing system in the very near future. At that time, EOB remark codes will be re-evaluated to ensure compliance with states' laws so that the insured and/or provider have appropriate and sufficient information forming the basis for any denial. However, in the meantime, supervisors have been instructed that certain EOB remark codes can no longer be used.

- Within 30 days, the Company should provide a status update of their new claim system and enhanced EOB denial explanation program.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

Company History:

GTL is a mutual legal reserve life and health insurance company founded in 1936 by the R. S. Holson family. It is domiciled in the state of Illinois and licensed to do business in 49 states, the District of Columbia and Puerto Rico.

During the exam period, GTL was managed by officials who have been associated with the company for many years and was under the direction of the late Chairman of the Board and Chief Executive Officer R. S. Holson, Jr. The President and Chief Operating Officer of GTL was R. S. Holson, III.

Lines of Business and Distribution Methods:

Life Insurance: Product distribution is achieved under an agency system in which GTL is represented by a field force of approximately 15,000 independent agents. The company markets a standard portfolio of individual life products including term and ordinary life contracts. In addition to agency distribution, GTL mass markets juvenile and senior life insurance products via direct mail and television advertising.

Group Credit Life and Disability: This line is primarily written by GA's through automobile dealerships, small and mid-sized banks and credit unions in 34 states. Coverage is primarily on installment loans on a single premium basis.

Special Risk Student Accident and Health (Blanket): This line is written by a group of GA's who specialize in the student (K-12) and college markets. GTL's three main markets in this area are: (1) student accident; (2) college accident and health; and (3) non-student, which is

comprised of accident insurance for youth groups, such as camps, scouting, and non-scholastic sports.

Individual Accident and Health: This line is written by both independent agents and through joint-venture marketing partnerships that the company has established. Products sold in this line are directed to the senior market and include Medicare Supplement, LTC insurance, and hospital indemnity. Accident and Specified Disease products are available to the general population.

Group Accident and Health: This line of business consists of major medical benefit products marketed to large employers who provide coverage for retirees 65 years and older who are covered under Medicare Parts A & B and not covered by a Medicare supplement plan. This line also consists of small group health products, and dental programs in which GTL is the issuing carrier and cedes all or most of the risk to U.S. reinsurers.

Annuities: The Company maintains a closed block of individual annuities.

Certificate of Authority

The Kansas Certificates of Authority were reviewed and found to be in order.

Company Agreements

The exam team reviewed two marketing and administrative service agreements that GTL provided for two of their Third Party Administrators (TPA's) and found them to be in order.

Marketing & Sales

A. Group & Association Business

1. Special Markets

The Company has a Special Markets line of business, which partners with TPA's and marketing companies to develop and market a variety of individual, group and association group insurance products. During the period 1/1/04 through 3/31/09 Special Markets had two programs: a small group and short term medical program and an association group medical program which provided coverage to Kansas residents.

- *National Marketing Services, LLC:* National Marketing Services, LLC ("NMS") markets the small group and short term medical program administered by Allied National. NMS is responsible for recruiting and training Kansas licensed agents and recommending them for appointment. It does not recruit unlicensed agents, but instead seeks agents who have been active in the small group or short term medical markets.

GTL appoints agents recommended by NMS once they have received the required application and a valid Kansas license.

NMS provides continuing training for the agents using webinars, phone calls and in person contact.

- Truckers Service Association: Truckers Service Association ("TSA") provides fuel discounts, lease truck options, tires, hotels, maintenance plans and medical insurance benefits to independent contractors who are contracted with Marten Transport, a Wisconsin motor carrier, to drive over-the-road trucks for Marten.

2. Special Risk-Schoolchild

GTL also markets special risk student accident coverage. The three main markets are: college accident and health, student accident, and non-student which is comprised of accident insurance for youth groups, such as scouting, camps, and non-scholastic sports. These products are marketed exclusively through GA's who specialize in the schoolchild market.

3. Association-24-Hour Accident Coverage

GTL makes its 24-hour accident coverage available as part of membership benefits to qualified associations. The association products are marketed through various advertising media: television and radio commercials, internet, telemarketing, and print ads.

B. Marketing Groups

GTL contracts with existing insurance marketing organizations to distribute its Special Markets program products. These groups must have a track record in medical insurance distribution and possess an existing agency force. In addition, they must be capable of recruiting, training and monitoring their agents. By contract, they are responsible for the actions of their agents. In addition, they generate and provide all marketing materials, provided they have been previously submitted to GTL for review and approval.

Agents contracted with a marketing group receive an agent code specific to that marketing group. These agents may sell other GTL products if so approved by GTL. When approved, these agents receive separate agent codes that enable them to submit business for the specific products they have been granted the ability to sell.

C. Individual agents or agencies

GTL recruits agents through various methods, which include: trade publications; trade meetings; or agent to agent referrals. Minimum requirements would be the completion of the application and to have a valid health insurance license.

The Company contracts with individuals currently holding a valid and appropriate insurance license in the state(s) in which they intend to solicit business for life and or health insurance. The Company does not provide state insurance license exam preparation materials or supplemental training. It is the responsibility of the individual or in cases of general agency contracts, the GA to ensure a prospective new agent appointee has satisfied all state insurance licensure requirements prior to requesting appointment with the Company.

Internal Audits

GTL provided audits for 2004 and 2005 that were performed on TPA's who serviced Kansas business. Audits conducted in 2007 and 2008 did not include TPA's who handled Kansas business. The overall conclusions for the 2005 audits indicated that there was an acceptable performance by the TPA. The Company also provided claim department audit procedures and several audit reports.

Prior Market Conduct Examination Report(s)

The Company provided the examiners with the market examination reports by other states conducted during the exam period. There were no recommendations in these exams outside the scope of this exam that warranted additional scrutiny by the exam team.

Fines and/or Penalties

The NAIC I-Site database was reviewed. There was nothing noted that warranted follow-up by this exam team outside the issues already identified in KID complaint analysis and feedback from other KID Divisions.

Tests for Company Operations/Management

Standard 1

The regulated entity has an up-to-date, valid internal or external audit program.

See the comments above under Internal Audits.

The Company passed Standard 1.

Standard 5

Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, MGA's, GA's, TPA's and management agreements must comply with applicable licensing requirements, statutes, rules and regulations.

The exam team reviewed two marketing and administrative service agreements that GTL provided for two of their TPA's and found them to be in order.

The Company passed Standard 5.

Standard 6

The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

Individual Products

The Company does not have a formal agency disciplinary action program. All written complaints against agents would, at a minimum, be reviewed by a supervisor, manager, or higher level of authority prior to resolution. Where a trend appears to exist, or where the seriousness of the allegation is warranted, the information gathered will be brought to the attention of the Vice-President of Sales. After a review of all facts, appropriate action would be taken, which may include termination of appointment for cause. The Company's General Counsel must approve of all terminations for cause.

Group and Association Business

For the most part GTL relies on the TPA and marketing groups to recruit, train and monitor the agents that are marketing their group and association business. Disciplinary action taken against agents in the Special Markets line does not differ from individual health. Although, in the case of Special Markets it may be the TPA or marketing group that reviews and investigates the allegations against the agent and forwards all information to the Company for final disposition.

TPA's and marketing groups are required to inform GTL, of any inappropriate agent activity and to participate with GTL when responding to any formal complaints. GTL maintains a log of all formal DOI complaints. For the most part, the Company has delegated the responsibility of agency management to the TPA or marketing group.

Standard 7

Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. K.S.A. 40-222 (a)(b)(c)(g).

The Company maintained adequate records as required for a Market Conduct examination.

The Company passed Standard 7.

Standard 8

The regulated entity is licensed for the lines of business that are being written.

The Kansas Certificate of Authority was reviewed and the company was in compliance with business written.

The Company passed Standard 8.

Standard 9

The regulated entity cooperates on a timely basis with examiners performing the examinations.

The Company provided the exam team with the necessary records and documents in a timely fashion.

The Company passed Standard 9.

OPERATIONS/MANAGEMENT - LTC STANDARDS

Standard 1

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

The company provided copies of LTC insurance annual report as required by K.A.R. 40-4-37. Copies of the LTC insurance replacement and lapse rates records for each agent for calendar years 2004, 2005, 2006 and 2007 were reviewed.

The Company passed Standard 1.

COMPLAINT HANDLING

Complaints/Appeals/Grievances:

The Company defines a “complaint” as any written communication primarily expressing a grievance.

The Company has two sets of procedures. One is for complaints received through the Department of Insurance (DOI). The other is for complaints received directly from an insured, or their representative, which are entered onto their on-line complaint tracking system.

Consumer complaints received from the DOI and other intermediaries are maintained separately by Product Approval and Compliance.

The Company keeps a record of each and every inquiry they receive from the DOI. The Consumer Affairs Specialist assigns a case number to all incoming correspondence. The information is entered into an Access database and a case number is assigned to the correspondence.

Once the case is completed, the data needed to complete the database record is entered. The following fields are required for a complete record: case number, state, DOI reference number, policyholder name, line of business, reason code, resolution code, received date, completed date and agent code if related to an agent inquiry.

Quarterly and annual reports are generated from information and disbursed to servicing department managers. Cases which do not involve the DOI, such as the Better Business Bureau, Attorney General’s office or from a legal firm, are logged into the non DOI tracking book.

Replies or delay letters to the DOI are due every 10 days from the date the Department writes the Company. The Claim Department maintains a file on each state for Non-Insurance Department Complaints or Appeals.

Tests for Complaint Handling

Standard 1

All complaints are recorded in the required format on the company complaint register. K.S.A. 40-2404 (10).

The Company provided a complaint register. It was up-to-date and contained all columns as required by Kansas Statute.

The Company passed Standard 1.

Standard 2

The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34, Sections 5(a) & 6.

The company has written Complaint procedures. See above for these procedures.

The Company passed Standard 2.

Standard 3

The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. K.A.R. 40-1-34, Section 6.

The Company passed Standard 3.

Standard 4

The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. K.A.R. 40-1-34, Sections 6 & 8(a)&(c).

The Company passed Standard 4.

MARKETING AND SALES

Tests for Marketing and Sales

MARKETING AND SALES - GENERAL STANDARDS

Standard 1

All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

1. Individual Products

a. Advertising forms for Student Blanket Coverage

1). There were six student blanket coverage advertising forms that did not have a form number to identify the advertising brochure. These materials were in violation of K.A.R. 40-9-100, Guideline 2-B.

2). In two brochures the first two points under the section, “The Coverage: Blanket Accident” read: “Broad coverage without the usual inside limitation or controls found in most programs;” and, “Reduction of paperwork to a minimum”. This is a violation of K.A.R. 40-9-100 Guideline Section 11.

3). On the last page under, “Why Blanket Accident Coverage?”, the first two items read: “Recent studies have shown that health care costs have increased more than 250% in the last decade;” and, “the number of people without health insurance continues to grow (approximately 1 in 8 Americans).” The above captioned material is quoting statistics and is not documented as to the source of these numbers. This is a violation of K.A.R. 40-9-100, Guideline 9-B.

b. LTC Policy

The advertising for LTC policies was reviewed and found to be acceptable.

c. Specified Disease Policy

The advertising for specified disease policies was reviewed and found to be acceptable.

d. Critical Provider Program

1). The company markets a 10 and 20 year term life policy under the banner of their “Critical Provider Program”. Included in this program is an additional coverage provided through a Critical and Terminal Illness Benefit Rider. The “Critical Provider Product Brochure” did not conform to Kansas administrative regulations.

The Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b) requires an accelerated benefit form approved in Kansas to include the phrase, “accelerated benefit” or words of similar import in its title. The Life Advertising regulation, K.A.R. 40-9-118, Section 5 (5) requires advertising to clearly define the type of policy being advertised. The cover page of the brochure has to clearly and prominently describe the type of policy advertised. The brochure in question suggests that it provides cash benefits for 18 critical conditions but in no way clarifies that it is an acceleration of a term life insurance product.

2). The cover letter sent by the Company to a new customer with the policy appears misleading. The first point made in the letter talks about lump sum cash benefits being paid out for critical or terminal illness or being confined to a nursing

home and using the money for paying health insurance deductibles or medical expenses etc. This gives the impression that it is a health policy. It isn't until the third paragraph that the letter indicates that they are actually buying a life insurance policy. The letter does not indicate to the consumer that they are actually buying a term life insurance policy with a rider that provides some accelerated benefits. This is violation of K.S.A. 40-2404 (1)(a)&(e).

3). Agency Marketing, Cover Letter and Application

a). In one complaint regarding the sale of a Critical Provider Plan policy, the agent did not use the application that had been filed and approved by KID. The unfiled application was used in four other submissions from that agency. This is in violation of K.S.A. 40-442 and K.S.A. 40-443.

b). In a telephone script used by this agency to solicit business, they identified themselves as representing GTL. They made reference to affordable healthcare. The document goes on to talk about being treated for different diseases and doctor visits. The third page references GTL's Critical Illness policy:

“The premier program also includes a Guarantee Trust Life Insurance Company Critical Illness policy for any hospital visit you might have that occurs as a result of a critical illness like a heart attack, stroke or cancer. Additionally, this program includes a \$5,000 emergency room benefit. Between these two items, you will see a significant reduction in out of pocket costs for critical illnesses and emergency room visits. If something happens Guarantee Trust Life Insurance Company will send you or your family a lump sum check for the face value of your critical illness policy. Your critical illness policy includes \$ **(FACE AMOUNT)** in coverage and this will help you pay medical bills and other living expenses you have while you recover.”

c). The agency cover letter that was sent to a new customer with the policy identified it as a critical illness policy. The letter was even produced on what appears to be a GTL letterhead.

This marketing script and cover letter are very misleading since they identify the GTL policy as being a “critical illness policy.” It is not a critical illness policy, but a term life insurance policy with an accelerated benefits rider attached. The marketer does not explain that this is a term life policy or explain the rider. This gives the impression that it is a health policy. This is a deceptive act and violates the Kansas Unfair Trade Practices Act, K.S.A. 40-2404 (1)(a)(e).

