Title 114

WEST VIRGINIA ADMINISTRATIVE REGULATION
INSURANCE COMMISSIONER

No. 17
1981

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE

MEDICARE SUPPLEMENT INSURANCE COVERAGE THIS DATE _____
Administrative Law Div.

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Title 114
Legislative Rule

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INSURANCE COMMISSIONER

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FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 12-10-82

Medicare Supplement Insurance Coverage

Section 1. General

1:01 Identification of Rule - This regulation is a Legislative Rule, as defined by the provisions of Chapter 29A, Article 1, Section 2(d) of the Code of West Virginia of 1931, as amended.

1:02 Reference - This regulation relates to Chapter 33, Article 16, Section 3d and Chapter 33, Article 28, Section 5b of the Code of West Virginia of 1931, as amended.

1:03 Authority - This regulation is promulgated under the authority vested in the Insurance Commissioner by Chapter 33, Article 2, Section 10; Chapter 33, Article 16, Section 3d; and Chapter 33, Article 28, Section 5b of the Code of West Virginia of 1931, as amended.

1:04 Scope ~~Purpose~~ - The purpose of this regulation is to establish certain minimum standards and provide reasonable standardization and simplification of terms and coverages for policies or subscriber contracts of accident and sickness insurance which are issued to persons eligible for Medicare by reason of age and which are designed to supplement Medicare or which are advertised, marketed or otherwise purported to be a supplement to Medicare, to eliminate provisions contained in any policy or contract sold to a person eligible for Medicare by reason of age which may be misleading or confusing, to establish certain loss ratio requirements and provide for full disclosure in the sale of such coverages.

~~1:05 Applicability and Scope -~~

(A) This regulation shall apply to:

(1) All individual Medicare Supplement or Limited Benefit Medicare Supplement policies and subscriber contracts delivered or issued for delivery in this State on or after the effective date hereof, and

(2) All certificates issued under group Medicare Supplement or Limited Benefit Medicare Supplement policies

or subscriber contracts, which policies or contracts have been delivered or issued for delivery in this State, and

(3) Where applicable, all policies or contracts purporting to offer medical or surgical coverage which are delivered or issued for delivery in this State to persons eligible for Medicare by reason of age, including hospital confinement indemnity coverage, nursing home coverage, and specified disease coverage sold to such persons.

(B) This regulation shall not apply to:

(1) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations, or

(2) A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation; has been maintained in good faith for purposes other than obtaining insurance; and has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members, or

(3) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this section, or

(4) Individual or group policies or contracts issued to employees or members as additions to franchise plans in existence on the effective date of this regulation.

(C) 12 This regulation shall apply in conjunction with Series ~~XIII, 1974, Administrative Regulation Insurance Commissioner,~~ Individual Accident and Sickness Insurance Minimum Standards, together with all other applicable laws and regulations.

1:06 Effective Date - This regulation shall become effective December 28, 1981.

1:07 Filing Date - This regulation was filed in the Office of the Secretary of State on November 12, 1981.

1:08 Certification - This regulation is certified authentic by the Insurance Commissioner of the State of West Virginia by Certificate Number 17.

Section 2. Definitions

2:01 Applicant - Shall mean:

(A) In the case of an individual Medicare Supplement or Limited Benefit Medicare Supplement policy or subscriber contract, the person who seeks to contract for insurance benefits, and

(B) In the case of a group Medicare Supplement or Limited Benefit Medicare Supplement policy or subscriber contract, the proposed certificateholder.

2:02 Certificate - Shall mean any certificate issued under a group Medicare Supplement or Limited Benefit Medicare Supplent policy which policy has been delivered or issued for delivery in this State.

2:03 Duplication of Insurance - Shall mean a transaction involving the purchase of accident and/or sickness insurance where it is known or should be known to the agent or, in the case of direct response solicitation, to the insurer, that the new insurance will provide some of the benefits or coverages to which the proposed insured is already entitled under an existing policy or contract of insurance.

