Rule and Regulation 4 **Agency # 054.00**

REGULATIONS CONCERNING UNDERWRITING PRACTICES, UNFAIR TRADE PRACTICES AND RELATIONS WITH POLICYHOLDERS

SECTION:

SECTION 1. Underwriting practices for individual accident, health, cash income, and life insurance policies.

A. The following principles for the underwriting of individual policies shall be used by insurers authorized to transact such insurance in the State. A medical examination shall be required for all applicants over the age of 65 years for life insurance purchased from companies writing other than on a legal reserve basis. The remainder of this regulation shall not apply to life insurance.

1. Insurance requires a high degree of good faith from all participating parties, and nowhere more than in the underwriting of individual policies.

2. Most applicants for such insurance are insurable as standard risks. A significant proportion are substandard to some degree, but are insurable either at a larger premium or with some limitation of coverage. A proportion of applicants are uninsurable. Evaluation of risk is made by the insurer on the basis of information furnished in the application, supplemented by other investigation to the extent necessary.

Disputes between insured and insurer based on underwriting practices are uncommon when a policy has been issued on an application which has elicited full pertinent information. If a policy is issued on incomplete or inaccurate information, the risk cannot be properly evaluated since there has been no meeting of minds between applicant and insurer. In such cases dispute is likely.

3. Evaluation of the disability insurance risk requires knowledge of any hazard associated with the applicant's activities; knowledge of his economic circumstances, including the existence of other insurance; and information about the applicant's health, including previous medical history. The degree of information required may vary with the nature of the benefits applied for. Dispute is most likely to arise from inadequate information about the applicant's

health; and deficiency in health information furnished in connection with the application is most likely to come to light in the investigation which follows a claim.

4. An insurer which learns that it has issued a policy on the basis of inexact information about the applicant's health must choose one of the following courses:

a. The fact of misinformation will be disregarded if the matter misrepresented is not material, as provided in Section 66-3208 of the Arkansas Insurance Code.

b. Where the misrepresentation is material, the insurer has a right to rescind. But, the insurer may offer reformation to provide the coverages which would have been furnished if full and correct information had been available with the application. Of course, in the absence of fraud, the insurer's right to rescind to limited by the first three policy years as provided in Section 66-3605(1) of the Arkansas Insurance Code.

c. Where the material misrepresentation involves a pre-existing condition from which the present claim developed, the insurer may acknowledge the validity of the policy contract but defend the claim in accordance with a provision of the valid contract. It is most important to distinguish between rescission of a contract, on the one hand, and defense of a claim in accordance with a provision of a valid contract. The insurer's right to deny liability on the ground of prior origin is limited by law to the first three policy years, as provided in Section 66-3605 (1) of the Arkansas Insurance Code.

5. The principles noted in the previous paragraphs illustrate the importance of having full and accurate information with the application. The insurer has an obligation to design its application so as to request all information which it considers pertinent. The applicant has an obligation to answer the questions accurately and completely.

6. If an application contains conflicting answers, or if an answer is clearly incomplete, the insurer has an obligation to investigate further. For example, if a question about medical history is answered with the name of a doctor, but there is no statement concerning the condition treated or the reason for the visit, the insurer has an obligation to investigate further. An insurer failing to make such an investigation would be estopped from using the material it would have found by such inquiry, either for the purposes of rescission or for the purposes of rejecting the claim on the basis of pre-existing condition.

7. If an application does not contain conflicting answers and the answers appear to be complete, the insurer should not be expected or required to investigate further to confirm the accuracy of the information given or to establish that certain details may have been omitted by the applicant which would have been of underwriting significant. For example, if a question about medical history is answered with the name of a doctor and a statement of a condition treated or reason for the visit, the insurer is entitled to rely on that information without further investigation. Information revealed on the application may cause the policy to be ridered or endorsed to exclude liability for a pre-existing condition. Otherwise, the insurer may not use the

defense of prior origin in connection with a claim based on such pre-existing condition unless there are other unadmitted details which clearly make the condition of materially greater underwriting significance than is shown on the application.