4). Company Application

GTL is marketing a term life policy with an Accelerated Benefit Rider, and each has a separate premium. The application lists them as one product. The accelerated benefit regulation K.A.R. 40-2-20(b) requires accelerated benefit forms to include “accelerated benefit” or words of similar import in its title. It is the exam team’s position that this should also be clearly identified on the application. The rider is not listed in the Optional Benefit Rider section of the application. The term, “with Full Critical Illness Coverage” appears misleading and suggestive of health coverage. The application appears misleading and deceptive which would be in violation of the Kansas Unfair Trade Practices Act, K.S.A. 40-2404 (1)(a)&(e).

2. Group & Assoc Business - Sales and Advertising materials

As mentioned above, marketing groups are allowed to develop their own advertising materials provided they have previously submitted the materials to GTL’s Compliance department for review and approval.

a. Association Business

1). In five different situations a particular Association’s marketer incorrectly used enrollment forms which reflected their prior carrier and not GTL. Kansas does not require filings for out-of-state based association business and the individual certificates issued to Kansas members for those associations are not subject to Kansas statutes and regulations. The agreement to provide 24-hour accident insurance to members of the Association is between Guarantee Trust Life and the Association itself. It is the master application between these parties and not the Association enrollment form which forms the basis of the insurance contract

The Company indicated that had they become aware that the Association’s enrollment form did not reflect GTL as the carrier, they would have requested the Association to immediately discontinue its use and implement the proper enrollment form reflecting GTL as the carrier for accident only coverage.

2). In reviewing the Association membership form there was only one dollar amount shown. The application for the blanket sickness and accident insurance must be separate from the association membership application. The insurance premium must be clearly visible to the insured and not co-mingled with the association dues per K.S.A. 40-2215.

The Company agreed to revise the enrollment form to separate the insurance premium from the association dues.

The Company failed Standard 1.

Standard 2

Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

The Company provided a copy of a package for an appointment of a GA. The *New Agent Guide* is part of this kit. Since most of the agents appointed with the Company are sub-agents through a GA, it is the GA who will go over these materials with a new agent; the GA has supervisory responsibility for producers under their agency.

GTL does not have a formal training program for new agents, nor does GTL have a captive agency. In using independent agents/brokers, GTL feels that the majority of agents appointed with the Company have had experience in soliciting the types of supplemental health insurance products the Company markets.

Insofar as educating a new agent on specific products, the agent will be provided copies of product literature. Additionally, the Company's sales support staff is broken down by regional location, so new agents may tap into the regional sales managers and other sales support staff for questions about a product.

When the Company is about to introduce a new product into the marketplace, the regional sales managers, or the Company's Vice-President of Sales may conduct in-person product presentations for key general agencies. The general agency, in turn, will provide the information needed to the agents who will be writing the business.

Training may also be provided in the form of Microsoft Office PowerPoint presentations that are available in CD format. This type of training presentation is also available on the Company's website where agents log in, under the Agent Connection link.

The Company passed Standard 2.

Standard 3

Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

Newsletters and bulletins are sent to field representatives, on various subjects and discuss different issues. The Company also provides their agents with copies of the Buyers/Shoppers Guides for Long-Term Care Insurance and Medicare Supplement Insurance products.

The Company passed Standard 3.

MARKETING AND SALES - HEALTH STANDARDS

GTL is primarily responsible for the design and content of all of its advertising and marketing materials. It will allow exceptions to this policy for key marketers. However, in no event, are advertising and marketing materials that are developed for use by such marketers authorized for use without the Company's Compliance Department reviewing and approving all content.

The Company's Compliance Department is responsible for the reviewing and approving of all advertising and marketing materials promoting GTL's insurance products. This department also reviews ad pieces submitted for specific use by agents.

Standard 1

Regulated entity rules on replacement are in compliance with applicable statutes, rules and regulations.

Only applicable to LTC. See comments for LTC below.

Standard 2

Outline of coverages are in compliance with all applicable statutes, rules and regulations.

1. LTC Outline of Coverage

The LTC Outline of Coverage was reviewed and it was acceptable.

2. Cancer Outline of Coverage

a. One outline of coverage form did not include a designation for the date, name and signature of the insurance agent or the name of the employee of the insurer if no agent is involved, who assumes responsibility for the outline. This is a violation of K.A.R. 40-4-23(b)(3)(A).

b. The outline of coverage form failed to disclose policy provisions relating to the cancelation of coverage. This is a violation of K.A.R. 40-4-23(b)(3)(F).

c. The outline of coverage also failed to disclose policy premiums. This is a violation of K.A.R. 40-4-23(b)(3)(E).

The Company failed Standard 2.

Standard 3

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

Only applicable to LTC. See LTC comments.

MARKETING AND SALES - LTC STANDARDS

To comply with the requirements of K.A.R 40-4-37p (c)(1)(A), the Company filed form CMPR-LTC, which is expressly used to compare an applicant's existing coverage with the applied for coverage. This form is required to be completed when the application indicates replacement of existing LTC coverage is intended. One copy is left with the applicant and one copy sent to the Home Office with the application.

To comply with the requirements of K.A.R. 40-4-37p (c)(1)(B) and (C), the company relies on the Existing Coverage section of the application which asks about the type and amount of LTC currently in force for the applicant. If an applicant already has LTC coverage in effect with the Company and either chooses to upgrade existing coverage or purchase a newer plan, the Company has an internal maximum limit established for all long-term care insurance to be in-force with GTL.

To comply with the requirements of K.A.R. 40-4-37p (c)(1)(D), the Company has set limits for the amount of LTC insurance an insured is allowed to have with the Company. If the application indicates existing coverage with GTL, the underwriter will check the in-force coverage for the daily benefit amount. If the applied for coverage would exceed the internal limit, the underwriter will contact the writing agent to advise the requested daily benefit amount will be lowered so as not to exceed the Company's internal limits.

Company LTC Replacement and Lapse reports are prepared for state reporting, and the analyst will review agent replacement numbers. For replacement activity that appears to exceed the norm, the analyst would bring this to the attention of the Vice-President of Life and Health Sales.

The above components help to serve as the auditable process by which the Company complies with the requirements of K.A.R. 40-4-37p (c)(1)(A)(B) and (C). A special audit is not performed.

Standard 1

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

The Company passed Standard 1.

Standard 2

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

The Company passed Standard 2.

Standard 3

Marketing for long term care products complies with applicable statutes, rules and regulations.

The Company offered to convert existing LTC policies that were due to have a significant rate increase implemented after the expiration of the initial rate guarantee period to a new LTC policy offered by GTL. The offer included refunding premiums paid for the CIP and ROP riders back to the inception of the policy.

There were a number of complaints regarding high pressure sales practices used by agents trying to convert these older LTC policies to the newer LTC policy offered by GTL.

The Company failed Standard 3.

Standard 4

All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

The Company passed Standard 4.

Standard 5

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

The Company passed Standard 5.

Standard 6

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

The Company passed Standard 6.

Marketing and Sales Recommendations

A. General

There were twenty-seven (27) total complaints closed at KID against the Company in 2008. Of those complaints, fourteen (14) had reasons related to marketing and sales. Following is a breakdown of the specific reasons for the marketing and sales complaints:

<u>No.</u>	<u>Reason</u>
9	High Pressure Sales Tactics
2	Agent Handling
2	Misleading Advertising
1	Misrepresentation

- GTL needs to take a more proactive approach to training and monitoring their agents. Within 60 days the Company should provide KID with an oversight plan for more stringent controls over the entities (TPA’s, GA’s and marketing groups) that market and sell their products.

B. Critical Provider Program

GTL’s Critical Provider Product Brochure does not clearly define the type of policy being advertised; this is in violation of the life advertising regulation, K.A.R. 40-9-118 Section 5, (5). The cover page of the brochure has to clearly and prominently describe the type of policy advertised.

The Company markets a 10 and 20 year term life policy under the banner of their “Critical Provider Program”. Included in this program is a Critical and Terminal Illness Benefit Rider.

Their Critical Provider Product Brochure is in violation of the Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b). The brochure did not have the phrase, “accelerated benefit” or words of similar import in its title. The Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b) requires an accelerated benefit form approved in Kansas to include the phrase, “accelerated benefit” or words of similar import in its title.

Examiner Note: The Company has since revised the brochure for this product.

The cover letter sent to a new customer with the policy appears misleading and is a violation of K.S.A. 40-2404 (1)(a)&(e). The first point made in the letter talks about lump sum cash benefits being paid out for critical or terminal illness or being confined to a nursing home and using the money for paying health insurance deductibles or medical expenses etc. This gives the impression that it is a health policy. It isn't until the third paragraph that the letter indicates that they are actually buying a life insurance policy. The letter does not indicate to the consumer that they are actually buying a term life insurance policy with a rider that provides some accelerated benefits.

Examiner Note: The Company has already revised this cover letter.

The application for the Critical Provider Product is in violation of K.A.R. 40-2-20(b) as well as K.S.A. 40-2404 (1) (a)&(e). It does not clearly indicate it is a term life policy with “accelerated benefit”. It includes the term “Full Critical Illness Coverage,” which appears to be misleading and suggestive of health coverage.

- Within 30 days the Company shall provide KID a revised application for this product.

The Company was accepting applications for their critical provider program that were not filed with KID. This is a violation of K.S.A. 40-442 and K.S.A. 40-443.

- The Company should implement procedures to better monitor applications being submitted for coverage to ensure the applications being used are adequate.

C. Cancer Policy Outline of Coverage

- GTL needs to revise their outline of coverage cancer form to come into compliance with K.A.R. 40-4-23(b)(3)(A)(E)&(F). The following areas need addressed:
 1. The outline of coverage needs to include a designation for the date, name and signature of the insurance agent or the name of the employee of the insurer, if no agent is involved, who assumes responsibility for the outline.
 2. The outline of coverage form needs to disclose policy provisions relating to the cancellation of coverage.
 3. The outline of coverage form needs to disclose policy premiums

Examiner Note: The Company has already re-filed this form.

D. Individual Products - Advertising forms for Student Blanket Coverage

- There are several advertising forms for student blanket coverage that need updated to be in compliance with provisions within K.A.R. 40-9-100. Within 30 days, the Company needs to provide evidence that the following documents have been revised:
 1. Six student blanket coverage advertising forms need to be revised and have a form number to identify the brochure per K.A.R. 40-9-100 Guideline 2-B.
 2. Two brochures are in violation of K.A.R. 40-9-100 Guideline Section 11 and need to be revised removing any disparaging comparisons and statements of non-comparable policies.
 3. One brochure needs to be revised to indicate the source of the statistics quoted in the material per K.A R. 40-9-100 Guideline 9-B.

E. Association Business

1. In five different situations a particular Association's marketer incorrectly used enrollment forms which reflected a carrier other than GTL. Kansas does not require filings for out-of-state based association business and the individual certificates issued to Kansas members for those associations are not subject to Kansas statutes and regulations. The agreement to provide 24-hour accident insurance to members of the Association is between Guarantee Trust Life and the Association itself. It is the master application between these parties and not the Association enrollment form which forms the basis of the insurance contract.

- The Company needs to implement more stringent monitoring procedures on marketers for this product or require more documentation when policies are written.

2. In reviewing the association membership form there was only one dollar amount shown. The application for the blanket sickness and accident insurance must be separate from the association membership application. The insurance premium must be clearly visible to the insured, not co-mingled with the association dues per K.S.A. 40-2215(a).

- Within 30 days, the Company should provide confirmation that the membership form has been revised to separate insurance premium from the association dues.

POLICYHOLDER SERVICE - LTC STANDARDS

Standard 4

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

In 2004, GTL began marketing and selling long-term care (LTC) policies with a rate guarantee for a five-year term to Kansas consumers. There were 2 riders that were sold as part of the LTC policy. These riders were the Return of Premium (ROP) and Spousal Enhancement (SE) riders. The Company informed policyholders in 2005 that due to a computer miscalculation, an increase in premium would be assessed. One of the options given to avoid this was to convert existing LTC policies to a new policy. This offer included the refunding of premiums paid for the riders. The examiners looked at the following four

different groups to determine how the Company handled different options available to their Kansas policyholders:

Group #1 - Policies lapsed before the expiration of the initial rate guarantee period or before the KID agreement processed. The Company processed the refund per the Illinois Consent Agreement.

<u>Sample</u>	<u>Errors</u>	<u>Compliance %</u>
48	0	100%

Group #2 – Policyholder had accepted an offer to convert existing LTC coverage that was due to have a significant rate increase implemented after the expiration of the initial rate guarantee period to a newer LTC policy offered by GTL. The offer included refunding premiums paid for the CIP and ROP riders.

<u>Sample</u>	<u>Errors</u>	<u>Compliance %</u>
50	14	72%

- Twelve accounts had a premium miscalculation. The Company’s refund of premium calculation did not take into consideration the difference between the original and corrected SE rider premium.

- One account’s refund of premium calculation should have included an additional month’s premium for the ROP, CIP, and SE riders.

- One account’s refund did not include the difference for the SE rider.

*As a result of these errors the company ran a query and identified a total of 286 accounts where the refund was incorrectly calculated due to the SE rider. The company has since corrected this problem and refunded the money to its clients.

Group #3 - KID agreement – future consent money

<u>Sample</u>	<u>Errors</u>	<u>Compliance %</u>
49	0	100%

Group #4 - Any policies that did not fit into the other three categories

<u>Sample</u>	<u>Errors</u>	<u>Compliance %</u>
50	0	100%

The Company’s comment regarding the entire conversion process was that “due to the complexity of the refund calculations, as well as a variety of ongoing coverage and premium changes requested by policyholders, the refund calculations were performed manually. The complexity of the manual calculations as well as the volume of cases being refunded may have led to some cases being unintentionally under or over refunded due to human error.”

Company failed a portion of Standard 4.

CLAIM HANDLING

Tests for Claims Handling

CLAIM STANDARDS - GENERAL

Standard 1

The initial contact by the regulated entity with the claimant is within the required time frame. K.A.R. 40-1-34, Sections 6(a)&(d); K.S.A. 40-2442(a)(b).

