211 CMR 42.00: THE FORM AND CONTENTS OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

Section

42.01: Purpose

The purpose of 211 CMR 42.00 is to provide reasonable simplification of terms and coverage of individual accident and sickness insurance policies in order to facilitate public understanding and comparison, to encourage flexibility and responsible innovation in the development of individual policies, and to eliminate provisions which may be misleading, confusing or contrary to the needs of the public.

42.02: Applicability

211 CMR 42.00 applies to all individual accident and sickness insurance policies, including basic hospital expense, basic hospital-surgical expense, hospital confinement indemnity, major medical expense, specified accident, specified disease, accident only, disability income, and restricted benefit insurance policies on and after December 31, 1996. The requirements contained in 211 CMR 42.00 are in addition to any other applicable statutory provisions or lawful regulations.

42.03: Authority

211 CMR 42.00 is issued under the authority granted to the Commissioner under M.G.L. c. 175, §§ 108 and 110E, c. 176, c. 176A, c. 176B, and c. 176D.

42.04: Definitions

As used in 211 CMR 42.00, the following words shall mean:

Accident, Accidental Injury, Accidental Means must be defined to employ "result" language and may not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. Such definition may be modified or an exception or limitation may be included to provide that injuries shall not include injuries for which benefits are provided under any workmen's compensation, occupational disease, employer's liability or similar law.

Anticipated Loss Ratio means the present value at issue of the expected future benefits, excluding dividends, divided by the present value of the expected future annualized premiums, using a reasonable interest rate and reasonable assumptions as to the distribution of the policy form by age and by various options available.

Carrier means a commercial insurance company licensed to write accident and health insurance under M.G.L. c. 175, a fraternal benefit society licensed under M.G.L. c. 176, a non-profit hospital service corporation organized under M.G.L. c. 176A, a medical service corporation organized under M.G.L. c. 176B, a dental service corporation organized under M.G.L. c. 176E, and an optometric service corporation organized under M.G.L. c. 176F.

42.04: continued

Class means underwriting and rating classifications used when a policy was originally issued.

Commissioner means the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Elimination Period means the number of days during which services are provided to an insured person or during which the insured person is unable to work because of accident or sickness before the insurance policy begins to pay benefits.

Medicare means the program established under Title XVIII of the federal Social Security Act, "Health Insurance for the Aged Act", 42 USCS § 1395 *et seq*.

Policy means any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides insurance benefits whether as a service or on an indemnity reimbursement or prepaid basis.

Pre-existing Condition means a medical condition for which an insured person received medical advice or treatment during a period to be determined by the carrier prior to the effective date of coverage or because of which an individual had symptoms which would have led an ordinarily prudent person to seek medical advice or treatment for that medical condition, or a pregnancy existing on the effective date of coverage.

Sickness must be defined to be no more restrictive than a sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be modified to exclude sickness or disease for which benefits are provided under any workmen's compensation, occupational disease, employer's liability, or similar law.

42.05: Policy Types

(1) General Standards.

(a) A policy paying benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import must define and explain the terms in its outline of coverage;

(b) All pre-existing condition provisions must be labeled as "Pre-existing Condition Provision" and appear as a separate paragraph on the first page of the policy;

(c) In the event of cancellation or refusal to renew by the carrier, policies providing pregnancy benefits must provide benefits for pregnancy commencing while the policy is in force.

(d) A policy provision relating to recurrent confinements or recurrent disabilities will be considered to be in compliance with the provisions of M.G.L. c. 176D if does not specify that such confinements or such disabilities be separated by a period greater than six months.

(e) A policy's "free-look" section or right of examination will be considered to be in compliance with the provisions of M.G.L. c. 176D if it is for at least a ten-day period from the date of policy delivery.

(2) Minimum Benefits for Specific Types of Policies.

(a) Basic Hospital Expense Insurance. Basic hospital expense provides coverage for services rendered while confined in a hospital.

(b) Basic Medical-surgical Expense Insurance. Basic medical-surgical insurance provides coverage for in-hospital or surgical health services rendered by a physician or other covered health care provider

(c) Hospital Confinement Indemnity Insurance. Hospital confinement indemnity insurance provides coverage on other than an expense-incurred basis while the covered person is confined as a hospital inpatient.

(d) Major Medical Expense Insurance. Major medical expense insurance provides coverage for inpatient and outpatient health care services.

42.05: continued

(e) Specified Disease or Specified Accident Insurance.

1. Specified Disease Coverage. Specified disease coverage provides coverage as described in 211 CMR 146.00. Any policy covering specified diseases may not be sold as Restricted Health Insurance as defined in 211 CMR 42.05(2)(i).