2:04 Limited Benefit Medicare Supplement Policy - Shall mean any policy or subscriber contract or accident and/or sickness insurance which is issued to a person eligible for Medicare by reason of age, which is designed to supplement Medicare coverage or which is advertised, marketed or otherwise purported to be a Supplement to Medicare coverage and which includes terms and benefits which do not meet the requirements of Section 4:02 of this regulation.

2:05 Medicare Supplement Policy - Shall mean a group or individual policy or contract of accident and sickness insurance which is designed primarily to supplement Medicare coverage or which is advertised, marketed or otherwise purported to be a supplement to Medicare coverage and which includes terms and benefits which meet the requirements of Section 4 of this regulation.

2:06 Replacement of Insurance - Shall mean a transaction involving the purchase of accident and/or sickness insurance where it is known or should be known to the agent or, in the case of direct response solicitation, to the insurer, that previously existing accident and/or sickness insurance has been or will be lapsed, cancelled or otherwise terminated as a result of the transaction.

2:07 Sales Materials - Shall mean any and all promotional materials, replacement forms, duplication forms, or any other forms or informational material used in connection with the promotion, solicitation or sale of accident and/or sickness insurance.

Section 3. Policy Definitions and Terms

No Medicare Supplement or Limited Benefit Medicare Supplement policy or contract delivered or issued for delivery in this State to any person eligible for Medicare by reason of age shall contain definitions or terms respecting the matters set forth herein unless such definitions or terms conform to the requirements of this Section.

3:01 Medicare - Shall be defined in the policy, and may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or words of similar import.

3:02 Medicare Benefit Period or Benefit Period - Shall not be defined as more restrictive than as defined in the Medicare program.

3:03 Medicare Eligible Expenses - Shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.

3:04 Preexisting Condition - Shall not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within a six month period preceding the effective date of coverage.

Section 4. Minimum Standards for Medicare Supplement and Limited Benefit Medicare Supplement Policies and Contracts

No Medicare Supplement or Limited Benefit Medicare Supplement policy or contract shall be delivered or issued for delivery in this State which does not meet the requirements of this Section. These are minimum standards and do not preclude the inclusion of other provisions or benefits in addition to, and which are not inconsistent with, these standards.

4:01 General Policy Provisions -

(A) Limitations based on preexisting conditions shall not exclude coverage for more than six months after the effective date of coverage of the insured person for a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of the coverage of an insured person.

(B) Coverage shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(C) Coverage shall provide that benefits designed to cover cost sharing amounts under Medicare will be proportionally changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be changed to correspond with such changes, subject to prior approval by the Commissioner or the filed rates may include incremental increases which anticipate changes in Medicare coverage.

(D) The terms "Medicare Supplement," "Medigap" and words of similar import shall not be used in any manner to describe a policy or contract unless the policy or contract is issued in compliance with this regulation.

4:02 Minimum Benefit Standards for Medicare Supplement Coverage - Medicare Supplement policies or contracts shall provide at least the following benefits to an insured person:

(A) Coverage of the initial Part A Medicare deductible as established from time to time by the Social Security Administration;

(B) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(C) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 91st day through the 150th day in any Medicare benefit period;

(D) Upon exhaustion of all Medicare hospital in-patient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days;

(E) Coverage of Part A Medicare eligible expenses for post-hospitalization skilled nursing facility care to the extent not covered by Medicare from the 21st day to the 80th day in any Medicare benefit period;

(F) Coverage of Part A Medicare eligible expenses for any number of pints of blood to the extent not covered by Medicare in any Medicare benefit period;

(G) Coverage of the initial Part B Medicare deductible as established from time to time by the Social Security Administration; and

(H) Coverage of 20% of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum of at least $5,000 per calendar year.

4:03 Minimum Benefit Standards for Limited Benefit Medicare Supplement Coverage - Limited Benefit Medicare Supplement policies or contracts shall provide at least the following benefits to an insured person:

(A) The initial Part A Medicare deductible as established from time to time by the Social Security Administration;

(B) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital in-patient reserve days;

(C) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(D) Upon exhaustion of all Medicare hospital in-patient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization

not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days; and

(E) Coverage of 20% of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum of at least $5,000 per calendar year.