<u>Plan</u>	<u>SampleErrors</u>		<u>Compliance %</u>
Major Medical Claims Allied National (TPA)	38	0	100%
Group Blanket Business	49	0	100%
Group Claims First Agency (TPA)	39	0	100%
Individual Paid Claims	50	0	100%
Individual Non Paid Claims	<u>50</u>	<u>0</u>	<u>100%</u>
Total	226	0	100%

The Company passed Standard 1.

Standard 2

Timely investigations are conducted. KAR 40-1-34, Sections 7 & 8(c); K.S.A. 40-2442(a)(b).

<u>Plan</u>	<u>SampleErrors</u>		<u>Compliance %</u>
Major Medical Claims Allied National (TPA)	38	0	100%
Group Blanket Business	49	0	100%
Group Claims First Agency (TPA)	39	6	85%
Individual Paid Claims	50	0	100%
Individual Non Paid Claims	<u>50</u>	<u>0</u>	<u>100%</u>
Total	226	6	97%

- Six Group Claims for First Agency failed to include what additional information was necessary in order to consider the claim for payment. This is a violation of K.S.A. 40-2442 (a)(d).

The Company failed one portion of Standard 2.

Standard 3

Claims are resolved in a timely manner. K.A.R. 40-1-34, Section 8(a); K.S.A. 40-2442(a)(b).

<u>Plan</u>	<u>SampleErrors</u>		<u>Compliance %</u>
Major Medical Claims Allied National (TPA)	38	0	100%
Group Blanket Business	49	0	100%
Group Claims First Agency (TPA)	39	3	92%
Individual Paid Claims	50	1	98%
Individual Non Paid Claims	<u>50</u>	<u>2</u>	<u>96%</u>
Total	226	6	97%

- Two Group Claims were never paid. This is a violation of K.S.A. 40-2442(a)&(b).
- One Group Claim was never adjudicated. This is a violation of K.S.A. 40-2442(a)&(d).
- Two Individual Non Paid Claims failed to send a delay letter within 45 days of initial claim notification. This is a violation of K.A.R. 40-1-34, Section (8)(c).
- One Individual Paid Claims was a clean claim but not paid within 30 days. This is a violation of K.S.A. 40-2442(a)

The Company failed one portion of Standard 3.

Standard 4

The regulated entity responds to claim correspondence in a timely manner. K.A.R. 40-1-34; Sections 6(a)&(d); K.S.A. 40-2442(a)(b).

<u>Plan</u>	<u>SampleErrors</u>		<u>Compliance %</u>
Major Medical Claims Allied National (TPA)	38	0	100%
Group Blanket Business	49	0	100%
Group Claims First Agency (TPA)	39	0	100%
Individual Paid Claims	50	0	100%

Individual Non Paid Claims	<u>50</u>	<u>0</u>	<u>100%</u>
Total	226	0	100%

The Company passed Standard 4.

Standard 5

Claim files are adequately documented. K.A.R. 40-1-34, Sections 4, 6(a) & 8(c); K.S.A. 40-2442(a)(b).

<u>Plan</u>	<u>SampleErrors</u>	<u>Compliance %</u>	
Major Medical Claims Allied National (TPA)	38	0	100%
Group Blanket Business	49	0	100%
Group Claims First Agency (TPA)	39	0	100%
Individual Paid Claims	50	0	100%
Individual Non Paid Claims	<u>50</u>	<u>0</u>	<u>100%</u>
Total	226	0	100%

The Company passed Standard 5.

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. K.A.R. 40-1-34, Sections 5(a), 8; K.S.A. 40-3110; K.S.A. 40-2-126.

<u>Plan</u>	<u>SampleErrors</u>	<u>Compliance %</u>	
Major Medical Claims Allied National (TPA)	38	0	100%
Group Blanket Business	49	0	100%
Group Claims First Agency (TPA)	39	7	82%
Individual Paid Claims	50	0	100%
Individual Non Paid Claims	<u>50</u>	<u>1</u>	<u>100%</u>
Total	226	8	96%

- Seven Group Claims handled by First Agency did not produce an EOB when they paid the full amount of what the contract called for in settling a claim. This is a violation of K.A.R. 40-1-34, Section 8(a).
- One Individual Non Paid claim failed to pay a covered benefit. This is a violation of K.A.R. 40-2-34, 5(a).

The Company failed one portion of Standard 6.

Standard 7

Regulated entity claim forms are appropriate for the type of product.

The Company passed Standard 7.

Standard 8

Claim files are reserved in accordance with the company’s established procedures.

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any reserving abnormalities would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 9

Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. K.A.R. 40-1-34, Sections 8(a)(b)&(c).

<u>Plan</u>	<u>SampleErrors</u>		<u>Compliance %</u>
Major Medical Claims Allied National (TPA)	18	0	100%
Group Blanket Business	19	1	95%
Group Claims First Agency (TPA)	19	0	100%
Individual Non Paid Claims	<u>50</u> 106	<u>0</u> 1	<u>100%</u> 99%

- One Group Blanket Claim was a clean claim but was not denied within 30 days. This is a violation of K.S.A. 40-2442(a)

The EOBs use a numeric code with a few words to explain the reason for the denial. The specific policy provision, condition or exclusion usually is not referenced by policy page number, section or paragraph. Many of the denials on the EOB’s sent to the claimant were vague. K.A.R. 40-1-34, Section 8(a) requires an insurer to reference the provision, condition, or exclusion in the denial if it is based on a specific policy language.

GTL provided several sample form letters to cover situations when claims are denied for lack of a heart attack or stroke diagnosis, cancer treatment during the waiting period or pended

until more information is gathered to document the claim. However, only one letter was sent in the sample of 50 individual non paid claims. Either letters need to be sent with the EOB when claims are denied or the “Description of Remarks” section of the EOB needs more specificity similar to the pertinent paragraphs of the denial letters.

The Company indicates it is preparing to convert to a new claims processing system. At that time, EOB remark codes will be re-evaluated to ensure compliance with states’ laws so that the insured and/or provider have appropriate and sufficient information forming the basis for any denial. However, in the meantime, supervisors have been instructed that certain EOB remark codes can no longer be used.

The Company passed Standard 9.

Standard 11

Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy. K.S.A. 40-2404 (9) (f)&(g).

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any attempts to not settle a claim fair and promptly would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

CLAIM STANDARDS - HEALTH

Standard 1

Claim files are handled in accordance with policy provisions, HIPAA and state law.

Claims were not of one of the triggers for this exam. Due to a number of other issues that showed up in the complaints analysis, the exam team felt that a sample review of GTL’s claim handling practices would be in order. Any Claim handling issues were noted in the General Exam Claim Standards.

Standard 2

The company complies with the requirements of the federal “Newborns and Mothers” Health Protection Act of 1996.

There were no maternity claims within the file samples.

Standard 3

The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA).

There were no mental health claims within the file samples.

Standard 4

The company complies with applicable statutes, rules and regulations for group coverage replacements.

There were no replacements within the file samples.

Claim Recommendations

1. Both the Company and their TPA, First Agency, need to review their procedures to insure if a claim cannot be processed within 30 days as clean claim because of lack of documentation, they must send notification and include what additional information is necessary in order to consider the claim for payment per K.S.A. 40-2442 (a).

Company Response: First Agency has been advised to revise its procedure when it receives notice of claim without the medical bills. Going forward, it will include (within the receipt of claim notification) a sentence requesting the medical bills to be sent so that the claim may be considered for payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.

2. The Company and their TPA, First Agency, need to revise their procedures to notify the claimants when the full amount of the claim was paid per K.A.R. 40-1-34, Section 8(a).

Company Response: The Company's home office claim management staff is in the process of working with First Agency to revise its current procedures so that in all situations a claimant will be notified on the status of claim payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.

3. The EOB's use a number code with a few words to explain the reason for the denial. The specific policy provision, condition or exclusion usually is not referenced by policy page number, section or paragraph. Many of the denials on the EOB's sent to the claimant were vague. This is a violation of K.A.R. 40-1-34, Section 8(a).

Company Response: The Company provided an electronic communication sent from GTL's Claim Department manager to Claim Department supervisors addressing the use of EOB remark codes and to use more specific description for a claim denial.

The Company plans to convert to a new Claims Processing system in the very near future. At that time, EOB remark codes will be re-evaluated to ensure compliance with states' laws so that the insured and/or provider have appropriate and sufficient information forming the basis for any denial. However, in the meantime, supervisors have been instructed that certain EOB remark codes can no longer be used.

- Within 30 days, the Company should provide a status update of their new claim system and enhanced EOB denial explanation program.

SUMMARIZATION

This examination was conducted to review the operations/management policies, marketing and sales practices, complaint files, and claim files, of this Company. The tests and standards were applied to create uniformity in the reporting of passes and failures. The examiners believe the recommendations are critical for the Company to implement as tools to treat all Kansas certificate and policyholders with uniformity and fairness. Our recommendations are listed below:

Marketing and Sales Recommendations

A. General

There were twenty-seven (27) total complaints closed at KID against the Company in 2008. Of those complaints, fourteen (14) had reasons related to marketing and sales. Following is a breakdown of the specific reasons for the marketing and sales complaints:

<u>No.</u>	<u>Reason</u>
9	High Pressure Sales Tactics
2	Agent Handling
2	Misleading Advertising
1	Misrepresentation

- GTL needs to take a more proactive approach to training and monitoring their agents. Within 60 days the Company should provide KID with an oversight plan for more stringent controls over the entities (TPA's, GA's and marketing groups) that market and sell their products.

B. Critical Provider Program

GTL's Critical Provider Product Brochure does not clearly define the type of policy being advertised; this is in violation of the life advertising regulation, K.A.R. 40-9-118 Section 5, (5). The cover page of the brochure has to clearly and prominently describe the type of policy advertised.

The Company markets a 10 and 20 year term life policy under the banner of their "Critical Provider Program". Included in this program is a Critical and Terminal Illness Benefit Rider. Their Critical Provider Product Brochure is in violation of the Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b). The brochure did not have the phrase, "accelerated benefit" or words of similar import in its title. The Kansas Accelerated Benefit regulation, K.A.R. 40-2-20(b) requires an accelerated benefit form approved in Kansas to include the phrase, "accelerated benefit" or words of similar import in its title.

Examiner Note: The Company has since revised the brochure for this product.

The cover letter sent to a new customer with the policy appears misleading and is a violation of K.S.A. 40-2404 (1)(a)&(e). The first point made in the letter talks about lump sum cash benefits being paid out for critical or terminal illness or being confined to a nursing home and using the money for paying health insurance deductibles or medical expenses etc. This gives the impression that it is a health policy. It isn't until the third paragraph that the letter indicates that they are actually buying a life insurance policy. The letter does not indicate to the consumer that they are actually buying a term life insurance policy with a rider that provides some accelerated benefits.

Examiner Note: The Company has already revised this cover letter.

The application for the Critical Provider Product is in violation of K.A.R. 40-2-20(b) as well as K.S.A. 40-2404 (1) (a)&(e). It does not clearly indicate it is a term life policy with "accelerated benefit". It includes the term "Full Critical Illness Coverage," which appears to be misleading and suggestive of health coverage.

- Within 30 days the Company shall provide KID a revised application for this product.

The Company was accepting applications for their critical provider program that were not filed with KID. This is a violation of K.S.A. 40-442 and K.S.A. 40-443.

- The Company should implement procedures to better monitor applications being submitted for coverage to ensure the applications being used are adequate.

C. Cancer Policy Outline of Coverage

- GTL needs to revise their outline of coverage cancer form to come into compliance with K.A.R. 40-4-23(b)(3)(A)(E)&(F). The following areas need addressed:
 1. The outline of coverage needs to include a designation for the date, name and signature of the insurance agent or the name of the employee of the insurer, if no agent is involved, who assumes responsibility for the outline.
 2. The outline of coverage form needs to disclose policy provisions relating to the cancellation of coverage.
 3. The outline of coverage form needs to disclose policy premiums

Examiner Note: The Company has already re-filed this form.

D. Individual Products - Advertising forms for Student Blanket Coverage

- There are several advertising forms for student blanket coverage that need updated to be in compliance with provisions within K.A.R. 40-9-100. Within 30 days, the Company needs to provide evidence that the following documents have been revised:
 1. Six student blanket coverage advertising forms need to be revised and have a form number to identify the brochure per K.A.R. 40-9-100 Guideline 2-B.
 2. Two brochures are in violation of K.A.R. 40-9-100 Guideline Section 11 and need to be revised removing any disparaging comparisons and statements of non-comparable policies.

3. One brochure needs to be revised to indicate the source of the statistics quoted in the material per K.A R. 40-9-100 Guideline 9-B

E. Association Business

1. In five different situations a particular Association's marketer incorrectly used enrollment forms which reflected a carrier other than GTL. Kansas does not require filings for out-of-state based association business and the individual certificates issued to Kansas members for those associations are not subject to Kansas statutes and regulations. The agreement to provide 24-hour accident insurance to members of the Association is between Guarantee Trust Life and the Association itself. It is the master application between these parties and not the Association enrollment form which forms the basis of the insurance contract.

- The Company needs to implement more stringent monitoring procedures on marketers for this product or require more documentation when policies are written.

2. In reviewing the association membership form there was only one dollar amount shown. The application for the blanket sickness and accident insurance must be separate from the association membership application. The insurance premium must be clearly visible to the insured, not co-mingled with the association dues per K.S.A. 40-2215(a).

- Within 30 days, the Company should provide confirmation that the membership form as been revised to separate insurance premium form the association dues.

Claims Recommendations

1. Both the Company and their TPA, First Agency, need to review their procedures to insure if a claim cannot be processed within 30 days as clean claim because of lack of documentation, they must send notification and include what additional information is necessary in order to consider the claim for payment per K.S.A. 40-2442 (a).

Company Response: First Agency has been advised to revise its procedure when it receives notice of claim without the medical bills. Going forward, it will include (within the receipt of claim notification) a sentence requesting the medical bills to be sent so that the claim may be considered for payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.

2. The Company and their TPA, First Agency, need to revise their procedures to notify the claimants when the full amount of the claim was paid per K.A.R. 40-1-34, Section 8(a).