2. Specified Accident Insurance provides coverage which is limited to a delineated or defined type of accident, such as an automobile accident or one occurring during a trip.

(f) Accident Only Health Insurance. Accident only coverage provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident and must comply with the following:

1. Waiting periods are prohibited in accident policies.

2. All accident policies shall display prominently in letters at least ¼" high on the first page of the policy the following: "This is an accident only policy and it does not pay benefits in event of sickness."

3. All accident policies shall be non-cancelable for the life of the insured without any right of the carrier to increase the premium rate.

(g) Disability Income Insurance. Disability income insurance provides weekly or monthly benefits to replace income that is lost due to disability resulting from accident and/or sickness. It also includes business expense insurance and business buy-out insurance policies that condition receipt of benefits upon the disability of the insured. To promote clarity and readability, total disability must be defined to make clear the time, if any, for which an insured must be disabled, whether by being unable to engage in his or her own occupation, or in others, for which he or she is qualified by education, training, and experience, or otherwise. Definitions should avoid hard-to-understand expressions like inability to perform "each and every" or "any and every" duty of an insured's occupation.

To promote clarity and readability, partial disability, if included, shall be defined in relation to the insured person's inability to perform some part or all of the "major," "important" or "essential" duties of employment or occupation. If a policy covers both total and partial disability, the partial disability benefit will be considered to be in compliance with the provisions of M.G.L. c. 176D, if it is not contingent upon prior payments for total disability benefits.

The policy must clearly explain all limitations and elimination periods, including elimination periods affecting different levels of benefits. In addition, no benefits can be reduced in coordination with any increased benefits that the insured may receive from the Social Security System after the effective date of the benefit period.

(h) Long-term Care Insurance. Long-term care insurance provides coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services in a setting other than an acute care unit of a hospital as described in 211 CMR 65.00.

(i) Restricted Benefit Health Insurance. Any accident or sickness insurance policy not defined under 211 CMR 42.05(1)(a) through (g) must be labeled "Restricted Benefit Health Insurance." 211 CMR 42.05(2)(i) may not be used to issue a policy that is defined in 211 CMR 42.00 or any other statute or regulation and that does not meet the requirements set forth therein.

42.06: Review of Policy Forms and Rate Filings

(1) Policy forms will be reviewed according to 211 CMR 42.00 as well as any other relevant statute or regulation. This provision, 211 CMR 42.06, may not be used to issue a policy that is defined in 211 CMR 42.00 or any other statute or regulation and that does not otherwise meet the requirements set forth therein.

42.06: continued

(2) All rate filings shall at least explain formulas used to derive rates, expected claim costs, assumptions regarding mortality, morbidity and lapse rates, and the detailed commission schedule and anticipated administrative expenses associated with the policy. In order to substantiate rate revision filings, filings must maintain experience for that policy form, may combine experience for different policy forms where the coverage is substantially the same, and must demonstrate that the carrier is using fund accounting for guaranteed renewable policies to reflect premiums, investment income, losses, expenses, and provisions for reserves specific to that policy form. Any rates filed, whether initial or revised, will be disapproved unless the aggregate anticipated loss ratio for the entire period for which rates are computed to provide coverage meets the following standards:

(a) for purposes of 211 CMR 42.06(2)(b) and 42.06(2)(c) optionally renewable means renewal is at the option of the insurance company; conditionally renewable means renewal can be declined by the insurance company only for stated reasons other than deterioration of health; guaranteed renewable means renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis; and guaranteed rate means renewal cannot be declined nor can rates be revised by the insurance company;

(b) for hospital and medical expense policies (including indemnity policies) and for similar policies the minimum loss ratio shall be:

1. 60% for optionally renewable policies;
2. 55% for conditionally renewable and guaranteed renewable policies; and
3. 50% for guaranteed rate policies.

(c) for loss of income policies, including business buyout and business expense policies, the actuarial memorandum may be limited to lifetime loss ratios as certified by an actuary and the minimum loss ratio shall be:

1. 60% for optionally renewable policies;
2. 55% for conditionally renewable policies;
3. 50% for guaranteed renewable policies; and
4. 45% for guaranteed rate policies.

