Long-Term Care Insurance Disclosures

Disclosure Requirements from Long-Term Care Insurance Model Act (#640)

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Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

A. The commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Drafting Note: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

B. No long-term care insurance policy may:

(1) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

C. Preexisting condition.

(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of “preexisting condition” that is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of “preexisting condition” does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that
insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization.

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2) (a) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.

(b) A long-term care insurance policy or rider that conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

(3) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

Drafting Note: Section 6D(3) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(3) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

E. The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return—free look. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act, the applicant is not satisfied for any reason.
This subsection shall also apply to denials of applications and any refund must be made within thirty (30) days of the return or denial.

G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6G(2)(a) through (f) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

Drafting Note: States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded;

(f) A brief description of the relationship of cost of care and benefits; and

(g) A statement that discloses to the policyholder or certificateholder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

H. A certificate issued pursuant to a group long-term care insurance policy that policy is delivered or issued for delivery in this state shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and
(3) A statement that the group master policy determines governing contractual provisions.

**Drafting Note:** The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

I. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

J. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or byrider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant’s request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

3. Any exclusions, reductions and limitations on benefits of long-term care;

4. A statement that any long-term care inflation protection option required by [cite to state’s inflation protection option requirement comparable to Section 11 of the Long-Term Care Insurance Model Regulation] is not available under this policy;

5. If applicable to the policy type, the summary shall also include:
   
   a. A disclosure of the effects of exercising other rights under the policy;
   
   b. A disclosure of guarantees related to long-term care costs of insurance charges; and
   
   c. Current and projected maximum lifetime benefits; and

6. The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with [cite to state’s basic illustration requirement comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation] or into the life insurance policy summary which is required to be delivered in accordance with [cite to state’s life insurance policy summary requirement comparable to Section 5 of the Life Insurance Disclosure Model Regulation].

K. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

1. Any long-term care benefits paid out during the month;

2. An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

3. The amount of long-term care benefits existing or remaining.
L. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

M. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Disclosures from Long-Term Care Insurance Model Regulation (#641)


A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

(2) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy that 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 these terms and an explanation of the terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.”

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of the limitations or conditions, including any required
number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits.”

F. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured’s need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits.” Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 31E(3) that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 31E(3) that the policy is not intended to be a qualified long-term care insurance contract.

Section 9. Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

Drafting Note: One method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder’s or certificateholder’s option in the event of a premium rate revision;
(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (3) if the premium rate or rate schedule is changed;

(5) (a) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(b) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(d) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subparagraph (a) of this paragraph.

(e) If the acquiring insurer in Subparagraph (d) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (d), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (d).

Drafting Note: Section 10 requires that the commissioner be provided with any information to be disclosed to applicants. Information about past rate increases needs to be reviewed carefully. If the insurer expects to provide additional information (such as a brief description of significant variations in policy provisions if the form is not the policy form applied for by the applicant or information about policy forms offered during or before the calendar years of forms with rate increases), the commissioner should be satisfied that the additional information is fairly presented in relation to the information about rate increases.
Drafting Note: It is intended that the disclosures in Section 9B be made to the employer in those situations where the employer is paying all the premium, with no contributions or coverage elections made by individual employees. In addition, if the employer has paid the entire amount of any premium increases, there is no need for disclosure of the increases to the applicant for a new certificate.

Drafting Note: States should be aware of and review situations where a group policy is no longer being issued but new certificates are still being added to existing policies.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in Appendices B and F to comply with the requirements of Subsections B and C of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

Section 20.1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings.

Drafting Note: Section 20.1 applies to policies issued for effective dates on or after the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC in 2014. Policies issued prior to the date that is six (6) months after adoption of the amended regulation should adhere to the requirements of Section 20 instead of Section 20.1. Section 20 and Section 20.1 are identical with the exception of Subsections A, C and G.

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve (12) months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, “shall provide notice” may be changed to “shall request approval.” States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;
(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing is in compliance with the provisions of this section;

(c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10.B(2)(e) or Section 20.B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;
(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

Appendix B: Disclosure Statement

☐ The answers to the questions above describe my financial situation.

Or

☐ I choose not to complete this information.

(Check one.)

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed: ___________________________   ___________________________  

(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed: ___________________________   ___________________________  

(Agent) (Date)

Agent’s Printed Name: ____________________________________________

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: ___________________________   ___________________________  

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.
The company may contact you to verify your answers.

**Drafting Note:** When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading “Disclosure Statement” to the end of the page may be removed.

**Appendix F**

**Instructions:**

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

**Insurers shall provide all of the following information to the applicant:**

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application]$_____

**Drafting Note:** Use “approved” in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): ________________.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

* Turn the Page
Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn’t buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here’s how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you’ve paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you’ve paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered “paid-up” with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your “paid-up” policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 and under</td>
<td>200%</td>
</tr>
<tr>
<td>30-34</td>
<td>190%</td>
</tr>
<tr>
<td>35-39</td>
<td>170%</td>
</tr>
<tr>
<td>40-44</td>
<td>150%</td>
</tr>
<tr>
<td>45-49</td>
<td>130%</td>
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<td>50-54</td>
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<td>62%</td>
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<td>63</td>
<td>58%</td>
</tr>
<tr>
<td>64</td>
<td>54%</td>
</tr>
</tbody>
</table>
In addition to the contingent nonforfeiture benefits described above, the following reduced “paid-up” contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced “paid-up” benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced “paid-up” contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>50%</td>
</tr>
<tr>
<td>66</td>
<td>48%</td>
</tr>
<tr>
<td>67</td>
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a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your “paid-up” policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced “paid-up” policy.

Disclosures from Guidance Manual

In separate pdf file