Company Response: The Company's home office claim management staff is in the process of working with First Agency to revise its current procedures so that in all situations a claimant will be notified on the status of claim payment.

- Within 30 days, the Company should provide confirmation that their TPA is in fact following this new procedure.

3. The EOB's use a number code with a few words to explain the reason for the denial. The specific policy provision, condition or exclusion usually is not referenced by policy page number, section or paragraph. Many of the denials on the EOB's sent to the claimant were vague. This is a violation of K.A.R. 40-1-34, Section 8(a).

Company Response: The Company provided an electronic communication sent from GTL's Claim Department manager to Claim Department supervisors addressing the use of EOB remark codes and to use more specific description for a claim denial.

The Company plans to convert to a new Claims Processing system in the very near future. At that time, EOB remark codes will be re-evaluated to ensure compliance with states' laws so that the insured and/or provider have appropriate and sufficient information forming the basis for any denial. However, in the meantime, supervisors have been instructed that certain EOB remark codes can no longer be used.

- Within 30 days, the Company should provide a status update of their new claim system and enhanced EOB denial explanation program.

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by Allan Heindl, Vice President Product Approval and Compliance, and Theresa Tyc, Director Product Approval and Compliance, and the staff at GTL.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Lyle Behrens
Market Conduct Supervisor

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Market Conduct Examiner

Respectfully submitted,

Lyle Behrens
Examiner-In-Charge

APPENDIX I

A. Statutes

K.S.A. 40-222. Examination of condition of company, when; report, disclosure; suspension or revocation of certificate; notice and hearing. (a) Whenever the commissioner of insurance deems it necessary but at least once every five years, the commissioner may make, or direct to be made, a financial examination of any insurance company in the process of organization, or applying for admission or doing business in this state. In addition, at the commissioner's discretion the commissioner may make, or direct to be made, a market regulation examination of any insurance company doing business in this state.

(b) In scheduling and determining the nature, scope and frequency of examinations of financial condition, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the examiner's handbook adopted by the national association of insurance commissioners and in effect when the commissioner exercises discretion under this subsection.

(c) For the purpose of such examination, the commissioner of insurance or the persons appointed by the commissioner, for the purpose of making such examination shall have free access to the books and papers of any such company that relate to its business and to the books and papers kept by any of its agents and may examine under oath, which the commissioner or the persons appointed by the commissioner are empowered to administer, the directors, officers, agents or employees of any such company in relation to its affairs, transactions and condition.

(d) The commissioner may also examine or investigate any person, or the business of any person, in so far as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company, but such examination or investigation shall not infringe upon or extend to any communications or information accorded privileged or confidential status under any other laws of this state.

(e) In lieu of examining the financial condition of a foreign or alien insurance company, the commissioner of insurance may accept the report of the examination made by or upon the authority of the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports as they relate to financial condition may only be accepted if:

(1) The insurance department conducting the examination was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program; or

(2) the examination is performed under the supervision of an accredited insurance department, or with the participation of one or more examiners who are employed by such an accredited insurance department and who after a review of the examination work papers and report state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(f) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting an examination of financial condition, the examiner shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the national association of insurance commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

(g) The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted in accordance with the provisions of the Kansas administrative procedures act.

(h) When making an examination under this act, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the company which is the subject of the examination.

- (i) Nothing contained in this act shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state.
- (j) Nothing contained in this act shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report in the furtherance of any legal or regulatory action which the commissioner may, in the commissioner's sole discretion, deem appropriate.
- (k) (1) No later than 30 days following completion of the examination or at such earlier time as the commissioner shall prescribe, the examiner in charge shall file with the department a verified written report of examination under oath. No later than 30 days following receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford such company examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.
- (2) Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiners workpapers and enter an order:
- (A) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violations; or
- (B) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refile pursuant to subsection (k); or
- (C) call and conduct a fact-finding hearing in accordance with K.S.A. 40-281 and amendments thereto for purposes of obtaining additional documentation, data, information and testimony.
- (3) All orders entered as a result of revelations contained in the examination report shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers and any written submissions or rebuttals. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.
- (4) Upon the adoption of the examination report, the commissioner shall hold the content of the examination report as private and confidential information for a period of 30 days except to the extent provided in paragraph (5). Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.
- (5) (A) Except as provided in paragraph (B), nothing contained in this act shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, at any time to:
- (i) The insurance department of this or any other state or country;
- (ii) law enforcement officials of this or any other state or agency of the federal government or any other country; or
- (iii) officials of any agency of another country.
- (B) The commissioner shall not share any information listed in paragraph (A) unless the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this act.
- (6) In the event the commissioner determines that regulatory action is appropriate as a result of any examination, the commissioner may initiate any proceedings or actions as provided by law.

(7) All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this act must be given confidential treatment and are not subject to subpoena and may not be made public by the commissioner or any other person, except to the extent otherwise specifically provided in K.S.A. 45-215 et seq. and amendments thereto. Access may also be granted to the national association of insurance commissioners. Such parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

Whenever it appears to the commissioner of insurance from such examination or other satisfactory evidence that the solvency of any such insurance company is impaired, or that it is doing business in violation of any of the laws of this state, or that its affairs are in an unsound condition so as to endanger its policyholders, the commissioner of insurance shall give the company a notice and an opportunity for a hearing in accordance with the provisions of the Kansas administrative procedure act. If the hearing confirms the report of the examination, the commissioner shall suspend the certificate of authority of such company until its solvency shall have been fully restored and the laws of the state fully complied with. The commissioner may, if there is an unreasonable delay in restoring the solvency of such company and in complying with the law, revoke the certificate of authority of such company to do business in this state. Upon revoking any such certificate the commissioner shall commence an action to dissolve such company or to enjoin the same from doing or transacting business in this state.

K.S.A. 40-442. Issuance of life insurance policy; filing of form prior to issuance. No individual policy of life insurance shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof has been filed with the commissioner of insurance.

K.S.A. 40-443. Same; approval of commissioner. No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until such policy, application, rider or endorsement has been approved by the commissioner or until thirty (30) days after the filing of any such form, whichever first occurs.

K.S.A. 40-2201. Accident and sickness policy; definition. (a) The term "policy of accident and sickness insurance" as used herein includes any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident, or both, issued by a stock, or mutual company or association or any other insurer.

(b) The term "policy of stop loss or excess loss insurance coverage" means a policy, contract, endorsement, attachments, amendments or other modifications that insure against losses of the policyholder issued by a stock, or mutual company or association or any other insurer.

K.S.A. 40-2215. Forms and premium rates, filing, duties of commissioner; procedure; rules and regulation, violations, penalties. (a) No individual policy of accident and sickness insurance as defined in [K.S.A. 40-2201](#) and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket policy or certificate of accident and sickness insurance providing hospital, medical or surgical expense benefits shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto has been filed with the commissioner of insurance.

(c) (1) No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

(2) (A) The commissioner shall create a requirements document containing filing requirements for each type of insurance. Such requirements document shall contain a list of all product filing requirements for each type of

insurance that is required to be filed. For each type of insurance, such requirements document shall contain an appropriate citation to each requirement contained in any statute, rule and regulation and published bulletins in this state having the force and effect of law. Such requirements document shall be available on the insurance department internet website.

(B) The commissioner shall update the requirements document referred to in subparagraph (A) no less frequently than annually. The commissioner shall update the requirements document referred to in subparagraph (A) within 30 days after the effective date of any change in law, rule and regulation or bulletin published by the commissioner having the force and effect of law in this state.

(3) A filer shall submit with each policy form filing a document indicating the location within the policy form or any supplemental document for information establishing compliance with each requirement contained in the requirements documents referenced in subparagraph (A) of paragraph (2) of this subsection. A filer shall certify that the policy form, including any accompanying supplemental document, meets all requirements of state law.

(d) (1) Any risk classifications, premium rates, rating formulae, and all modifications thereof applicable to Kansas residents shall not establish an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket sickness and accident policies providing hospital, medical or surgical expense benefits issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminate against any individuals eligible for participation in a group, or establish rating classifications within a group that are based on medical conditions. In no event shall the rates charged to any group to which this subsection applies increase by more than 75% during any annual period unless the insurer can clearly document a material and significant change in the risk characteristics of the group

(2) All rates for sickness and accident insurance providing hospital, medical or surgical expense benefits covering Kansas residents shall be made in accordance with the following provisions and due consideration shall be given to:

(A) Past and prospective loss experience;

(B) past and prospective expenses;

(C) adequate contingency reserves; and

(D) all other relevant factors within and without the state.

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act

(e) All parties in the filing process shall act in good faith and with due diligence in performance of their duties pursuant to this section

(f) (1) Within 30 days of receipt of the initial filing, the commissioner shall review and approve such filing or provide notice of any deficiency or disapprove the initial filing. Any notice of deficiency or disapproval shall be in writing and based only on the specific provisions of applicable statutes, regulations or bulletins published by the commissioner having the force and effect of law in this state and contained in the requirements document created by the commissioner pursuant to subparagraph (A) of paragraph (2) of subsection (c). The notice of deficiency or disapproval shall provide specific reasons for notice of deficiencies or disapproval. Such reasons shall contain sufficient detail for the filer to bring the policy form into compliance, and shall cite each specific statute, rule and regulation or bulletin having the force and effect of law in this state upon which the notice of deficiency or disapproval is based. Any notice of disapproval provided by the commissioner shall state that a hearing will be granted within 20 days after receipt of a written request therefor by the insurer. At the end of the 30 day period, the policy form shall be deemed approved if the commissioner has taken no action.

(2) In addition to the statutes, regulations or bulletins described in paragraph (2) of subsection (c), the commissioner may disapprove a filing or provide a notice of deficiency for any form for which the

commissioner determines that the benefits provided therein are unreasonable in relation to the premium charged; or if such form contains any provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. Any notice of disapproval provided by the commissioner pursuant to this paragraph shall state that a hearing will be granted within 20 days after receipt of a written request therefor by the insurer.

(3) If the insurer has received a disapproval or notice of deficiency or disapproval regarding a policy form, it shall be unlawful for an insurer to issue such policy form or use such policy form in connection with any policy until that policy form has received a later approval by the commissioner.

(4) Within 30 days of receipt of the commissioner's notice of deficiency or disapproval, a filer may resubmit a policy form that corrects any deficiencies or resubmit a disapproved policy form and a revised certification. Any policy form not resubmitted to the commissioner within 30 days of the notice of deficiency shall be deemed withdrawn. Any disapproved policy form not resubmitted to the commissioner within 30 days of the notice of disapproval shall be deemed disapproved.

(5) (A) Within 30 days of receipt of a resubmitted filing and certification, the commissioner shall review the resubmitted filing and certification, and shall approve or disapprove such resubmitted filing and certification. Any notice of disapproval pertaining to the resubmitted filing and certification shall be in writing and provide a detailed description of the reasons for the disapproval in sufficient detail for the filer to bring the policy form into compliance. The notice of disapproval shall cite each specific statute, rule and regulation or bulletin having the force and effect of law in this state upon which the disapproval is based. No further extension of time may be taken unless the filer has introduced new provisions in the resubmitted filing and certification or the filer has materially modified any substantive provisions of the policy form, in which case the commissioner may extend the time for review by an additional 30 days. At the end of this 30 day review period, the policy form shall be deemed approved if the commissioner has taken no action.

(B) (i) Subject to clause (ii) of this subparagraph, the commissioner may not disapprove a resubmitted policy form for reasons other than those initially set forth in the original notice of deficiencies or disapproval sent pursuant to paragraph (1) of this subsection..

(ii) The commissioner may disapprove a resubmitted policy form for reasons other than those initially set forth in the original notice of deficiencies or disapproval sent pursuant to this subsection if:

(a) The filer has introduced new provisions in the resubmitted policy form and certification;

(b) the filer has materially modified any substantive provisions of the policy form;

(c) there has been a change in any statute, rule and regulation or published bulletin in this state having the force and effect of law; or

(d) there has been reviewer error and the written disapproval fails to state a specific provision of applicable statute, regulation or bulletin published by the commissioner having the force and effect of law in this state that is necessary to have the policy form conform to the requirements of law.

(6) At the end of the review period, the policy form shall be deemed approved if the commissioner has taken no action.

(7) Notwithstanding any other provision in this section, the commissioner may return a grossly inadequate filing to the filer without triggering any of the time deadlines set forth in this section. For purposes of this paragraph, the term "grossly inadequate filing" means a filing that fails to provide key information, including state-specific information, regarding a product, policy or rate, or that demonstrates an insufficient understanding of what is required to comply with state statutes or regulations.

(g) Except in cases of a material error or omission in a policy form that has been approved or deemed approved pursuant to the provisions of this act, the commissioner shall not:

(1) Retroactively disapprove that filing; or

(2) with respect to those policy forms, examine the filer during a routine or targeted market conduct examination for compliance with any later-enacted policy form filing requirements.

(h) If a rate filing or marketing material is required to be filed or approved by state law for a specific policy form, the time frames for review, approval or disapproval, resubmission, and re-review of those rate filings or marketing materials shall be the same as those provided for in subsection (f) for the review of policy forms.

(i) For purposes of this section:

(1) "Accident and sickness carrier" means an entity licensed to offer accident and sickness insurance in this state, or subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or any insurer that provides policies of supplemental, disability income, medicare supplement or long-term care insurance.

(2) "Commissioner" means the commissioner of insurance.

(3) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness or disease.

(4) "Policy form" means any policy, contract, certificate, rider, endorsement, evidence of coverage of any amendments thereto that are required by law to be filed with the commissioner for approval prior to their sale or issuance for sale in this state.

(5) "Supplemental documents" means any documents required to be filed in support of policy forms that may or may not be subject to approval.

(6) "Type of insurance" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans, policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance.

(j) This section shall apply to any individual or group policy form issued by an accident and health carrier required to be filed with the commissioner for review or approval.

(k) Violations of subsection (d) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.