(d) for policies providing either substantially full coverage for specified perils (*e.g.*, auto, common carrier) or short term non-renewable coverage (*e.g.*, trip insurance) the minimum loss ratio is 45%;

(e) for policies providing coverage for accidents only, the minimum loss ratio shall be 45%;

(f) for policies meeting the requirements of both 211 CMR 42.06(2)(d) and 42.06(2)(e), the minimum loss ratio is 45%;

(g) for policies issued to and actually held by persons ages 65 or older, the minimum loss ratio shall be 65%;

(h) for policies under 211 CMR 42.06(2)(b) or 42.06(2)(c), the minimum loss ratio shall be five percentage points less than those given if the expected average annual premium for the policy, including riders and endorsements, is less than $200; and

(i) for long-term care insurance policies, whether the filling is for an initial or revised rate, the aggregate lifetime loss ratio shall be no less than 60% for policies sold as standard individual policies and no less than 80% for policies sold as group conversion policies; provided, that "aggregate lifetime loss ratio" means the present value at the form's inception of all expected future benefits under the form divided by the present value at the form's inception of all future premiums to be received under the form; and

(j) for specified disease policies, whether the filing is for an initial or revised rate, the minimum loss ratio shall be no less than 60% for individual policies; any rate filing for a specified disease insurance policy shall state the carrier's Expected Durational Loss Ratios that will be used in completing future experience monitoring forms described in 211 CMR 146.102.

(k) if, for any policy which provides benefits of substantial economic value to the insured, it can be demonstrated that the minimum loss ratio standards given above cannot possibly be attained, a lower loss ratio is allowable.

(3) Time Provisions. The following provisions shall apply to individual accident and health insurance policies subject to M.G.L. c. 175, § 108.

(a) All rate filings are subject to review by an actuary specified by the Commissioner whose costs will be paid by the company submitting the filing.

42.06: continued

(b) If a filing has been disapproved and is resubmitted, the cover letter shall note the disapproval and any changes made since the earlier filing, with an explanation of why the new filing should be approved. Resubmission of disapproved forms should, where possible, be made within 90 days of disapproval.

(c) The filer shall have the right to request a hearing within ten days of receiving a final disapproval. Within 20 days of the receipt of the request, the Division shall schedule a date for the hearing, which must occur within 30 days of the scheduling. At least ten days written notice of the hearing shall be given to all interested parties.

(d) The hearing officer may order a pre-hearing conference for the resolution or simplification of issues, to be held no less than three days prior to the scheduled date of a hearing.

(e) For a time period of ten days or less only, business days shall be counted. For time periods greater than ten days, calendar days must be used.

(4) Rate Manual. Every carrier must maintain on file with the Division an up-to-date rate manual for all individual accident and health policies, riders, and endorsements currently available for sale in Massachusetts. The manual must include:

(a) name of the carrier on each page;

(b) table of contents or index; and

(c) identification by form number of each policy or endorsement to which the rates apply.

42.07: Loss Ratio Guarantee Filings and Review

Pursuant to the provisions of M.G.L. c. 175 §108, only nongroup major medical policies are allowed to file for loss ratio guarantees. Medicare Supplement policies subject to 211 CMR 71.00, specified disease or specified accident insurance subject to 211 CMR 42.05(2)(e), accident only health insurance subject to 211 CMR 42.05(2)(f), disability income policies subject to 211 CMR 42.05(2)(g), long-term care insurance policies subject to 211 CMR 42.05(2)(h) or any other policy forms under which more than 50% of the policies are issued to individuals age 65 or over, are excluded from the provisions of 211 CMR 42.07 related to loss ratio guarantees.

(1) Definitions pertinent to 211 CMR 42.07:

Actual Loss Ratio means the loss ratio attributable solely to Massachusetts if there are 2,000 or more policyholders in the state on the policy form. If there are 500 or more policyholders on the policy form in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio for the policy form. For example, if there are 1,200 policyholders in the state, the actual loss ratio is:

(1,200 - 500) /(2,000 - 500) state loss ratio +
(2,000 - 1,200)/(2,000 - 500) U.S. loss ratio.

If there are fewer than 2,000 policyholders nationwide, the applicable loss ratio will be calculated using combined experience of current calendar year and each subsequent year until the sum of policyholders in all such calendar years adds up to 2,000.

Anticipated Durational Loss Ratio means the ratio of incurred claims to earned premium for a given policy duration (*i.e.*, first year, second year, *etc.*)

Anticipated Lifetime Loss Ratio means the ratio of the present value of all past and future incurred claims to the present value of all past and future earned premiums where the present values are calculated at a rate of interest at least equal to the health valuation rate of interest at the time the policy is approved and as prescribed in Massachusetts law or regulation, or if no such rate is prescribed, at the rate prescribed by the National Association of Insurance Commissioners.

Experience Period means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

Loss Ratio means ratio of incurred claims to earned premium for any individual policy form.

42.07: continued

(2) Initial Filing of Loss Ratio Guarantee.

