CHAPTER 45-03-06
PREMIUM TAX PAYMENTS - ESTIMATES

45-03-06-01. Application of chapter - Exceptions.

This chapter applies to all companies doing business in the state as described in North Dakota Century Code section 26.1-03-17 and applies to all business conducted in this state, except business specifically exempted by statute, i.e., annuities (North Dakota Century Code section 26.1-03-17) and North Dakota uniform group insurance program (North Dakota Century Code chapter 54-52.1).

History: Effective September 1, 1983.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-03-17

45-03-06-02. Definitions.

Unless otherwise defined or made inappropriate by context, all words used in this chapter have meanings as given them under North Dakota Century Code chapter 26.1-03.

History: Effective September 1, 1983.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-03-17

45-03-06-03. Quarterly payments - Reconciliation.

1. Every company required to pay premium taxes in this state shall make and file a statement of estimated premium taxes for the period covered by the quarterly installment tax payment. The statement shall be on forms prescribed by the commissioner. The payments shall be made on an individual quarterly basis on or before May thirtieth, August twenty-ninth, November twenty-ninth, and March first.

2. The tax imposed under North Dakota Century Code section 26.1-03-17 shall be an estimated tax of at least twenty-five percent of the premium tax on the prior calendar year's business or eighty percent of the premium tax on the current calendar year's business for each of the first three quarters and shall be reconciled for the entire calendar year on the insurance department form and filed on or before March first of the following calendar year.

3. Any company with a certificate of authority to conduct business in this state must file a quarterly estimate form even when no tax is owed. No payment is required until the final quarter when the tax is reconciled if the estimated tax for the quarter is less than twenty-five dollars.

History: Effective September 1, 1983; amended effective May 1, 1997.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-03-17

45-03-06-04. Credits.

1. The principal office ad valorem tax credit shall be used as a credit against the premium tax liability for the calendar year in which the ad valorem tax was paid. Any unused credit may be carried over as a credit against the premium tax liability for the following calendar years but not beyond 1985. North Dakota Century Code section 26.1-03-17 requires that the credit be prorated on a quarterly basis. Credit shall be used for each quarter and shall be fully reconciled, along with the premium tax, as of the end of each calendar year, on or before March first of the subsequent year.

2. The examination credit shall be used as a credit against the premium tax liability for the quarter in which expense was paid and the succeeding three quarters. The credit is limited to expenses incurred and paid to the North Dakota department of insurance. North Dakota Century Code section 26.1-03-17 requires that the credit be prorated on a quarterly basis. The credit shall be reconciled along with the premium tax as of the end of each calendar year, on or before March first of the subsequent year.

3. The credit taken for assessments paid to the comprehensive health association of North Dakota shall be taken in the calendar year in which paid and any remaining credit used as completely as possible in each succeeding year. Credit cannot be taken for any assessments paid prior to March 21, 1983.

4. The credit for assessments paid to the North Dakota life and health insurance guaranty association shall be twenty percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid.

5. Credit may be taken in the following year for miscalculations resulting in an overpayment in a preceding reconciliation submitted with the March first payment.

6. The credit for assessments paid to the reinsurance association of North Dakota shall be taken in the calendar year in which paid. If the credit exceeds the premium tax liability the excess is not eligible to carried over to subsequent years.

History: Effective September 1, 1983; amended effective April 1, 1996; May 1, 1997; April 1, 2021.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-03-17

45-03-06-05. Fees payable annually.

All fees will be paid annually, on or before March first of each calendar year.

History: Effective September 1, 1983.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-03-17

45-03-06-06. Interest and penalties.

1. Penalties and interest shall be assessed in accordance with the provisions of North Dakota Century Code section 26.1-03-17 for a failure to file the quarterly estimated tax statement or the reconciled tax statement or both, or pay the estimated or reconciled tax.

2. If an insurance company fails to pay the quarterly estimated tax or reconciled taxes prescribed by North Dakota Century Code section 26.1-03-17 in the time required, penalties of five percent shall accrue thereon, or one hundred dollars, whichever is greater, plus six percent of the tax for each day of delay except the first day after the tax became due for that quarter or year.

3. Failure of the company to make each estimated return and payments of at least one quarter of the total reconciled tax paid during the previous calendar year, or eighty percent of the actual reconciled tax for the current calendar year, shall subject the company to the penalty and interest provided in subsection 2 on the tax payable for that calendar year.

History: Effective September 1, 1983.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-03-17

CHAPTER 45-03-26
PRINCIPLE-BASED VALUATION

45-04-12-01. Adoption.