(l) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

K.S.A. 40-2404. Unfair methods of competition or unfair and deceptive acts or practices; title insurance agents, requirements; disclosure of nonpublic personal information; rules and regulations. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) *Misrepresentations and false advertising of insurance policies.* Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison which:

(a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

- (b) misrepresents the dividends or share of the surplus to be received on any insurance policy;
 - (c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;
 - (d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;
 - (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;
 - (f) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;
 - (g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or
 - (h) misrepresents any insurance policy as being shares of stock.
- (2) *False information and advertising generally.* Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, which is untrue, deceptive or misleading.
- (3) *Defamation.* Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.
- (4) *Boycott, coercion and intimidation.* Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance, or by any act of boycott, coercion or intimidation monopolizing or attempting to monopolize any part of the business of insurance.
- (5) *False statements and entries.* (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.
- (b) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.
- (6) *Stock operations and advisory board contracts.* Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Nothing herein shall prohibit the acts permitted by K.S.A. 40-232, and amendments thereto.
- (7) *Unfair discrimination.* (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.
- (b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or

- health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.
- (c) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses such person's eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.
 - (d) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available for accident and health and life insurance to an applicant who is the proposed insured or charge a different rate for the same coverage or excluding or limiting coverage for losses or denying a claim incurred by an insured as a result of abuse based on the fact that the applicant who is the proposed insured is, has been, or may be the subject of domestic abuse, except as provided in subpart (v). "Abuse" as used in this subsection (7)(d) means one or more acts defined in subsection (a) or (b) of K.S.A. 60-3102 and amendments thereto between family members, current or former household members, or current or former intimate partners.
 - (i) An insurer may not ask an applicant for life or accident and health insurance who is the proposed insured if the individual is, has been or may be the subject of domestic abuse or seeks, has sought or had reason to seek medical or psychological treatment or counseling specifically for abuse, protection from abuse or shelter from abuse.
 - (ii) Nothing in this section shall be construed to prohibit a person from declining to issue an insurance policy insuring the life of an individual who is, has been or has the potential to be the subject of abuse if the perpetrator of the abuse is the applicant or would be the owner of the insurance policy.
 - (iii) No insurer that issues a life or accident and health policy to an individual who is, has been or may be the subject of domestic abuse shall be subject to civil or criminal liability for the death or any injuries suffered by that individual as a result of domestic abuse.
 - (iv) No person shall refuse to insure, refuse to continue to insure, limit the amount, extent or kind of coverage available to an individual or charge a different rate for the same coverage solely because of physical or mental condition, except where the refusal, limitation or rate differential is based on sound actuarial principles
 - (v) Nothing in this section shall be construed to prohibit a person from underwriting or rating a risk on the basis of a preexisting physical or mental condition, even if such condition has been caused by abuse, provided that:
 - (A) The person routinely underwrites or rates such condition in the same manner with respect to an insured or an applicant who is not a victim of abuse
 - (B) the fact that an individual is, has been or may be the subject of abuse may not be considered a physical or mental condition; and
 - (C) such underwriting or rating is not used to evade the intent of this section or any other provision of the Kansas insurance code.
 - (vi) Any person who underwrites or rates a risk on the basis of preexisting physical or mental condition as set forth in subsection (7)(d)(v), shall treat such underwriting or rating as an adverse underwriting decision pursuant to K.S.A. 40-2,112, and amendments thereto.

- (vii) The provisions of subsection (d) shall apply to all policies of life and accident and health insurance issued in this state after the effective date of this act and all existing contracts which are renewed on or after the effective date of this act.
- (8) *Rebates.* (a) Except as otherwise expressly provided by law, knowingly permitting, offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon; paying, allowing, giving or offering to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling, purchasing or offering to give, sell or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.
- (b) Nothing in subsection (7) or (8)(a) shall be construed as including within the definition of discrimination or rebates any of the following practices:
- (i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance. Any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;
- (ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or
- (iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.
- (9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.
- (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- (b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- (c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- (d) refusing to pay claims without conducting a reasonable investigation based upon all available information;
- (e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;
- (f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
- (g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
- (h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

- (i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;
 - (j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;
 - (k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
 - (l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
 - (m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or
 - (n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.
- (10) *Failure to maintain complaint handling procedures.* Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.
- (11) *Misrepresentation in insurance applications.* Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual.
- (12) *Statutory violations.* Any violation of any of the provisions of K.S.A. 40-216, 40-276a, 40-2,155 or 40-1515 and amendments thereto.
- (13) *Disclosure of information relating to adverse underwriting decisions and refund of premiums.* Failing to comply with the provisions of K.S.A. 40-2,112, and amendments thereto, within the time prescribed in such section.
- (14) *Rebates and other inducements in title insurance.* (a) No title insurance company or title insurance agent, or any officer, employee, attorney, agent or solicitor thereof, may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction or abatement of any rate or charge made incident to the issuance of such insurance, any special favor or advantage not generally available to others of the same classification, or any money, thing of value or other consideration or material inducement. The words "charge made incident to the issuance of such insurance" includes, without limitations, escrow, settlement and closing charges.
- (b) No insured named in a title insurance policy or contract nor any other person directly or indirectly connected with the transaction involving the issuance of the policy or contract, including, but not limited to, mortgage lender, real estate broker, builder, attorney or any officer, employee, agent representative or solicitor thereof, or any other person may knowingly receive or accept, directly or indirectly, any rebate, reduction or abatement of any charge, or any special favor or advantage or any monetary consideration or inducement referred to in (14)(a).
- (c) Nothing in this section shall be construed as prohibiting:

- (i) The payment of reasonable fees for services actually rendered to a title insurance agent in connection with a title insurance transaction;
 - (ii) the payment of an earned commission to a duly appointed title insurance agent for services actually performed in the issuance of the policy of title insurance; or
 - (iii) the payment of reasonable entertainment and advertising expenses.
- (d) Nothing in this section prohibits the division of rates and charges between or among a title insurance company and its agent, or one or more title insurance companies and one or more title insurance agents, if such division of rates and charges does not constitute an unlawful rebate under the provisions of this section and is not in payment of a forwarding fee or a finder's fee.
- (e) As used in paragraphs (e) through (i)(7) of this subpart, unless the context otherwise requires:
- (i) "Associate" means any firm, association, organization, partnership, business trust, corporation or other legal entity organized for profit in which a producer of title business is a director, officer or partner thereof, or owner of a financial interest; the spouse or any relative within the second degree by blood or marriage of a producer of title business who is a natural person; any director, officer or employee of a producer of title business or associate; any legal entity that controls, is controlled by, or is under common control with a producer of title business or associate; and any natural person or legal entity with whom a producer of title business or associate has any agreement, arrangement or understanding or pursues any course of conduct, the purpose or effect of which is to evade the provisions of this section.
 - (ii) "Financial interest" means any direct or indirect interest, legal or beneficial, where the holder thereof is or will be entitled to 1% or more of the net profits or net worth of the entity in which such interest is held. Notwithstanding the foregoing, an interest of less than 1% or any other type of interest shall constitute a "financial interest" if the primary purpose of the acquisition or retention of that interest is the financial benefit to be obtained as a consequence of that interest from the referral of title business.
 - (iii) "Person" means any natural person, partnership, association, cooperative, corporation, trust or other legal entity.
 - (iv) "Producer of title business" or "producer" means any person, including any officer, director or owner of 5% or more of the equity or capital or both of any person, engaged in this state in the trade, business, occupation or profession of:
 - (A) Buying or selling interests in real property;
 - (B) making loans secured by interests in real property; or
 - (C) acting as broker, agent, representative or attorney for a person who buys or sells any interest in real property or who lends or borrows money with such interest as security.
 - (v) "Refer" means to direct or cause to be directed or to exercise any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral.
 - (f) No title insurer or title agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if it knows or has reason to believe that the applicant was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller and lender the financial interest of the producer of title business or associate referring the title insurance business.
 - (g) No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title

agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent, and (ii) 70% or more of the closed title orders of that title insurer or title agent during the 12 full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions contained in this subparagraph shall not apply to transactions involving real estate located in a county that has a population, as shown by the last preceding decennial census, of 10,000 or less.

(h) Within 90 days following the end of each business year, as established by the title insurer or title agent, each title insurer or title agent shall file with the department of insurance and any title insurer with which the title agent maintains an underwriting agreement, a report executed by the title insurer's or title agent's chief executive officer or designee, under penalty of perjury, stating the percent of closed title orders originating from controlled business. The failure of a title insurer or title agent to comply with the requirements of this section, at the discretion of the commissioner, shall be grounds for the suspension or revocation of a license or other disciplinary action, with the commissioner able to mitigate any such disciplinary action if the title insurer or title agent is found to be in substantial compliance with competitive behavior as defined by federal housing and urban development statement of policy 1996-2.

(i)(1) No title insurer or title agent may accept any title insurance order or issue a title insurance policy to any person if it knows or has reason to believe that such person was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed in writing to the person so referred the fact that such producer or associate has a financial interest in the title insurer or title agent, the nature of the financial interest and a written estimate of the charge or range of charges generally made by the title insurer or agent for the title services. Such disclosure shall include language stating that the consumer is not obligated to use the title insurer or agent in which the referring producer or associate has a financial interest and shall include the names and telephone numbers of not less than three other title insurers or agents which operate in the county in which the property is located. If fewer than three insurers or agents operate in that county, the disclosure shall include all title insurers or agents operating in that county. Such written disclosure shall be signed by the person so referred and must have occurred prior to any commitment having been made to such title insurer or agent.

(2) No producer of title business or associate of such producer shall require, directly or indirectly, as a condition to selling or furnishing any other person any loan or extension thereof, credit, sale, property, contract, lease or service, that such other person shall purchase title insurance of any kind through any title agent or title insurer if such producer has a financial interest in such title agent or title insurer.

(3) No title insurer or title agent may accept any title insurance order or issue a title insurance policy to any person it knows or has reason to believe that the name of the title company was pre-printed in the sales contract, prior to the buyer or seller selecting that title company.

(4) Nothing in this subpart (i) shall prohibit any producer of title business or associate of such producer from referring title business to any title insurer or title agent of such producer's or associate's choice, and, if such producer or associate of such producer has any financial interest in the title insurer, from receiving income, profits or dividends produced or realized from such financial interest, so long as:

(a) Such financial interest is disclosed to the purchaser of the title insurance in accordance with part (i)(1) through (4) of this subpart;

(b) the payment of income, profits or dividends is not in exchange for the referral of business; and

(c) the receipt of income, profits or dividends constitutes only a return on the investment of the producer or associate.

(5) Any producer of title business or associate of such producer who violates the provisions of paragraphs (i)(2) through (i)(4), or any title insurer or title agent who accepts an order for title insurance knowing that it is in violation of paragraphs (i)(2) through (i)(4), in addition to any other action which may be taken by the commissioner of insurance, shall be subject to a fine by the commissioner in an amount equal to five times the

premium for the title insurance and, if licensed pursuant to K.S.A. 58-3034 et seq., and amendments thereto, shall be deemed to have committed a prohibited act pursuant to K.S.A. 58-3602, and amendments thereto, and shall be liable to the purchaser of such title insurance in an amount equal to the premium for the title insurance.

(6) Any title insurer or title agent that is a competitor of any title insurer or title agent that, subsequent to the effective date of this act, has violated or is violating the provisions of subpart (i), shall have a cause of action against such title insurer or title agent and, upon establishing the existence of a violation of any such provision, shall be entitled, in addition to any other damages or remedies provided by law, to such equitable or injunctive relief as the court deems proper. In any such action under this subsection, the court may award to the successful party the court costs of the action together with reasonable attorney fees.

(7) The commissioner shall also require each title agent to provide core title services as required by the real estate settlement procedures act.

(j) The commissioner shall adopt any regulations necessary to carry out the provisions of this act.

(15) *Disclosure of nonpublic personal information.* (a) No person shall disclose any nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley act of 1999 (public law 106-102). The commissioner may adopt rules and regulations necessary to carry out this section. Such rules and regulations shall be consistent with and not more restrictive than the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation".

(b) Any rules and regulations adopted by the commissioner which implement article V of the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation" shall become effective on and after February 1, 2002.

(c) Nothing in this paragraph (15) shall be deemed or construed to authorize the promulgation or adoption of any regulation which preempts, supersedes or is inconsistent with any provision of Kansas law concerning requirements for notification of, or obtaining consent from, a parent, guardian or other legal custodian of a minor relating to any matter pertaining to the health and medical treatment for such minor.

K.S.A. 40-3110. Same; primary status of benefits, exception; when payable; time limitation on claims; overdue payments. (a) Except for benefits payable under any workmen's compensation law, which shall be credited against the personal injury protection benefits provided by subsection (f) of K.S.A. 40-3107, personal injury protection benefits due from an insurer or self-insurer under this act shall be primary and shall be due and payable as loss accrued, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued in compliance with this act. An insurer or self-insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the insurer's policy of motor vehicle liability insurance affords the coverage required by this act. No claim for personal injury protection benefits may be made after two (2) years from the date of injury.

(b) Personal injury protection benefits payable under this act shall be overdue if not paid within thirty (30) days after the insurer or self-insurer is furnished written notice of the fact of a covered loss and of the amount of same, except that disability benefits payable under this act shall be paid not less than ever two (2) weeks after such notice. If such written notice is not furnished as to the entire claim, any partial amounts supported by written notice is overdue if not paid within thirty (30) days after such written notice is furnished. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within thirty (30) days after such written notice is so furnished: *Provided*, That no such payment shall be deemed overdue where the insurer or self-insurer has reasonable proof to establish that it is not responsible for the payment, notwithstanding that written notice has been furnished. For the purpose of calculating the extent to which any personal injury protection benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of eighteen percent (18%) per annum.

B. Regulations

A. K.A.R. 40-1-31. Unfair Claims Settlement Practices Model Regulation

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Section 1. Authority

Section 1 is not adopted.

Section 2. Scope

This regulation applies to all persons and to all insurance policies and insurance contracts except policies of Workers' Compensation insurance. This regulation is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of K.S.A. 40-2404, and amendments thereto.

Section 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in K.S.A. 40-2404, and amendments thereto shall apply to this regulation and, in addition, where used in this regulation:

- (a) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;
- (b) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;
- (c) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;
- (d) "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this State;
- (e) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;
- (f) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;
- (g) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer; and
- (h) "Workers' Compensation" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

Section 4. File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of

such events can be reconstructed.