(a) In addition to the provisions of 211 CMR 42.07(2)(b), all benefits of individual major medical policies issued subject to M.G.L. c. 175, § 108 shall be deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the anticipated durational and lifetime loss ratios in the original filing of the form have been approved by the Commissioner.

(b) All filings submitted under 211 CMR 42.07(2) shall have renewability provisions no less favorable to the policyholder than conditional renewability.

(c) The initial filing of a loss ratio guarantee shall include a specific written statement as to the detail of the loss ratio guarantee, which shall contain at least the following:

1. the policy form number;
2. a recitation of the anticipated lifetime and durational loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved, and a copy of the original actuarial memorandum. If the original actuarial memorandum did not include anticipated durational loss ratios, these ratios shall be included in the initial filing of the loss ratio guarantee;
3. the first calendar year in which the loss ratio guarantee is to be effective;
4. a guarantee that the actual loss ratios for each experience period shall meet or exceed the anticipated lifetime and durational target loss ratios approved by the Commissioner pursuant to 211 CMR 42.07(2)(a);
5. a guarantee that the actual loss ratio results for the experience period will be independently audited in the form prescribed by 211 CMR 42.07(4) at the carrier's expense by an auditor who is a certified public accountant or Member of the American Academy of Actuaries;
6. a guarantee that the audit shall be performed in the second calendar quarter of the year following the end of the experience period and the audited results shall be reported to the Commissioner no later than the end of such quarter;
7. a guarantee that the audit shall be done in accordance with generally accepted auditing or actuarial standards;
8. a guarantee that affected policyholders in Massachusetts shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the actual experience period loss ratio up to the anticipated durational loss ratio approved by the Commissioner pursuant to 211 CMR 42.07(2)(a);
9. a sample calculation and illustration of the refund methodology; and
10. the signature of an officer of the carrier.

(3) Subsequent Rate Filings.

(a) Notwithstanding the provisions of 211 CMR 42.07(2), renewal premium rates for individual major medical policies issued subject to M.G.L. c. 175, § 108 shall be deemed to be approved upon filing with the Commissioner, if the filing includes sufficient evidence that it meets the standards of 211 CMR 42.07 and is accompanied by a copy of the loss ratio guarantee filed pursuant to 211 CMR 42.07(2).

(b) The Commissioner shall have the right to bring an administrative action should he or she deem that the lifetime loss ratio approved pursuant to 211 CMR 42.07(2)(a) will not be met or exceeded.

(4) Form and Contents of the Audit. The audit required under 211 CMR 42.07(2) shall include:

(a) the number of policyholders in Massachusetts and the nation, on both a durational and total basis;

(b) the incurred claims and earned premium by policy duration period for the audited experience period;

(c) a signed opinion by the independent auditor that the audit has been performed in accordance with generally accepted accounting or actuarial standards and that the audit report presents fairly and accurately the amount of incurred claims, including incurred but not reported claims, and earned premium, for the audited experience period;

(d) the durational and lifetime loss ratios guaranteed;

(e) a statement of any refunds due for the current experience period and the refund calculation; and

42.07: continued

(f) the currently anticipated lifetime loss ratio on the policy block. This loss ratio shall be defined as the present value of past and future expected incurred claims divided by the present value of past and future expected earned premiums.

(5) Refund Calculation.

(a) The refund shall be made to all policyholders in Massachusetts who are insured under the applicable policy form for at least six months of the experience period, except that no refund need be made to a policyholder in an amount less than ten dollars. Refunds less than $10.00 shall be aggregated and paid pro rata to the policyholders receiving refunds.

(b) The refund shall include interest compounded monthly at the then current variable loan interest rates for life insurance policies established by the National Association of Insurance Commissioners (NAIC), from the end of the experience period until the date of payment.

(c) Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the Commissioner has adequate time to review the report.

(d) The refund shall be subtracted from earned premiums in the loss ratio calculation. The premium refund shall not be considered a benefit payment.

42.08: Requirements for Replacement

(1) Application forms must contain a question to elicit information as to whether the insurance to be issued is to replace any other accident and sickness insurance currently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(2) An agent or carrier soliciting the sale, upon determining that the sale would involve replacement, must furnish to the applicant, at the time of taking the application, or before the policy is issued, the notice described in 211 CMR 42.99. A copy of the notice must be left with or retained by the applicant and a signed copy must be retained by the carrier.

42.09: Requirements for Disclosure

(1) General Rules.

(a) No misleading policy names may be used and no policy may be marketed or advertised as a group policy unless it qualifies as such. A carrier's policy name may not misrepresent the extent of benefits actually provided nor may a name be used which conflicts with the prescribed category name or which is similar to the prescribed name of a different category.