The commissioner shall adopt the most current version of the Valuation Manual as adopted by the members of the National Association of Insurance Commissioners.

45-04-12-01. Applicability.

When establishing reserves using the principle-based valuation, the most current version of the Valuation Manual as adopted by the commissioner shall be utilized by insurers.

History: Effective April 1, 2021
General Authority: NDCC 28-32-02; NDCC 26.1-35-00.2(4)
Law Implemented: NDCC 26.1-35

CHAPTER 45-06-05.1
LONG-TERM CARE INSURANCE MODEL REGULATION

45-06-05.1-01. Applicability and scope.

Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after March 1, 2004, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations, and all similar organizations. Certain provisions of this chapter apply only to qualified long-term care insurance contracts as noted. Policies delivered or issued for delivery in this state before March 1, 2004, are governed by chapter 45-06-05.

Additionally, this chapter is intended to apply to policies having indemnity benefits triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

2. The disability income policy is advertised, marketed, or offered as insurance for long-term care services; or

3. Benefits under the policy may commence after the policyholder has reached social security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-02. Definitions.

For the purpose of this chapter, the terms "long-term care insurance", "qualified long-term care insurance", "group long-term care insurance", "commissioner", "applicant", "policy", and "certificate" shall have the meanings set forth in North Dakota Century Code section 26.1-45-01. In addition, the following definitions apply:

1. a. "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

(1) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(2) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

b. Except as provided in section 45-06-05.1-18, exceptional increases are subject to the same requirements as other premium rate schedule increases.

c. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

d. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

2. "Incidental", as used in subsection 10 of section 45-06-05.1-18, means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

3. "Qualified actuary" means a member in good standing of the American academy of actuaries.

4. "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-03. Policy definitions.

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

3. "Adult day care" means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

4. "Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

5. "Cognitive impairment" means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

6. "Continence" means the ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

7. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

8. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table or by a feeding tube or intravenously.

9. "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

10. "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

11. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended" or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as The Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

12. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

13. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

14. "Skilled nursing care", "personal care", "home care", "specialized care", "assisted living care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

15. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

16. "Transferring" means moving into or out of a bed, chair, or wheelchair.

17. All providers of services, including "skilled nursing facility", "extended care facility", "convalescent nursing home", "personal care facility", "specialized care providers", "assisted living facility", and "home care agency", shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. When the definition requires the provider be appropriately licensed, certified, or registered, it also must state what requirements a provider must meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies, or registers the provider of services under another name.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-04. Policy practices and provisions.

1. **Renewability.** The terms "guaranteed renewable" and "noncancelable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section 45-06-05.1-06.

    a. A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancelable".

    b. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

    c. The term "noncancelable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

    d. The term "level premium" may only be used when the insurer does not have the right to change the premium.

    e. In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

2. **Limitations and exclusions.** A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

    a. Preexisting conditions or diseases.

    b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of alzheimer's disease.

    c. Alcoholism and drug addiction.

d. 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 insurrection;

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

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

(5) Aviation (this exclusion applies only to non-fare-paying passengers).

e. Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available 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 provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.

f. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

g. (1) This subsection is not intended to prohibit exclusions and limitations by type of provider. However, a long-term care issuer may not deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(a) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

(b) When the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

(2) For purposes of this subdivision, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

h. This subsection is not intended to prohibit territorial limitations.

3. Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

4. Continuation or conversion.

a. Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

b. For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of

premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

c. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and any group policy which it replaced, for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

d. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. When the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. When the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except when:

   (1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

   (2) The terminating coverage is replaced not later than thirty-one days after termination, by group coverage effective on the day following the termination of coverage:

      (a) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

      (b) The premium for which is calculated in a manner consistent with the requirements of subdivision f.

h. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

j. Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon the insured individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

k. For the purposes of this section, a "managed care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

5. **Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

   a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

   b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

6. a. The premium charged to an insured shall not increase due to either:

      (1) The increasing age of the insured at ages beyond sixty-five; or

      (2) The duration the insured has been covered under the policy.

   b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under section 45-06-05.1-24, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

   c. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under section 45-06-05.1-24, the initial annual premium shall be based on the reduced benefits.

7. **Electronic enrollment for group policies.**

   a. In the case of a group defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(1) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(2) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

(3) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of nonpublic personal financial information and nonpublic personal health information as defined by chapter 45-14-01 is maintained.

b. The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-05. Unintentional lapse.