Section 5. Misrepresentation of Policy Provisions

- (a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.
- (b) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.
- (c) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.
- (d) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.
- (e) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.
- (f) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

Section 6. Failure to Acknowledge Pertinent Communications

- (a) Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
- (b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.
- (c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
- (d) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

Section 7. Standards for Prompt Investigation of Claim

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

- (a) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
- (b) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of this subsection. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
- (c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-

five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(d) Section 8(d) is not adopted.

(e) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

(f) If a claim is denied for reasons other than those described in section 8(a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(g) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(h) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or a contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(i) No insurer shall make statements which indicate the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

(a) When the insurance policy provides, for the adjustment and settlement of automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:

(1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the claimant, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect to pay a cash settlement, based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined by any source or method for determining statistically valid fair market value that meets both of the following criteria:

(A) The source or method's database, including nationally recognized automobile evaluation publications, shall provide values for at least eighty-five percent (85%) of all makes and models of private passenger vehicles for the last fifteen (15) model years taking into account the values for all major options for such vehicles; and

(B) The source, method, or publication shall provide fair market values for a comparable automobile based on current data available for the local market area as defined in subsection (j)(2).

(3) When an automobile total loss is settled on a basis which deviates from the methods and criteria described in subsection (a)(1) and (a)(2)(A) and (B) of this section, the deviation must be supported by documentation giving the particulars of the automobile condition and the basis for the deviation. Any deviations from such cost, including deductions for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the claimant.

(b) Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

(c) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(e) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.

- (f) When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.
- (g) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.
- (h) Insurers shall include consideration of applicable taxes, license fees, and other fees incident to transfer of evidence of ownership in third party automobile total losses and shall have sufficient documentation relative to how the settlement was obtained in the claim file. A measure of damages shall be applied which will compensate third party claimants for the reasonable loss sustained as the proximate result of the insured's negligence.
- (i) A claimant has the right of recourse if the claimant notifies the insurer, within thirty (30) days after the receipt of the claim draft, that claimant is unable to purchase a comparable automobile for the amount of the claim draft. Upon receipt of this notice, the insurer shall reopen its claim file within five (5) business days, and one of the following actions shall apply.
- (1) the Insurer shall either pay the claimant the difference between the market value as determined by the insurer and the cost of the comparable vehicle of like kind and quality which the claimant has located, or negotiate and effect the purchase price of this vehicle for the claimant; or
 - (2) the insurer may elect to offer a replacement in accordance with provisions of subsection 9(a)(1).
- (j) As used in this regulation the following terms shall have the following meanings:
- (1) comparable automobile means a vehicle of the same make, model, year, style and condition, including all major options of the claimant vehicle;
 - (2) local market area means the fifty (50) mile area surrounding the place where the claimant vehicle was principally garaged.

K.A.R. 40-2-20. Life insurance; accelerated benefits; requirements and restrictions. (a) As used in this regulation, these terms shall have the following meanings:

- (1) "Accelerated benefits" shall mean benefits that meet the following conditions:
 - (A) Are payable under an individual or group life insurance or annuity contract to a policyowner or certificate holder, during the lifetime of the insured for the occurrence of a qualifying condition;
 - (B) reduce the death benefit otherwise payable under the life insurance contract; and
 - (C) are payable upon the occurrence of a single qualifying condition, which results in the payment of a benefit amount fixed at the time of acceleration.
- (2) "Qualifying condition" shall mean any of the following conditions:
 - (A) A medical condition that a health care provider licensed to practice medicine and surgery or osteopathy predicts will result in a limited life expectancy of 24 months or less;
 - (B) a medical condition that has required or requires extraordinary medical intervention, including a major organ transplant or continuous artificial life support, without which the insured would die;
 - (C) any condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of the insured's life;
 - (D) a medical condition that medical evidence indicates would, in the absence of extraordinary medical intervention, result in a limited life expectancy of 24 months or less. Such conditions may include any of the following:
 - (i) Coronary artery disease resulting in an acute infarction or requiring surgery;
 - (ii) a permanent neurological deficit resulting from a cerebral vascular accident;
 - (iii) end stage renal failure;
 - (iv) acquired immune deficiency syndrome;
 - (v) cancer;
 - (vi) paralysis;
 - (vii) blindness;
 - (viii) muscular sclerosis;
 - (ix) Alzheimer's disease;
 - (x) HIV;
 - (xi) anterior lateral sclerosis; or
 - (xii) severe burns; and
- (E) any other condition approved by the commissioner as the basis for a qualifying event.

- (3) "Commissioner" shall mean the commissioner of insurance, state of Kansas.
- (b) Each accelerated benefit shall have a title printed on or attached to the first page of the policy or rider. The title shall describe the coverage provided and shall be followed or accompanied by a description of the coverage containing the phrase "accelerated benefit" or words of similar import.
- (c) Each applicant shall be given a summary of the accelerated benefit provisions at or before the time an application is completed. For group policies, each certificate holder shall be given a copy of the summary with the certificate. This summary shall include the following:
- (1) A brief description of the accelerated benefit and definitions of the qualifying conditions that would result in payment of the benefit;
 - (2) the existence and amount of any separately identifiable premium for the accelerated benefit and a description of any charge for administrative expense;
 - (3) a generic illustration numerically demonstrating the effect of the payment of a benefit on cash values, accumulation accounts, death benefits, premiums, policy loans, and policy liens;
 - (4) a statement that receipt of the accelerated benefit could be taxable;
 - (5) a statement that receipt of accelerated benefits could affect medicaid eligibility; and
 - (6) an acknowledgement, signed and dated by the agent and the applicant for the group or individual coverage, that the summary has been furnished. Each direct response insurer shall incorporate the summary and acknowledgement in the application or attach them to the application.
- (d) Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.
- (e) No restrictions shall be permitted on the use of the proceeds.
- (f) If the accelerated benefit is offered without an additional premium, a separate written explanation of how the benefit is funded shall be filed with the commissioner and included with the summary.
- (g) Each time an accelerated benefit is requested and whenever a previous summary becomes invalid, the irrevocable beneficiary and either the individual policyowner or group certificate holder shall be given a summary. This summary shall include statements meeting the following conditions:
- (1) Warning that receipt of the accelerated benefit could be taxable and that assistance from a tax advisor is suggested;
 - (2) showing the effect that the payment of the benefit will have on cash values, accumulation accounts, death benefits, premiums, policy loans, and policy liens; and
 - (3) disclosing that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for medicaid or other government benefits or entitlements.
- (h) Each time an accelerated benefit option is exercised, the policyowner and certificate holder shall be given an endorsement, rider, or schedule page that reflects any revisions to cash values, death benefits, accumulation accounts, premiums, policy loans, policy liens, and any other values that change as a result of the payment or payments.
- (i) Insurers shall not unfairly discriminate among insureds with different or similar qualifying conditions covered under the policy. Insurers shall not apply any additional conditions to the payment of the accelerated benefits other than those conditions specified in the policy or rider.
- (j) Any insurer may offer a waiver of premium for the accelerated benefit provision if a regular waiver of premium provision is not in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.
- (k) Accelerated benefits shall be funded by any of the following methods:
- (1) Requiring the policyowner to pay an additional premium;
 - (2) utilizing the present value of the face amount of the policy if the following conditions are met:
 - (A) The present value calculation is based on an actuarial discount appropriate to the policy design;
 - (B) the interest rate used in the present value calculation is based on sound actuarial principles and disclosed in the contract or actuarial memorandum; and
 - (C) the maximum interest rate is no greater than the greater of either of the following:
 - (i) The current yield on 90-day treasury bills; or
 - (ii) the current maximum policy loan interest rate permitted by K.S.A. 40-420c and amendments thereto; or
 - (3) accruing an interest charge on the amount of the accelerated benefits at an interest rate based on sound actuarial principles and disclosed in the contract or actuarial memorandum and no greater than the greater of either of the following:
 - (i) The current yield on 90-day treasury bills; or
 - (ii) the current maximum policy loan interest rate permitted by K.S.A. 40-240c and amendments thereto.
- (l) When an accelerated benefit is payable, no greater than a pro rata reduction in the cash value shall be made, unless the payment of the accelerated benefits and any accrued interest can be treated as a lien against the death

benefit of the policy or rider. Therefore, access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans, and the lien and access to additional policy loans may be limited to the difference between the cash value and the sum of the lien and any other outstanding policy loans on the policy under which the accelerated benefits were paid.

(m) (1) If payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment shall not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans; or

(2) if the payment is considered a lien as provided in subsection (l), the insurance company may require any accelerated death benefit payment to be applied toward repaying the portion of any other outstanding policy loan that causes the sum of the accelerated death benefit and policy loan to exceed the cash value.

(n) The death benefit shall not be reduced more than the amount of the accelerated benefits after adjustment for any actuarial discount or accrued interest as provided in subsection (k) and any administrative expense charge required by policies providing accelerated benefits without an additional premium charge as disclosed on the summary required by subsection (c).

(o) If any death benefit remains after payment of an accelerated benefit, the accidental death benefit, if any, in a policy or rider shall not be affected by the payment of an accelerated benefit.

(p) The valuation method and assumptions used to produce the accelerated benefit provisions shall be filed with the insurance department with the related policy form or rider. The assumptions shall reflect the statutory mortality and interest rate assumptions for the life insurance provisions and appropriate assumptions for the other provisions incorporated in the policy or rider. Each insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits, which shall be made available for examination by the commissioner or a designee upon request.

(q) A qualified actuary shall describe the accelerated benefits, the risks, the expected costs, and the calculation of statutory reserves in an actuarial memorandum accompanying each filing of accelerated benefits products with the commissioner. Each insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner upon request.

(1) If benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, policy reserves shall be determined in accordance with the standard valuation law. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a member in good standing of the American academy of actuaries. Mortality tables and interest rates currently recognized for life insurance reserves by the national association of insurance commissioners may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary shall follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate shall be sufficient to cover the following:

(A) Policies upon which no claim has yet arisen; and

(B) policies upon which an accelerated claim has arisen.

(2) For policies and certificates that provide actuarially equivalent benefits, no additional reserves shall be required to be established.

(3) Policy liens and policy loans, including accrued interest, shall represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability, the excess shall be held as a non-admitted asset.

(r) The accelerated benefit provision shall become effective for accidents on the effective date of the policy or rider and shall become effective for illness no more than 30 days following the effective date of the policy or rider.

K.A.R. 40-4-23. Accident and sickness insurance; deceptive practices; requirements; prohibitions.

(a) Paragraphs (3), (4) and (5) of subsection (b) shall not apply to credit accident and sickness insurance, group accident and sickness insurance, nor to medicare supplement policies as defined in K.A.R. 40-4-35.

(b) Each authorized issuer of accident and sickness insurance contracts and each authorized insurance agent who solicits, negotiates or procures such insurance within this state shall meet the following requirements:

(1) Each agent shall, at the beginning of any solicitation, inform the prospective purchaser that he or she is acting as an insurance agent.

(2) The prospective purchaser shall be informed of the insurer's full name.

(3) The agent or insurer shall provide to the prospective purchaser before or with the delivery of a contract, a dated outline of coverage describing the elements of the contract including:

(A) The name and signature of the insurance agent, or if no agent is involved, the name of the employee of the insurer who assumes responsibility for completing the outline;

(B) the full name of the company writing the accident and sickness insurance;

(C) a statement identifying the applicable category or categories of coverage provided by the policy or contract and any supplemental riders as prescribed in K.S.A. 40-2218(a);

(D) a statement disclosing any provision in the policy or any supplemental riders which will reduce the benefits payable while the policy and riders are maintained in force on a premium-paying basis;

(E) the premiums for the accident and sickness insurance policy and a separate listing of the premiums for each optional or supplemental benefit provided by the contract;

(F) a statement disclosing the provisions of the policy and any supplemental riders relating to renewability, cancelability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons. The description shall be written in a manner which will not minimize or render obscure the qualifying conditions;

(G) a statement disclosing those exceptions, reductions and limitations affecting the basic provisions of the policy and any supplemental riders;

(H) a statement disclosing the existence of any waiting, elimination, probationary or similar time period between the effective date of the policy and effective date of coverage under the policy and any supplemental riders, or a period of time between the date that loss occurs and the date the benefits begin to accrue for the loss;

(I) a statement disclosing the extent to which any loss is not covered under the policy and any supplemental riders, if the cause of the loss is traceable to a condition existing before the effective date of the policy or rider;

(J) a statement disclosing all the principal benefits provided by the policy or contract and any supplemental riders;

(K) a statement that the outline of coverage is a summary of the policy or contract and any supplemental riders issued or applied for and that the policy or contract and any supplemental riders should be consulted to determine governing contractual provisions; and

(L) if the policy or contract and any supplemental riders do not provide the standards for benefits promulgated by the commissioner, as provided in K.A.R. 40-4-24 through 40-4-33, a statement which clearly sets forth the policy restrictions.

(4) The outline of coverage shall accompany the policy. Alternatively, the outline may be delivered to the prospective purchaser at the time application is made, if an acknowledgment of receipt or certificate of delivery of the outline is obtained with the application. If an outline of coverage was delivered at the time of application, and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract and any supplemental riders shall accompany the policy or contract and any supplemental riders when it is delivered. The substitute outline shall state clearly that the policy or contract and any supplemental riders are not the same as that for which application was made.

(5) The outline of coverage may consist of a separate written presentation or the outline may be included in the solicitation material advertising the policy. All information required to be disclosed shall be set out prominently in an uninterrupted sequence in one location in the separate, written presentation or advertising material. Additional material, other than that required, shall not be inserted between each required disclosure item. The style, arrangement and overall appearance of the outline of coverage shall not give any undue prominence to any portion of the text. Each printed portion of the text of the outline of coverage shall be plainly printed in lightfaced type of a style in

general use. The size of the type shall be uniform and shall not be less than tenpoint with a lowercase, unspaced alphabet length not less than 120 point.