(b) If age is to be used as a determining factor for reducing the benefits made available in the policy as originally issued, such fact must be prominently set forth in the policy.

(c) All insurance policies must contain a renewability provision on the first page of the policy in highlighted section.

(d) In the event that the policy is issued on a basis other than that applied for, a disclosure statement properly describing the policy must accompany the policy when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this disclosure statement carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested - it differs in the following respects: [list]."

(e) Any Non-Medicare-Supplement policy summary delivered to a person eligible for Medicare must conspicuously display on its first page the following statement unless the policy does not cover hospital, medical or surgical expenses: "This policy IS NOT A MEDICARE SUPPLEMENT POLICY." The statement may be printed or affixed by sticker.

(f) Policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage shall be on the policy form then being issued by the company for this purpose.

42.09: continued

(2) Requirements for Policy Applications. Any rider or endorsement forms used to reduce or eliminate coverage at date of policy issue shall be ineffective without signed acceptance by the policyholder. Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. When the Medical Information Bureau is used by the carrier, the policy application or another appropriate notice must indicate the possible use of this service as it relates to medical information concerning the insured.

(3) Required Disclosure Forms.

(a) No individual accident and sickness insurance policy or contract may be delivered or issued for delivery in Massachusetts unless the disclosure form is delivered with the policy, or is delivered to the applicant at the time application is made. This summary must be a part of the policy and must be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than 120-point.

(b) If the policy is issued on a changed basis, a revised summary must be affixed to the policy.

(c) Except as otherwise provided, disclosure forms must provide the following information when applicable:

1. The name of carrier, the description of the policy type, and the policy number.
2. A description of the benefits in a manner that does not misrepresent the actual coverage provided.
3. Any deductibles, coinsurance, and benefit maximums.
4. Whether the policy is renewable to eligibility for Medicare.
5. Whether there are age limitations.
6. Whether the policy is subject to increase in premiums.
7. Any pre-existing condition limitations.
8. Any waiting periods.
9. Whether mental illness is covered and the extent of benefits.
10. Whether pregnancy is covered.
11. Free look provisions and the procedure for returning the policy for a refund.
12. The following statement or similar language as approved by the Commissioner: "Read your policy carefully. This disclosure statement is a very brief summary of your policy. The policy itself sets forth the rights and obligations of both you and the insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY."
13. Exclusions, limitations, and reductions listed in a manner that does not misrepresent the actual coverage provided.
14. The following statement or similar language as approved by the Commissioner: "COMPLAINTS: If you have a complaint, call your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance."

(d) Policy summaries and disclosure forms for long-term care insurance must comply with the provisions of 211 CMR 65.00.

(4) Required Disclosure for Medicare-Eligible Policyholders and Certificateholders.

(a) Guide to Health Insurance for People with Medicare.

1. Carriers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for Medicare must provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. The Guide shall also include an attachment concerning the Massachusetts Medicare Supplement Insurance Program in a form prescribed by the Commissioner in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare Supplement policies or certificates as defined in 211 CMR 71.00. Except in the case of direct response carriers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the carrier. Direct response carriers shall deliver the Guide to the applicant upon request but not later than at the time the Policy is delivered.

42.09: continued

2. For the purposes of 211 CMR 42.09(4)(a)1., "form" means the language, format, type size, type proportional spacing, bold character and line spacing.

(b) Required Notice for Non-medicare Supplement Policies.

1. Any accident and sickness insurance or long-term care insurance policy or certificate, other than a Medicare Supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. § 1395, *et seq*.); disability income policy or other policy identified in 211 CMR 71.02(2), issued for delivery in Massachusetts to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare Supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:
"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance or long-term care insurance policies or certificates described in 211 CMR 71.13(2)(d)5.a shall disclose, using the applicable statement in 211 CMR 71.100: *Appendix H*, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

42.10: Severability

If any section or portion of a section of 211 CMR 42.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 42.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

42.11: Required Notice for Policy Replacement

The notice required by 211 CMR 42.08 shall be provided, in substantially the following form:

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application)/(the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by ___ Insurance Company. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

1. Health conditions which you may presently have, may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right, under the policy you have chosen.

The above "Notice to Applicant" was delivered to me on (date).

_____ Applicant

REGULATORY AUTHORITY

211 CMR 42.00: M.G.L. c. 175, §§ 108 and 110E; c. 176, § 26; c. 176A, B and D.

(PAGES 223 THROUGH 228 ARE RESERVED FOR FUTURE USE.)