Section 5. Prohibited Policy Provisions

5:01 Excluded Coverage by Type - No Medicare Supplement or Limited Benefit Medicare Supplement policy or contract shall limit or exclude coverage by type of illness, accident, treatment or medical condition except as to the following, where not inconsistent with Medicare:

(A) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic strain, or symptomatic complaints of the feet;

(B) Mental or emotional disorders, alcoholism and drug addiction;

(C) Illness, treatment or medical condition arising out of:

(1) War or act of war (whether declared or undeclared);

(2) Participation in a felony, riot or insurrections;

(3) Service in the armed forces or units auxiliary thereto;

(4) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(5) Aviation.

(D) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

(E) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column;

(F) Treatment provided in a governmental hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(G) Dental care or treatment;

(H) Eye glasses, hearing aids and examination for the prescription or fitting thereof;

(I) Rest cures, custodial care, transportation and routine physical examinations;

(J) Territorial limitations,

provided, however, that Medicare Supplement or Limited Benefit Medicare Supplement policies or contracts may not contain limitations or exclusions of the types included in Subdivisions (A), (E), (I), or (J) above that are more restrictive than those of Medicare. Medicare Supplement or Limited Benefit Medicare Supplement policies or contracts may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

5:02 Waivers - No Medicare Supplement or Limited Benefit Medicare Supplement policy or contract may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

Section 6. Required Disclosure Provisions

6:01 Term of Coverage - Each Medicare Supplement or Limited Benefit Medicare Supplement policy or contract shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy or contract, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy or contract is issued and for which it may be renewed.

6:02 Payment of Benefit Standards - A Medicare Supplement or Limited Benefit Medicare Supplement policy or contract which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary,"

or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

6:03 Preexisting Condition Limitations - If a Medicare Supplement or Limited Benefit Medicare Supplement policy or contract contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy or contract and be labeled as "Preexisting Condition Limitations."

6:04 Right to Return - Medicare Supplement or Limited Benefit Medicare Supplement policies, certificates, or contracts issued to persons eligible for Medicare by reason of age, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy, certificate, or contract, attached thereto stating in substance that the insured person shall have the right to return the policy, certificate, or contract within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, certificate, or contract, the insured person is not satisfied for any reason. Policies, certificates or contracts issued pursuant to a direct response solicitation to persons eligible for Medicare by reason of age shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder, certificateholder, or contractholder shall have the right to return the policy, certificate or contract within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

6:05 Buyer's Guide - Insurers issuing individual or group policies or contracts sold primarily to persons eligible for Medicare by reason of age, which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, shall provide to the policyholder a Medicare Supplement "Buyer's Guide" ~~in the form attached hereto as Appendix A,~~ provided, however, that such "Buyer's Guide" shall, at the time of issuance, reflect current Medicare benefits, co-payments and deductibles. Delivery of the Buyer's Guide shall be made whether or not such policy or contract qualifies as a Medicare Supplement or Limited Benefit Medicare Supplement policy as defined in this regulation. Except in the case of direct response insurers, delivery of the Buyer's Guide shall be made at the time of application, and acknowledgment of receipt of the Buyer's Guide shall be provided to the insurer. Direct response insurers shall deliver the Buyer's Guide upon request but not later than at the time the policy is delivered.

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6:06 Outline of Coverage Requirements for Medicare Supplement and Limited Benefit Medicare Supplement Policies, Certificates or Contracts:

(A) (1) Insurers issuing Medicare Supplement or Limited Benefit Medicare Supplement policies, certificates or contracts shall deliver an outline of coverage which meets the requirements of this Section to the applicant at the time application is made and, except for the direct response policy, secure an acknowledgment of receipt from the applicant; and

(2) If an outline of coverage was delivered at the time of application and the individual 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 shall accompany such policy or contract when it is delivered and shall contain the following statement, in no less than twelve point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(B) An outline of coverage, in the form prescribed below, shall be issued in connection with the issuance of Medicare Supplement or Limited Benefit Medicare Supplement policies or contracts. The items included in the outline of coverage must appear in the sequence prescribed.