(c) Unfair or deceptive acts or practices in the selling of the insurance subject to this regulation shall include:

(1) Making any misrepresentation or false, deceptive or misleading statement;

(2) using comparisons or analogies or manipulating amounts and numbers in a way that will mislead the prospective purchaser concerning the cost of the insurance protection to be provided by the insurance contract, or any other significant aspect of the contract;

(3) referring to an insurance premium as a deposit, an investment, a savings, or using other similar phrases when referring to an insurance premium; and

(4) Recommending to a prospective purchaser the purchase or replacement of any accident and sickness insurance policy or contract with reasonable grounds to believe that the recommendation is unsuitable for the applicant on the basis of any information furnished by the person or otherwise obtained.

K.A.R. 40-4-37. Long-term care insurance; application; definitions.

(a) These regulations shall apply to individual or group long-term care insurance policies, subscriber contracts, endorsements and riders delivered or issued for delivery in this state by the following:

(1) Insurance companies;

(2) fraternal benefit societies;

(3) nonprofit hospital and medical service corporations; and

(4) health maintenance organizations.

(b) A policy, rider or endorsement shall not be advertised, described, solicited or issued for delivery in this state as long-term care insurance unless it conforms to the requirements of these regulations.

(c) As used in these regulations, these terms shall have the following meanings:

(1) "Long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "certificate" and "policy" shall have the meanings set forth in K.S.A. 1991 Supp. 40-2227.

(2) "Medicare" means programs established by the "Health Insurance for the Aged Act," Title XVIII of the social security amendments of 1965, as then constituted or later amended.

(3) "Nursing facility" means a home, residence or institution, other than a hospital, which is primarily engaged in providing nursing care and related services on an inpatient basis under a license issued by the appropriate licensing agency. It may be a freestanding facility including the following:

(A) nursing facility;

(B) skilled nursing home;

(C) intermediate nursing care home;

(D) assisted living facility; or

(E) residential health care facility.

Any definition of a nursing facility shall adhere to the above definition unless otherwise approved by the commissioner of insurance.

(4) No insurance carrier shall define "mental or nervous disorder" more restrictively than the following:

(A) neurosis;

(B) psychoneurosis;

(C) psychopathy;

(D) psychosis; or

(E) any mental or emotional disease or disorder. However, no policy, contract or rider shall exclude or limit benefits on the basis of organic brain disease, including alzheimer's disease or senile dementia.

(5) The insurer may define "nurse" so that the description is restricted to a certain type of nurse, whether a registered graduate professional nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the insurer shall recognize the services of any individual who qualified under this terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(6) The insurer may include the words "duly qualified physician" or "duly licensed physician" in its definition of "physician." An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" includes the following: an illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a waiting period which will not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude illnesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(8) "Guaranteed renewable" means the following:

(A) The insured may continue the long-term care insurance in force by the timely payment of premiums; and

(B) the insurer shall not unilaterally make any change in any provision of the policy or rider while the insurance is in force and shall not decline to renew the policy. However, the insurer may revise the rates on a class basis.

(9) "Noncancellable" means the insured may continue the long-term care insurance in force by timely paying premiums during which period the insurer shall not unilaterally make any change in any provision of the insurance or in the premium rate.

(10) "Lapse" means termination of a policy due to the policyholder's failure to pay the premium within the time required.

(d) K.A.R. 40-4-37a, 40-4-37f and 40-4-37i shall not apply to group long-term care insurance policies issued to an employer-employee group.

K.A.R. 40-9-100. Accident and sickness insurance; advertising.

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Section 1. Purpose

Section 1 is not adopted.

Section 2. Applicability

A. This regulation shall apply to individual and group accident and sickness insurance (except Medicare supplement insurance or any other insurance that is covered by a separate state statute) “advertisement,” as that term is defined in Section 3B, G, H and I unless otherwise specified in this regulation, which the insurer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, producer or solicitor, as those terms are defined in the Insurance Code of this state.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised.

C. Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

Section 3. Definitions

A. (1) “Accident and sickness insurance policy” means a policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. An accident and sickness insurance policy does not include a Medicare supplement insurance policy, or any other type of accident and sickness insurance with advertising guidelines covered by a separate statute.

(2) The language “except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts” means it does not include disability, waiver of premium and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental to the above contracts that contain only provisions that:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(b) Operate to safeguard the contracts against lapse or to give a special surrender value, special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled as defined by the contract or supplemental contract.

B. (1) “Advertisement” means:

(a) Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other Internet displays or communications, other forms of electronic communications, billboards and similar displays;

(b) Descriptive literature and sales aids of all kinds issued by an insurer, agent, producer, broker or solicitor for presentation to members of the insurance-buying public, such as circulars, leaflets, booklets, depictions, illustrations, form letters and lead-generating devices of all kinds; and

(c) Prepared sales talks, presentations and material for use by agents, brokers, producers and solicitors whether prepared by the insurer or the agent, broker, producer or solicitor.

(2) The definition of “advertisement” includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

(3) The definition of advertisement extends to the use of all media for communications to the general public, to the use of all media for communications to specific members of the general public, and to the use of all media for communications by agents, brokers, producers and solicitors.

(4) The definition of advertisement does not include:

(a) Material used solely for the training and education of an insurer’s employees, agents or brokers;

(b) Material used in-house by insurers;

(c) Communications within an insurer’s own organization not intended for dissemination to the public;

(d) Individual communications of a personal nature with current policyholders other than material urging the policyholders to increase or expand coverages;

(e) Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

(f) Court-approved material ordered by a court to be disseminated to policyholders; or

(g) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided that the announcement clearly indicates that it is preliminary to the issuance of a booklet and that the announcement does not describe the specific benefits under the contract or program nor describe advantages as to the purchase of the contract or program. This does not prohibit a general endorsement of the program by the sponsor.

C. “Certificate” means a statement of the coverage and provisions of a policy of group accident and sickness insurance, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

D. “Exception” means any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

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E. “Insurer” means an individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, hospital service corporation, medical service

corporation, prepaid health plan and any other legal entity that is defined as an insurer in the insurance code of this state, and is engaged in the advertisement of itself or an accident and sickness insurance policy.

F. “Institutional advertisement” means an advertisement having as its sole purpose the promotion of the reader’s, viewer’s or listener’s interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance.

G. “Invitation to contract” means an advertisement that is neither an invitation to inquire nor an institutional advertisement.

H. “Invitation to inquire” means:

(1) An advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable but may contain:

- (a) The dollar amount of benefits payable; and
- (b) The period of time during which benefits are payable.

(2) An invitation to inquire may not refer to cost.

(3) An invitation to inquire shall contain a provision in the following or substantially similar form:

“This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable].”

I. “Lead-generating device” means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this State for the purchase of accident and sickness insurance.

J. “Limitation” means a provision that restricts coverage under the policy other than an exception or a reduction.

K. “Limited benefit health coverage” shall have the same meaning as defined in [insert reference to state law equivalent to Section 7L of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act].

L. “Person” means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

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M: “Prominently” or “conspicuously” means that the information to be disclosed prominently or conspicuously will be presented in a manner that is noticeably set apart from other information or images in the advertisement.

N. “Reduction” means a provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable and the reduction has not been used.

Section 4. Method of Disclosure of Required Information

All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of the following methods of disclosure:

A. Disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits; or

B. Disclosure not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase “under appropriate captions” means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: “Exceptions,” “Exclusions,” “Conditions Not Covered,” and “Exceptions and Reductions.” The use of captions such as the following are prohibited because they do not provide adequate notice of the significance of the material: “Extent of Coverage,” “Only these Exclusions,” or “Minimum Limitations.”

Section 5. Form and Content of Advertisements

A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions.

B. Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation.

C. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed.

D. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

E. An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words “insurance policy” or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

F. An insurer, agent, broker, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement:

(1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or

(2) Otherwise violates the provisions of this regulation.

G. An insurer, agent, broker, producer, solicitor or other person shall not solicit residents of this State for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement.

Section 6. Advertisements of Benefits Payable, Losses Covered or Premiums Payable

A. Covered Benefits.

(1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited.

- (2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited.
- (3) An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.
- (4) An advertisement shall not contain or use words or phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited,” “up to,” “as high as,” “this policy will help fill some of the gaps that Medicare and your present insurance leave out,” “the policy will help to replace your income,” (when used to express loss of time benefits), or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy.
- (5) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as “you collect,” “you get paid,” “pays you,” or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured.
- (6) (a) An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited if:
- (i) The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without also in the same headline, lead-in or caption specifying the applicable daily limits and other internal limits;
- (ii) The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or
- (iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim.
- (b) This paragraph does not apply to individual major medical expense coverage, individual basic medical expense coverage, or disability income insurance.
- (7) Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited unless the actual amounts payable per day for the indemnity or benefits are stated.
- (8) Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum payable benefit payable under the policy will be paid, when less than maximum benefits are paid in an average claim.
- (9) When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited.
- (10) Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited.

- (11) Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as “low,” “low cost,” “budget” or use qualifying words of similar import. The use of words such as “only” and “just” in conjunction with statements of premium amounts when used to imply a bargain are prohibited.
- (12) Advertisements that state or imply that premiums will not be changed in the future are prohibited unless the advertised policies expressly provide that the premiums will not be changed in the future.
- (13) An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective.
- (14) An advertisement that exaggerates the effects of statutorily mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited.
- (15) An advertisement that implies that a common type of policy or a combination of common benefits is “new,” “unique,” “a bonus,” “a breakthrough,” or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new.
- (16) Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited.
- (17) An advertisement that contains statements such as “anyone can apply,” or “anyone can join,” other than with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited.
- (18) An advertisement that states or implies immediate coverage of a policy is prohibited unless administrative procedures exist so that the policy is issued within fifteen (15) working days after the insurer receives the completed application.
- (19) An advertisement that contains statements such as “here is all you do to apply,” or “simply” or “merely” to refer to the act of applying for a policy that is not a guaranteed issue policy is prohibited unless it refers to the fact that the application is subject to acceptance or approval by the insurer.
- (20) An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance agent will call and no commissions will be paid to agents that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response.
- (21) Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services.
- (22) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited.
- (23) An advertisement that uses words such as “extra,” “special” or “added” to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as “tax-free,” “extra cash,” “extra income,” “extra pay,” or substantially similar words or phrases because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.
- (24) An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term “juxtaposition” means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement.

(25) An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(26) An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.

(27) An advertisement of a specified disease policy providing expense benefits shall not use the term “actual” when the policy only pays up to a limited amount for expenses. Instead, the term “charges” or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses.

(28) An advertisement that describes any benefits that vary by age shall disclose that fact.

(29) An advertisement that uses a phrase such as “no age limit,” if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact.

(30) A television, radio, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or to call the company or a subsequent advertisement prior to contact shall include information disclosing that an agent may contact the applicant.

(31) Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

(32) An advertisement, including invitations to inquire or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are:

(a) The use of phrases such as “cancer kills somebody every two minutes” and “total number of accidents” without reference to the total population from which the statistics are drawn;

(b) The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered;

(c) The use of phrases such as “the finest kind of treatment,” implying that the treatment would be unavailable without insurance;

(d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures;

(e) The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills;

(f) The use of phrases such as “financial disaster,” “financial distress,” “financial shock,” or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement;

(g) The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and

(h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly.

B. Exceptions, Reductions and Limitations

- (1) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a “benefit builder” or stating “even preexisting conditions are covered after two years.” Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered.
- (2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.
- (3) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of the periods.
- (4) An advertisement shall not use the words “only,” “just,” “merely,” “minimum,” “necessary” or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: “This policy is subject to the following minimum exceptions and reductions.”
- (5) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited.
- (6) An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact.
- (7) An advertisement that refers to “hospitalization for injury or sickness” omitting the word “covered” when the policy excludes certain sicknesses or injuries, or that refers to “whenever you are hospitalized,” “when you go to the hospital” or “while you are confined in the hospital” omitting the phrase “for covered injury or sickness,” if the policy excludes certain injuries or sickness, is prohibited. Continued reference to “covered injury or sickness” is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sicknesses or injuries not covered is prominently set forth.
- (8) An advertisement that fails to disclose that the definition of “hospital” does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited.
- (9) The term “confining sickness” shall be explained in an advertisement containing the term. The explanation might be as follows: “Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors.” Captions such as “Lifetime Sickness Benefits” or “Five-Year Sickness Benefits” are incomplete if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as “Lifetime House Confining Sickness Benefits” or “Five-Year House Confining Sickness Benefits” would be permissible.
- (10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited.
- (11) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: “THIS IS A LIMITED POLICY,” “THIS POLICY PROVIDES LIMITED BENEFITS,” “THIS IS A CANCER ONLY POLICY,” or “THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY.”

C. Preexisting Conditions

- (1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing prior to the effective date of the

policy. The use of the term “preexisting condition” without an appropriate definition or description shall not be used.

- (2) When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant’s physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase “no medical examination required” and phrases of similar import, but does not prohibit explaining “automatic issue.” If an insurer requires a medical examination for a specified policy, the advertisement if it is an invitation to contract shall disclose that a medical examination is required.
- (3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant’s signature. For example, the application form shall contain a question or statement substantially as follows:

“Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past? YES”

Or substantially the following statement:

“I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past.”

Section 7. Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination

- A. An advertisement that is an invitation to contract shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions.
- B. Advertisements of cancellable accident and sickness insurance policies shall state that the contract is cancellable or renewable at the option of the company, as the case may be, in language substantially similar to the following: A policy that is renewable at the option of the insurance company shall be advertised in a manner similar to, “This policy is renewable at the option of the company,” or “The company has the right to refuse renewal of this policy,” or “Renewable at the option of the insurer,” or “This policy can be cancelled by the company at any time.”
- C. Advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates if the policy so provides.
- D. Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums, and (3) the establishment of aggregate limits.
 - (1) Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits fifty percent (50%) after age sixty (60) although it is renewable to age sixty-five (65). Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth.
 - (2) An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured’s attained age shall disclose the rate increases and the times or ages at which the premiums increase.