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

1. a. Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision a need not be met until sixty days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

c. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subdivision a, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice

shall be given by first-class United States mail, postage prepaid, and notice may not be given until thirty days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

2. Reinstatement. In addition to the requirement in subsection 1, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past-due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-06. Required disclosure provisions.

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

   a. 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 noncancelable. 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.

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

2. **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. If 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.

3. **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.

4. **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".

5. **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 subsection 2 of North Dakota Century Code section 26.1-45-07 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".

6. **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.

7. **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.

8. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in subsection 5 of section 45-06-05.1-27, federal tax consequences, 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.

9. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in subsection 5 of section 45-06-05.1-27, federal tax consequences, that the policy is not intended to be a qualified long-term care insurance contract.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-07. Required disclosure of rating practices to consumers.

1. This section shall apply as follows:

   a. Except as provided in subdivision b, this section applies to any long-term care policy or certificate issued in this state on or after September 1, 2004.

   b. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, 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 March 1, 2005.

2. 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.

   a. A statement that the policy may be subject to rate increases in the future;

   b. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

c. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

d. A general explanation for applying premium rate or rate schedule adjustments that shall include:

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

(2) The right to a revised premium rate or rate schedule as provided in subdivision c if the premium rate or rate schedule is changed; and

e. (1) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

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

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

(c) 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.

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

(3) 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.

(4) 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 paragraph 1.

(5) If the acquiring insurer in paragraph 4 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 paragraph 4, the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase referenced in paragraph 4.

3. An applicant shall sign an acknowledgment 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 subdivisions a and e of subsection 2. If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

4. An insurer shall use the forms in appendices B and F to comply with the requirements of subsections 2 and 3.

5. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection 2 when the rate increase is implemented.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-08. Initial filing requirements.

1. This section applies to any long-term care policy issued in this state on or after September 1, 2004.

2. An insurer shall provide the information listed in this subsection to the commissioner sixty days prior to making a long-term care insurance form available for sale.

   a. A copy of the disclosure documents required in section 45-06-05.1-07; and

   b. An actuarial certification consisting of at least the following:

      (1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

      (2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

      (3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

      (4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

         (a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

         (b) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

         (c) A statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted; and

         (d) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations in which this does not occur:

            [1] An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

            [2] If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subsection 3 based on a standard age distribution; and

(5) (a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(b) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

3. a. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

b. In the event the commissioner asks for additional information under this provision, the period in subsection 2 does not include the period during which the insurer is preparing the requested information.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-08.1. Initial filing requirements for policies issued after ~~October 1, 2019~~ March 1, 2020.

1. This section applies to any long-term care policy issued in this state on or after March 1, 2020.

2. An insurer shall provide the information listed in this subsection to the commissioner sixty days prior to making a long-term care insurance form available for sale.

a. A copy of the disclosure documents required in section 45-06-05.1-07.

b. An actuarial certification consisting of at least the following:

(1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.

(2) A statement that the policy design and coverage provided have been reviewed and taken into consideration.

(3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.

(4) A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in subparagraphs a and b:

(a) A composite margin may not be less than ten percent of lifetime claims.

(b) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

(5) (a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(b) A comparison of the premium schedules for similar policy forms currently available from the insurer with an explanation of the differences.

(6) A statement that reserve requirements have been reviewed and considered. Support for this statement must include:

(a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

(b) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

c. An actuarial memorandum prepared, dated, and signed by the member of the academy of actuaries must be included and must address and support each specific item required as part of the actuarial certification and provide at least the following information:

(1) An explanation of the review performed by the actuary prior to making the statements in paragraphs 2 and 3 of subdivision b.

(2) A complete description of pricing assumptions.

(3) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in paragraph 1 of subdivision b of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans, or states must be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

(4) A demonstration that the gross premiums include the minimum composite margin specified in paragraph 4 of subdivision b.

History: Effective ~~October 1, 2019~~ March 1, 2020; amended effective April 1, 2021.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-09. Prohibition against post-claims underwriting.

1. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

2. a. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

b. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

3. Except for policies or certificates which are guaranteed issue:

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

c. Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the insurer shall obtain one of the following:

(1) A report of a physical examination;

(2) An assessment of functional capacity;

(3) An attending physician's statement; or

(4) Copies of medical records.

4. A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

5. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the national association of insurance commissioners in appendix A.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-10. Minimum standards for home health and community care benefits in long-term care insurance policies.

1. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

b. By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the worker's licensure or certification;

e. By excluding coverage for personal care services provided by a home health aide;

f. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

g. By requiring that the insured or claimant have an acute condition before home health care services are covered;

h. By limiting benefits to services provided by Medicare-certified agencies or providers; or

i. By excluding coverage for adult day care services.

2. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

3. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-11. Requirement to offer inflation protection.

1. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

   a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

   b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

   c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

2. Where the policy is issued to a group, the required offer in subsection 1 shall be made to the group policyholder; except, if the policy is issued to a group defined in subdivision d of subsection 3 of North Dakota Century Code section 26.1-45-01 other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

3. The offer in subsection 1 shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

4. a. Insurers shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

b. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

5. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

6. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

7. a. Inflation protection as provided in subdivision a of subsection 1 shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

b. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____ , and I reject inflation protection.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-12. Requirements for application forms and replacement coverage.

1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except when the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

a. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

b. Did you have another long-term care insurance policy or certificate in force during the last twelve months?

(1) If so, with which company?

(2) If that policy lapsed, when did it lapse?

c. Are you covered by Medicaid?

d. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

2. Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold that are still in force.

b. List policies sold in the past five years that are no longer in force.

3. Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be 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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

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

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, 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 interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. 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.

_____

(Signature of Agent, Broker, or Other Representative)

[Typed Name and Address of Agent or Broker]

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

_____

(Applicant's Signature) (Date)

4. Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance 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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

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 in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, 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 interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] 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 are answered fully and correctly. 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 thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

5. If replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address, including zip code. Notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

6. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the requirements of article 45-04. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-13. Reporting requirements.

1. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percentage of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percentage of the agent's total annual sales.

2. Every insurer shall report annually by June thirtieth the ten percent of its agents with the greatest percentages of lapses and replacements as measured by subsection 1. (Appendix G)

3. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

4. Every insurer shall report annually by June thirtieth the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)

5. Every insurer shall report annually by June thirtieth the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year. (Appendix G)

6. Every insurer shall report annually by June thirtieth, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

7. For purposes of this section:

   a. Subject to subdivision c, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

   b. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition;

   c. "Policy" means only long-term care insurance; and

   d. "Report" means on a statewide basis.

8. Reports required under this section shall be filed with the commissioner.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-14. Licensing.

A producer is not authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by chapter 45-02-02 and North Dakota Century Code chapter 26.1-26.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-15. Discretionary powers of commissioner.

The commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds;

2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

3. a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

   b. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

   c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-16. Reserve standards.

1. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with North Dakota Century Code section 26.1-35-02. Claim reserves shall also be established in the case when the policy or rider is in claim status.

   Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

   In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

   a. Definition of insured events;

   b. Covered long-term care facilities;

   c. Existence of home convalescence care coverage;

   d. Definition of facilities;

   e. Existence or absence of barriers to eligibility;

   f. Premium waiver provision;

   g. Renewability;

   h. Ability to raise premiums;

   i. Marketing method;

   j. Underwriting procedures;

   k. Claims adjustment procedures;

   l. Waiting period;

   m. Maximum benefit;

   n. Availability of eligible facilities;

   o. Margins in claim costs;

   p. Optional nature of benefit;

   q. Delay in eligibility for benefit;

   r. Inflation protection provisions; and

   s. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

2. When long-term care benefits are provided other than as in subsection 1, reserves shall be determined in accordance with generally accepted accounting and reserve practices.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-17. Life insurance long-term care benefits.

1. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

   a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

   b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of North Dakota Century Code sections 26.1-33-18 through 26.1-33-28;

   c. The policy meets the disclosure requirements of subsections 4, 5, and 6 of North Dakota Century Code section 26.1-45-09;

   d. Any policy illustration that meets the applicable requirements of the national association of insurance commissioners life insurance illustrations model regulation; and

   e. An actuarial memorandum is filed with the insurance department that includes:

      (1) A description of the basis on which the long-term care rates were determined;

      (2) A description of the basis for the reserves;

      (3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

      (4) A description and a table of each actuarial assumption used. For expenses, an insurer must include a percentage of premium dollars per policy and dollars per unit of benefits, if any;

      (5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

      (6) The estimated average annual premium per policy and the average issue age;

      (7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

      (8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-18. Premium rate schedule increases.

1. This section shall apply as follows:

   a. Except as provided in subdivision b, this section applies to any long-term care policy or certificate issued in this state on or after September 1, 2004.

   b. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, 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 March 1, 2005.