8. The applicant should not be expected to volunteer information which the insurer has not asked for in its application. If the policy which the insurer has not asked for in its application. If the policy applied for would contain a prior origin exclusion, the application should contain questions searching enough to elicit the material information. Where an insurer prefers to use a simplified application with or without are question as to the applicant's health at the time of application. Where an insurer prefers to use a simplified application with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy may exclude loss incurred within its first twelve months from a condition which pre-existed the policy, provided the policy clearly covers loss developing after twelve months from any preexisting condition not specifically excluded from coverage by the terms of the policy; and except as so provided, the policy will not be permitted to include working that would permit a defense based upon pre-existing conditions.

9. The following guides shall be used by all insurers authorized to transact disability insurance in this State in the underwriting and claims administration of such individual disability policies:

a. Questions in an application requiring the applicant's opinion regarding past or present health of a person proposed for coverage shall be asked to the best of the applicant's knowledge and belief. Questions regarding an applicant's past or present health which are phrased so as to require factual information rather than a statement of the applicant's opinion need not be so qualified. The applicant shall not be required to agree or state that he has not withheld any information or concealed any facts; however, he may be required to state that his answers are true and complete to the best of his knowledge and belief.

b. No claim shall be reduced or denied on the ground that the disease or physical condition for which claim is made pre-existing the effective date of the policy coverage unless the insurer has evidence that such disease or physical condition had manifested itself prior to the effective date of the benefit applicable thereto. Such manifestation shall be established by proof of:

1. Medical diagnosis or treatment of such disease or physical condition prior to the effective date of the benefit applicable thereto, or;

2. The existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

c. No policy provision which denies coverage because of a preexisting condition or which sets forth a waiting period shall use the phrase "the cause of which

originates". Violation will result in administrative action by this Department. In settling claims under existing policies which may contain such phrase, it is recommended that insurers be guided by the same standards as are applicable to any other phrase relating to preexisting sickness, as set forth in the paragraph immediately above.

d. Any insurer receiving information entitling it to rescind shall exercise its right thereto within a reasonable time thereafter or it shall have been deemed to have waived that right.

e. In the absence of fraud, rescission of a policy on material misrepresentation or concealment or defense of a claim on the ground of prior origin is limited to the first three policy years as provided in Section 66-3605 of the Arkansas Insurance Code. Thereafter an insurer has recourse to rescission only if fraud is involved.

f. Those parts of this section which relate to applications and the answers thereto do not apply to types of policies which do not normally lend themselves to individual underwriting, such as single premium nonrenewable policies, limited policies, credit policies, franchise policies and industrial policies.

SECTION 2. UNFAIR TRADE PRACTICES

A. The attention of all insurers and their agents is specifically directed to the provisions of the Arkansas Insurance Code, Section 66-3005, pertaining to misrepresentation of policy contracts; Section 66-2215 (1-f) providing for suspension or revocation of insurer certificates of authority; Section 66-2835 (1-f) providing for revocation, suspension or refusal to renew licenses of agents or brokers found to have used fraudulent or dishonest practices or trade practices prohibited by law. This Department will take such steps as are necessary to assure compliance with the provisions of the Insurance code dealing with fraud, misrepresentation and other injurious practices in the disability insurance field.

B. Section 66-2811 (3-c) of the Arkansas Insurance Code requires all insurers to notify the Commissioner of Insurance of the termination of any disability agent's license because of such agent's misrepresentation of policies, for acts of fraud or any other reason. The reasons for this are also required. Strict compliance with the provisions of this section is expected by this Department.

SECTION 3. RELATIONS WITH POLICYHOLDERS

A. Sections 66-3608 through 66-3612 of the Arkansas Insurance Code set forth the required individual policy provisions dealing with notice of claim, claim forms, proofs of loss, time of payment of claims and payment of claims. The provisions are clear as to the rights, duties and responsibilities of both insured and insurer in regard to the manner in which claims are to be submitted and administered. The provisions carry with them, however, the additional responsibility of the insurer to take prompt action upon receipt of any notice, inquiry or request

of the insured concerning the submission of a claim for benefits under a policy. Lax and inefficient claims administration by any insurer licensed to the business in this State is not in the public interest. Any such procedures and undue delays in the settling of claims will be investigated thoroughly by this Department and appropriate disciplinary action will be taken where warranted.