Section 8. Standards for Marketing

- A. An insurer, directly or through its agents or brokers, shall:

- (1) Establish marketing procedures to assure that any comparison of policies by its agents or brokers will be fair and accurate;
 - (2) Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group major medical expense coverage and disability income coverage; and
 - (3) Establish auditable procedures for verifying compliance with this subsection.
- B. In addition to the practices prohibited in [insert reference to state law equivalent to the NAIC Unfair Trade Practices Act], the following acts and practices are prohibited:
- (1) **Twisting.** Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer;
 - (2) **High Pressure Tactics.** Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and
 - (3) **Cold Lead Advertising.** Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

Section 9. Testimonials or Endorsements by Third Parties

- A. Testimonials and endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all the provisions of this regulation. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained.
- B. A person shall be deemed a “spokesperson” if the person making the testimonial or endorsement:
- (1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;
 - (2) Has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;
 - (3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or
 - (4) Is in any way directly or indirectly compensated for making a testimonial or endorsement.
- C. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially as follows: “Paid Endorsement.” The requirement of this disclosure may be fulfilled by use of the phrase “Paid Endorsement” or words of similar import in a type style and size at least equal to that used for the spokesperson’s name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence.
- D. The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists

of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances.

- E. An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.
- F. When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

Section 10. Use of Statistics

- A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised unless that is the fact, and when applicable to other policies or plans shall specifically so state.
 - (1) An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised.
 - (2) An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.
- B. An advertisement shall not represent or imply that claim settlements by the insurer are “liberal” or “generous,” or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.
- C. The source of any statistics used in an advertisement shall be identified in the advertisement.

Section 11. Identification of Plan or Number of Policies

- A. An advertisement that uses the word “plan” without prominently identifying it as an accident and sickness insurance policy is prohibited.
- B. When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.
- C. When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only through a combination of policies.

Section 12. Disparaging Comparisons and Statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

- A. An advertisement shall not contain statements such as “no red tape” or “here is all you do to receive benefits.”
- B. Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages.
- C. Advertisements that state or imply that an insurer’s premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited.

Section 13. Jurisdictional Licensing and Status of Insurer

- A. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.
- B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any division or agency of this state or the federal government. Terms such as “official” or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public.
- C. An advertisement which is seen or heard in this state shall not directly or indirectly create the impression that the policy being advertised is approved for issuance in the state, unless that is the fact. If the policy is not approved for issuance in this state, that fact shall be disclosed in the advertisement by a statement reading, “This policy is not available in Kansas.”

Section 14. Identity of Insurer

- A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an 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 that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.
- B. An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.
- C. Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted if they may lead the public to believe:
 - (1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;
 - (2) That the advertiser is the same as is connected with or is endorsed by the governmental agencies or the other insurers.

- D. An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description.
- E. An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.
- F. An advertisement may not incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase "[] Medicare Department of the [] Insurance Company," or language of similar import.
- G. An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement.
- H. The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark.
- I. The use of the name of an agency or "[] Underwriters" or "[] Plan" in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.
- J. The use of an address so as to mislead or deceive as to true identity of the insurer, its location or licensing status is prohibited.
- K. An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.
- L. Advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used.
- M. An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. An agent or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation.

Section 15. Group or Quasi-Group Implications

- A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact.
- B. This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.
- C. Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.
- D. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct

applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as “enroll” or “join” to imply group or blanket insurance coverage when that is not the fact.

- E. Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

Section 16. Introductory, Initial or Special Offers

- A. (1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts 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 the fact. An advertisement shall not contain phrases describing an enrollment period as “special,” “limited,” or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance.
- (2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase “any one insurer” includes all the affiliated companies of a group of insurance companies under common management or control.
- (3) This regulation prohibits any statement or implication to the effect 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, unless that is the fact.
- (4) The phrase “a particular insurance product” in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.
- B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.
- C. Special awards, such as a “safe drivers’ award,” shall not be used in connection with advertisements of accident and sickness insurance.

Section 17. Statements about an Insurer

An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations.

Section 18. Enforcement Procedures

- A. Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in an other state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.
- B. Section 18 B is not adopted.

Section 19. Severability Provision

If any section or portion of a section of this regulation, or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation, or the applicability of the provision to other persons or circumstances, shall not be affected.

Section 20. Filing for Prior Review

The commissioner may, at his or her discretion, require filing of any accident and sickness insurance advertising material for review prior to use.. The advertising material shall be filed by the insurer with the commissioner not less than thirty (30) days prior to the date the insurer desires to use the advertisement.

K.A.R. 40-9-118. Life insurance; advertising.

Section 1. Purpose

Section 1 is not adopted.

Section 2. Definitions

For the purpose of this regulation:

- A. (1) "Advertisement" means material designed to create public interest in life insurance or annuities or in an insurer, or in an insurance producer; or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy including:

Comment: See drafting note caveat immediately following the definition of "insurance producer" in this section.

- (a) printed and published material, audiovisual material, and descriptive literature of an insurer or insurance producer used in direct mail, newspapers, magazines, radio and television script, billboards and similar displays;
- (b) Descriptive literature and sales aids of all kinds, authored by the insurer, its insurance producers, or third parties, issued, distributed or used by the insurer or insurance producer; including but not limited to circulars, leaflets, booklets, web pages, depictions, illustrations and form letters;
- (c) Material used for the recruitment, training and education of an insurer's insurance producers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy;
- (d) Prepared sales talks, presentations and materials for use by insurance producers.

(2) "Advertisement" for the purpose of this regulation shall not include:

(a) Communications or materials used within an insurer's own organization and not intended for dissemination to the public;

(b) Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy;

(c) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

3. "Insurance producer" shall mean an individual who solicits, negotiates, effects, procures, renews, continues or binds policies of insurance covering risks located in this State.

Note: This term and words related thereto should not be included in life advertising regulations unless "insurance producer" also is statutorily defined and the definitions are identical.

4. "Insurer" shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an "insurer" in the insurance code of this State or issues life insurance or annuities in this State and is engaged in the advertisement of a policy.

5. "Policy" shall include any policy, plan, certificate, including a fraternal benefit certificate, contract, agreement, statement of coverage, rider or endorsement which provides for insurance or annuity benefits.

6. "Nonguaranteed Policy Element" shall mean any premium cash value, death benefit, endowment value, dividend or other policy benefit or pricing element or portion thereof whose amount is not guaranteed by the terms of the contract. Any policy element that contractually follows a separate account result or a defined index is not considered a nonguaranteed policy element.

7. "Preneed funeral contract or prearrangement" shall mean an agreement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 3. Applicability

1. This rules shall apply to any life insurance or annuity advertisement intended for dissemination in this state.

2. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer.

Section 4. Form and Content of Advertisements

1. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive.

Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

2. No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "deposit," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," "private

pension plan," "retirement plan" or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

Section 5. Disclosure Requirements

1. The information required to be disclosed by this regulation shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.
2. An advertisement shall not omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied or that the policy or contract includes a "free look" period that satisfies or exceeds regulatory requirements, does not remedy misleading statements.
3. In the event an advertisement uses "non-medical," "no medical examination required," or similar terms where issue is not guaranteed, terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions set forth in the application.
4. An advertisement shall not use as the name or title of a life insurance policy any phrase that does not include the words "life insurance" unless accompanied by other language clearly indicating it is life insurance. An advertisement shall not use as the name or title of an annuity contract any phrase that does not include the word "annuity" unless accompanied by other language clearly indicating it is an annuity. An annuity advertisement shall not refer to an annuity as a CD annuity, or deceptively compare an annuity to a certificate of deposit.
5. An advertisement shall prominently describe the type of policy advertised.
6. An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no insurance producer or commission involved there will be a cost saving to prospective purchasers unless that is the fact. No cost savings may be stated or implied without justification satisfactory to the commissioner prior to use.
7. An advertisement for a life insurance policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, that fact shall be commonly disclosed. An advertisement of or for a life insurance policy under which the death benefit varies with the length of time the policy has been in force shall accurately describe and clearly call attention to the amount of minimum death benefit under the policy.
8. An advertisement for the types of policies described in Subsections F and G of this section shall not use the words "inexpensive," "low cost," or other phrase or words of similar import when the policies being marketed are guaranteed issue.
9. **Premiums**
 - (a) An advertisement for a policy with non-level premiums shall prominently describe the premium changes.
 - (b) An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.

- (c) An advertisement shall not contain a statement or representation that premiums paid for a life 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.
- (d) An advertisement that represents that a pure endowment benefit has a "profit" or "return" on the premium paid, rather than a policy benefit for which a specified premium is paid is deemed to be deceptive and misleading and is prohibited.
10. Analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments must be complete and accurate.
11. An advertisement shall not state or imply in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or improper practice.
12. If nonforfeiture values are shown in any advertisement, the values must be shown either for the entire amount of the basic life policy death benefit or for each \$1,000 of initial death benefit.
13. The words "free," "no cost," "without cost," "no additional cost," "at no extra cost," or words of similar import shall not be used with respect to any benefit or service being made available with a policy unless true. If there is no charge to the insured, then the identity of the payor shall 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.
14. No insurance producer may use terms such as "financial planner," "investment adviser," "financial consultant," or "financial counseling" in such a way as to imply that he or she is generally engaged in an advisory business in which compensation is unrelated to sales unless that actually is the case.
15. Nonguaranteed Policy Elements
- (a) An advertisement shall not utilize or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead.
- (b) An advertisement shall not state or imply that the payment or amount of nonguaranteed elements is guaranteed. Unless otherwise specified in [insert reference to the state law or regulation based on the NAIC Life Insurance Illustrations Model Regulation], if nonguaranteed elements are illustrated, they shall be based on the insurer's current scale and the illustration shall contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.
- (c) An advertisement that includes any illustrations or statements containing or based upon nonguaranteed elements shall set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
- (d) If an advertisement refers to any nonguaranteed policy element, it shall indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way; such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience, the advertisement may indicate any such limitation on the insurer's right.
- (e) An advertisement shall not refer to dividends as "tax-free" or use words of similar import, unless the tax treatment of dividends is fully explained and the nature of the dividend as a return of premium is indicated clearly.
16. An advertisement shall not 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.

17. Testimonials, Appraisals, Analysis, or Endorsements by Third Parties

(a) Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective insureds as to the nature or scope of the testimonial, appraisal, analysis or endorsement. In using testimonials, appraisals or analysis; the insurer or insurance producer makes as its own all the statements contained therein, and these statements are subject to all the provisions of this rules.

(b) If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the insurer or related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(c) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the insurer, or receives any payment or other consideration from the insurer for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

18. An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

19. Policies Sold to Students

(a) The envelope in which insurance solicitation material is contained may be addressed to the parents of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student unless such is a correct and truthful statement.

(b) All advertisements including, but not limited to, informational flyers used in the solicitation of insurance shall be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities shall be clearly identified as such.

(c) The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.

20. Introductory, Initial or Special Offers and Enrollment Periods

(a) An advertisement of an individual policy or combination of policies shall not 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 the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

(b) An advertisement shall not 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.

(c) An advertisement shall not 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. A reduced initial or first year premium may not be described as constituting free insurance for a period of time. When 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 shall 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.

Note: Some states prohibit a reduced initial premium. This section does not imply that a state that prohibits an initial premium is not in conformity with the NAIC rules.

(d) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date on which the enrollment period is advertised for the first time. This regulation applies to all advertising media-i.e., mail, newspapers, radio, television, magazines and periodicals-by any one insurer or insurance producer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This regulation does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his or her request. It is also inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specified provisions of the insurance code for group, blanket or franchise insurance. In cases where insurance product is marketed on a direct mail basis to prospective insurance by reason of some common relationship with a sponsoring organization, this regulation shall be applied separately to each sponsoring organization.

21. An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group, or quasi-group and as such enjoy special rates, dividends or underwriting privileges, unless that is the fact.

22. An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not disparage other insurers, insurance producers, policies, services or methods of marketing.

23. For individual deferred annuity products or deposit funds, the following shall apply:

(a) Any illustrations or statements containing or based upon nonguaranteed interest rates shall likewise set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The nonguaranteed interest rate shall not be greater than those currently being credited by the company unless the nonguaranteed rates have been publicly declared by the company with an effective date for new issues not more than three (3) months subsequent to the date of declaration.

(b) If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it shall also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.

(c) If any contract does not provide a cash surrender benefit prior to commencement of payment of any annuity benefits, any illustrations or statements concerning such contract shall prominently state that cash surrender benefits are not provided.

24. Subsection 24 is not adopted.

25. An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement as defined in Section 2F that is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

(a) The fact that a life insurance policy or annuity contract is being used to fund a prearrangement as defined in Section 2F; and

(b) The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise services, the administrator and any other person.

Section 6. Identity of Insurer

1. The name of the insurer shall be clearly identified in all advertisements, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. If an application is a part of the advertisement, the name of the insurer shall be shown on the application. An advertisement shall not use a trade name, an 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 devise or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identify 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.
2. No advertisement shall use any combination of words, symbols or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with a governmental program or agency.

Section 7. Jurisdictional Licensing and Status of Insurer

1. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.
2. An advertisement may state that an insurer or insurance producer is licensed in a particular state or states, provided it does not exaggerate that fact or suggest or imply that competing insurers or insurance producers may not be so licensed.
3. An advertisement shall not 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 an advertisement.

Section 8. Statements About the Insurer

An advertisement shall not contain statements, pictures or illustrations that are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

Section 9. Enforcement Procedures

1. Each insurer shall maintain 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, hereafter disseminated in this State, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on the examination of the insurer, whichever is the longer period of time.
2. If the commissioner determines that an advertisement has the capacity or tendency to mislead or deceive the public, the commissioner may require an insurer or insurance producer to submit all or any part of the advertising material for review or approval prior to use.

3. Subsection 3 is not adopted.

Section 10. Penalties

An insurer or its officer, directors, producers or employees that violate any of the provisions of this regulation, or knowingly participate in or abet such violation, shall be subject to a fine up to \$1000 for each violation and suspension or revocation of its certificate of authority or license.

Section 11. Conflict With Other Rules

Section 11 is not adopted.

Section 12. Severability

Section 12 is not adopted.