(COMPANY NAME AND ADDRESS)

OUTLINE OF MEDICARE

SUPPLEMENT (OR LIMITED BENEFIT MEDICARE SUPPLEMENT) COVERAGE

(1) Read Your [*]Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Medicare Supplement Coverage -- Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is

provided for hospital in-patient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine [delete if such coverage is provided].

(3) (a) [Where agent used]:
Neither [insert company's name] nor its agents are connected with Medicare.

(b) [For direct responses]:
[Insert company's name] is not connected with Medicare.

(4) [A brief summary of the major benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, provided by the medicare supplement coverage in the following order:]

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $(204)		
	61st to 90th day	All but $(51) a day		
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services	91st to 150th day	All but $(102) a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE . . .	First 20 days	100% of costs		

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 14 days after hospital discharge.	Additional 180 days	All but $(25.50) a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge [after $(60) deductible]		

(5) [Statement that the policy does or does not cover the following:]

(a) Private duty nursing,

(b) Skilled nursing home care costs [beyond what is covered by Medicare],

(c) Custodial nursing home care costs,

(d) Intermediate nursing home care costs,

(e) Home health care above number of visits covered by Medicare,

(f) Physician charges [above Medicare's reasonable charge],

(g) Drugs [other than prescription drugs furnished during a hospital or skilled nursing facility stay],

(h) Care received outside of United States of America,

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

(6) [Include here a description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:

(a) That the chart summarizing Medicare benefits only briefly describes such benefits.

(b) That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.]

(7) [Include here a description of policy provisions or continuation of coverage, including any reservation or rights to change premium.]

(8) The amount of premium for this policy. [*Substitute "Certificate" for "policy" where appropriate.]

Section 7. Loss Ratio Standards

7:01 Aggregate Benefits - Medicare Supplement or Limited Benefit Medicare Supplement policies or contracts shall be expected to return to policyholders in the form of aggregate benefits under the policy, as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices:

(A) In the case of individual policies or contracts, at least 60 percent of the aggregate amount of premiums collected; and

(B) In the case of group policies, contracts or certificates, at least 75 percent of the aggregate amount of premiums collected.

7:02 Mail or Mass Media Advertising - For purposes of this Section, Medicare Supplement or Limited Benefit Medicare Supplement group policies or contracts issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

Section 8. Prohibited Acts or Practices

8:01 Solicitation or Sale - No person shall engage in any unfair, deceptive, misleading, or unreasonably confusing act or practice in the promotion, solicitation or sale of accident and health insurance delivered or issued for delivery in this State to persons eligible for Medicare by reason of age.

8:02 Prima Facie Violations - The following acts and practices shall be deemed prima facie evidence of a violation of this Section:

(A) Any act which encourages an applicant to omit pertinent underwriting information from an application;

(B) Any act which induces a prospective insured to sign a blank or incomplete application, acknowledgment, or form;

(C) Failure to disclose, during initial solicitation to a prospective insured, any affiliation with an insurer;

(D) Any representations, expressed or implied, unless specifically authorized in writing by the organization, of affiliation with or authorization by any civic, social, or other non-governmental organization;

(E) Any representation, expressed or implied, of affiliation with or authorization by any governmental agency or of access to any information from any such agency which is not generally available to the public;

(F) The making of any false or misleading statements as to the length of time an insurance policy or contract may or may not be available;

(G) The issuance of any policy or contract, which has not been submitted to and approved by the Commissioner;

(H) The sale of Medicare Supplement or Limited Benefit Medicare Supplement insurance to any person not eligible for Medicare;

(I) The sale of any accident and/or sickness insurance policy or contract to any person without ascertaining whether the person is eligible for Medicare by reason of age;

(J) The sale of any accident and sickness insurance policy or contract to any person who indicates eligibility for Medicare by reason of age, without strict adherence to the disclosure requirements of this regulation;

(K) Falsely answering any question or signing any certification in any application or form required to be completed by the prospective insured;

(L) Failure by an agent to deliver, within seven business days, any policy sent to the agent for delivery to an applicant;

(M) The taking of an application, except by direct response, without inquiring and recording the reply as to whether the proposed insurance will duplicate any insurance then in force; or

(N) Making any inquiry in such manner as to invite a response contrary to fact.