B. In order that residents of this State who purchase Individual Accident and Sickness insurance may realize more the importance of the application for insurance, no policy of such insurance, when an application containing questions relating to the medical history of the person or persons to be insured is attached thereto and made a part of the policy, shall be delivered or issued for delivery to any person in this State unless the insurer follows one of the procedures outlined below:

Procedure No. 1

A statement in the form of a sticker shall be placed on the policy and printed in a prominent manner or on paper or in ink of a contrasting color. The statement shall contain a caption and shall read substantially as follows:

IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to the company .....(Address) ..... within 10 days if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

Procedure No. 2

In lieu of Procedure No. 1, an insurer may use the method of sending the policyholder, attached to the fact page of the policy, the type of letter used by many insurers welcoming the policyholder as a new policyholder. Such a Policyholder Welcoming Letter shall contain the substance of the statement contained in Procedure No. 1 directing the attention of the insured to the answers to the questions. If Procedure No. 2 is the procedure used to comply with this regulation, the Welcoming Letter shall not be separated from the policy form when the policy is delivered personally by the agent or when the insurer sends the policy to the agent for mailing by the agent to the insured.

Procedure No. 3

In lieu of either Procedure No. 1 or Procedure No. 2., the insurer may elect to use the method of sending a letter and a photostatic copy of the application to the insured within a specified period of time from the date of delivery of the policy, such as 10 days, with a request the insured review the photostatic copy of the application, and suggesting the insured notify the insurer within 10

days if there is any error or mistake in the answers to the questions.

Other Methods of Procedure

Insurers may design methods of procedure other than the three procedures outlined above if the method is designed to achieve a similar result, especially if such procedures are designed to be used with electronic data processing equipment. Insurers shall notify this Department of the procedure they will adopt in order to comply with this regulation. If the procedure designed by a company is a procedure other than the three procedures outlined above, such a procedure shall be submitted to the Department for authorization of use of such a method of procedure prior to use.

Processing of Responses

Responses received from the policyholder to any procedure used by the insurer under the provisions of this regulation shall not be considered as constituting an amendment to the application form attached to the policy form. Responses which indicate the answers to one or more important questions are incorrect (an important question in the application is a question which relates to the acceptance of the risk or hazard assumed by the insurer), shall be processed by the insurer in a manner which develops corrective procedure.

C. The following paragraph shall apply only to persons over the age of 65 years:

1. In order to further prevent frauds, misrepresentations, sales of unnecessary insurance, and high pressure sales tactics involving senior citizens, no agent shall under any circumstances collect more than 5 per cent of the premium with the application for the period covered by the policy and this under no circumstances shall be kept by the agent but shall be immediately remitted to the company. Upon issuance of the policy by the company and delivery of this policy together with the application to the applicant either by agent or by mail, the company may then determine what period of time the applicant shall have within which to forward the remaining 95 per cent of the premium. With reference to solicitations by mail, no company shall accept more than 5 per cent of the total premium with the application, the balance to be remitted when the policy is delivered.

2. In lieu of the requirement contained in paragraph C-1, an insurer may, with the approval of the Commissioner, use a procedure providing for a Ten Day Right of Examination of such policies. Such procedure shall provide that the policy shall have printed thereon, or attached thereto, a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten days of its delivery to said person and to have the premium paid refunded if, after examination of the policy, the person is not satisfied with it for any reason. If a policyholder, pursuant to such notice, returns the policy to the company at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

The procedure set forth in this paragraph shall be filed with and approved by the

Commissioner. Such filing shall contain an explanation that it is intended to be used in lieu of the requirement set forth in paragraph C-1.

SECTION 4. EFFECTIVE DATE

This regulation shall be effective on June 15, 1967.

SECTION 5. ACKNOWLEDGEMENT

All insurers are directed to acknowledge receipt of this regulation and indicate their intention of compliance therewith.

History.-Issued April 18 1967, effective June 15, 1967.