Section 9. Duplication of Insurance

9:01 Question in Application - All applications involved in the sale of any Medicare Supplement or Limited Benefit Medical Supplement policy or contract shall include a question designed to elicit information regarding the existence of any accident and/or health insurance then in force on any proposed insured, and shall include a statement, to be dated and signed by the proposed insured, indicating whether any accident and/or health insurance is presently in force, the type and amount of coverage, the name of any insurer which issued such coverage and, where possible, the policy or contract number.

Section 10. Replacement of Insurance

No Medicare Supplement or Limited Benefit Medicare Supplement policy or contract shall be delivered or issued for delivery in this State to any person eligible for Medicare by reason of age unless issued in compliance with this Section.

10:01 Question in Application - Medicare Supplement and Limited Benefit Medicare Supplement application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and/or sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

10:02 Notice Required - Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish to the applicant, prior to issuance or delivery of the policy, the notice described in Subsection 10:03 below. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer for the period

of time in which the policy or contract is in force. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection 10:04 below. In no event, however, will such a notice be required in the solicitation of "single premium nonrenewable" policies.

10:03 Form of Notice - The notice required by Subsection 10:02 above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND/OR SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and/or sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy provides ten (10) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

10:04 Form of Notice for Direct Response Insurers - The notice required by Subsection 10:02 above for a direct response shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND/OR SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and/or sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions concerning your medical/health history are answered truthfully and completely. Material omissions or

misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

Section 11. Penalties for Violation

11:01 Penalties - Any person who fails to comply with any provision of this regulation or who commits any act which is determined to be in violation of any provision of this regulation shall, after Notice and Hearing, be subject to suspension or revocation of any license issued to it by the Insurance Commissioner, or shall forfeit a fine for each such act, or both.

STATE OF WEST VIRGINIA

RICHARD G. SHAW
INSURANCE COMMISSIONER

OFFICES OF THE
INSURANCE COMMISSIONER
2100 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305
TELEPHONE (304) 348-3386

JOHN D. ROCKEFELLER, IV
GOVERNOR

April 11, 1984

Honorable A. James Manchin
Secretary of State
State Capitol
Suite 157-K
Charleston, West Virginia 25305

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 4/11/84
Administrative Law Division

Re: Legislative Rule of the Insurance Commissioner, Series XX, Excess Line Brokers (1984)

Dear Secretary Manchin:

Pursuant to West Virginia Code § 29A-3-13, I am today presenting to you for filing in the State Register two copies of the above-noted legislative rule. The Insurance Commissioner was authorized to promulgate this rule by the 1984 session of the West Virginia Legislature under the provisions of Senate Bill 425. The rule was promulgated on April 11, 1984 and becomes effective on July 1, 1984. There were no amendments of the rule by the legislature.

Respectfully submitted,

Richard G. Shaw
Insurance Commissioner

RGS:amp
Enclosures

STATE OF WEST VIRGINIA

RICHARD G. SHAW
INSURANCE COMMISSIONER

OFFICES OF THE
INSURANCE COMMISSIONER
2100 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305
TELEPHONE (304) 348-3386

JOHN D. ROCKEFELLER, IV
GOVERNOR

STATE REGISTER FILING

I, Richard G. Shaw, Commissioner (Title or Position),

Insurance (Department or Division), hereby submit to record in the State Register on 8½ x 11" paper two (2) copies of

( ) proposed rules and regulations concerning topics of material not covered by existing rules and regulations;

( ) proposed rules and regulations superseding rules and regulations already on file;

( ) notice of hearing;

( ) findings and determinations;

(X) rules and regulations; or

( ) other - specify ( )

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 4/11/84
Administrative Law Divisic

This filing pertains to

Chapter 33
Article 12
Series XX
Section
Page No.

( ) proposed rules and regulations are required to go to Legislative Rule Making Committee;

( ) proposed rules and regulations are excluded from Legislative Rule Making Committee;

April 11, 1984
Date Submitted

Richard G. Shaw
Signature of Person Authorizing this Filing

EXCESS LINE BROKERS

Chapter 33-12
Series XX
1984

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