2. An insurer shall request approval of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to the notice to the policyholders and shall include:

   a. Information required by section 45-06-05.1-07;

   b. Certification by a qualified actuary that:

      (1) 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; and

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

   c. An actuarial memorandum justifying the rate schedule change request that includes:

      (1) 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;

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

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

         (c) The projections shall demonstrate compliance with subsection 3; and

         (d) For exceptional increases:

            [1] The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

            [2] In the event the commissioner determines as provided in subdivision d of subsection 1 of section 45-06-05.1-02 that offsets may exist, the insurer shall use appropriate net projected experience;

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

(3) 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;

(4) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration;

(5) 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

(6) 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 paragraph 4 of subdivision b of subsection 2 of section 45-06-05.1-08.1 is projected to be exhausted.

d. 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

e. Sufficient information for review and approval of the premium rate schedule increase by the commissioner.

3. All premium rate schedule increases shall be determined in accordance with the following requirements:

a. Exceptional increases shall provide that seventy percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(1) The accumulated value of the initial earned premium times fifty-eight percent;

(2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums times fifty-eight percent; and

(4) Eighty-five percent of the present value of future projected premiums not in paragraph 3 on an earned basis;

c. In the event that a policy form has both exceptional and other increases, the values in paragraphs 2 and 4 of subdivision b will also include seventy percent for exceptional rate increase amounts; and

d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

4. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in paragraph 1 of subdivision c of subsection 2,

annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

5. If any premium rate in the revised premium rate schedule is greater than two hundred percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph 1 of subdivision c of subsection 2, shall be filed for approval by the commissioner every five years following the end of the required period in subsection 4. For group insurance policies that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

6. a. If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection 3, the commissioner may require the insurer to implement any of the following:

(1) Premium rate schedule adjustments; or

(2) Other measures to reduce the difference between the projected and actual experience.

b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to paragraph 5 of subdivision c of subsection 2, if applicable.

7. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

a. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection 8; and

b. The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to subsection 3 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent been used in the calculations described in paragraphs 1 and 3 of subdivision b of subsection 3.

8. a. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms;

(2) The rate increase is not an exceptional increase; and

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

b. In the event significant adverse lapsation has occurred and is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the

insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

(a) Be subject to the approval of the commissioner;

(b) Be based on actuarially sound principles, but not be based on attained age; and

(c) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(a) The maximum rate increase determined based on the combined experience; and

(b) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.

9. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subsection 8, prohibit the insurer from either of the following:

a. Filing and marketing comparable coverage for a period of up to five years; or

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

10. Subsections 1 through 9 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection 2 of section 45-06-05.1-02, if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(1) North Dakota Century Code sections 26.1-33-18 through 26.1-33-28; and

(2) North Dakota Century Code section 26.1-34-02.

c. The policy meets the disclosure requirements of subsections 4, 5, and 6 of North Dakota Century Code section 26.1-45-09;

d. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(1) Policy illustrations as required by chapter 45-04-01.1; and

(2) Disclosure requirements in chapter 45-04-02.

e. An actuarial memorandum is filed with the insurance department that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include a percentage of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

11. Subsections 6 and 8 shall not apply to group insurance policies as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 when:

a. The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

b. The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than twenty percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-19. Filing requirement.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to North Dakota Century Code section 26.1-45-03, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-20. Filing requirements for advertising.

1. Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the insurance commissioner of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

2. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-21. Standards for marketing.

1. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

   a. Establish marketing procedures and agent training requirements to assure that:

      (1) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

      (2) Excessive insurance is not sold or issued.

   b. Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

      "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

   c. Provide copies of the disclosure forms required in subsection 3 of section 45-06-05.1-07 (appendices B and F) to the applicant.

   d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

   e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection 1.

   f. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address, and telephone number of the program.

g. For long-term care health insurance policies and certificates, use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to subdivision c of subsection 1 of section 45-06-05.1-04.

h. Provide an explanation of contingent benefit upon lapse provided for in subdivision c of subsection 4 of section 45-06-05.1-24 and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium payment periods in subdivision d of subsection 4 of section 45-06-05.1-24.

2. In addition to the practices prohibited in North Dakota Century Code section 26.1-04-03, the following acts and practices are prohibited:

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

b. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

3. a. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in subdivision b of subsection 3 of North Dakota Century Code section 26.1-45-01, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

b. The insurer shall file with the insurance department the following material:

(1) The policy and certificate;

(2) A corresponding outline of coverage; and

(3) All advertisements requested by the insurance department.

c. The association shall disclose in any long-term care insurance solicitation:

(1) The specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees, and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members; and

(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

d. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

e. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

f. The association shall also:

(1) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(2) Actively monitor the marketing efforts of the insurer and its agents; and

(3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

(4) Paragraphs 1 through 3 shall not apply to qualified long-term care insurance contracts.

g. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.

h. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

i. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of North Dakota Century Code section 26.1-04-03.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-22. Suitability.

1. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

2. Every insurer, health care service plan, or other entity marketing long-term care insurance (the "issuer") shall:

a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

b. Train its agents in the use of its suitability standards; and

c. Maintain copies of its suitability standards and make them available for inspection upon request by the commissioner.

3. a. To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

b. The issuer and, when an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subdivision a. The efforts shall include presentation to the applicant, at or prior to application, the "long-term care insurance personal worksheet". The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in appendix B, in not less than twelve-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

c. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

d. The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in appendix B is prohibited.

4. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

5. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

6. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in appendix C, in not less than twelve-point type.

7. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

8. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-23. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and

probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-24. Nonforfeiture benefit requirement.

1. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

2. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of North Dakota Century Code section 26.1-45-14:

   a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection 5; and

   b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

3. If the offer required to be made under North Dakota Century Code section 26.1-45-14 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subdivision d of subsection 4 still applies.

4. a. After rejection of the offer required under North Dakota Century Code section 26.1-45-14, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

   b. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

   c. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age and the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percentage Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%

55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

d. A contingent benefit on lapse also must be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased, and the ratio in paragraph 2 of subdivision f is forty percent

or more. Unless otherwise required, policyholders must be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision is in addition to the contingent benefit provided by subdivision c and where both are triggered, the benefit provided must be at the option of the insured.

e. On or before the effective date of a substantial premium increase as defined in subdivision c, the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection 5. This option may be elected at any time during the one hundred twenty-day period referenced in subdivision c; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period referenced in subdivision c shall be deemed to be the election of the offer to convert in paragraph 2 unless the automatic option in paragraph 3 of subdivision f applies.

f. On or before the effective date of a substantial premium increase as defined in subdivision d, the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period referenced in subdivision d; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period referenced in subdivision d is deemed to be the election of the offer to convert in paragraph 2 if the ratio is forty percent or more.

g. For any long-term care policy issued in this state on or after March 1, 2020:

(1) If the policy or certificate was issued at least twenty years before the effective date of the increase, a value of zero percent must be used in place of all values in the above table; and

(2) Values above one hundred percent in the table in subdivision c must be reduced to one hundred percent.

5. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subdivision c of subsection 4 but not subdivision d of subsection 4, are described in this subsection:

   a. For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty, and at least three percent per year beyond age fifty.

   b. For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subdivision c.

   c. The standard nonforfeiture credit will be equal to one hundred percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection 6.

   d. (1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

      (2) Notwithstanding paragraph 1, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

         (a) The end of the tenth year following the policy or certificate issue date; or

         (b) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

   e. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

6. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

7. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

8. The requirements set forth in this section shall become effective twelve months after adoption of this provision and shall apply as follows:

   a. Except as provided in subdivisions b and c, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

   b. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

c. The last sentence in subsection 3 and subdivisions d and f of subsection 4 apply to any long-term care insurance policy or certificate issued in this state after six months after their adoption, except new certificates on a group policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 one year after adoption.

9. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the requirements of section 45-06-05.1-17 or 45-06-05.1-18, treating the policy as a whole.

10. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision c or d of subsection 4, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

11. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

    a. The nonforfeiture provision shall be appropriately captioned;

    b. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

    c. The nonforfeiture provision shall provide at least one of the following:

        (1) Reduced paid-up insurance;

        (2) Extended term insurance;

        (3) Shortened benefit period; or

        (4) Other similar offerings approved by the commissioner.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-25. Standards for benefit triggers.

1. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

2. a. Activities of daily living shall include at least the following as defined in section 45-06-05.1-03 and in the policy:

        (1) Bathing;

        (2) Continence;

        (3) Dressing;

        (4) Eating;

(5) Toileting; and

(6) Transferring; and

b. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subdivision a as long as they are defined in the policy.

3. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections 1 and 2.

4. For purposes of this section, the determination of a deficiency shall not be more restrictive than:

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

5. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

6. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

7. The requirements set forth in this section shall be effective March 1, 2005, and shall apply as follows:

a. Except as provided in subdivision b, the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

b. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-26. Additional standards for benefit triggers for qualified long-term care insurance contracts.

1. For purposes of this section, the following definitions apply:

a. (1) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(a) Being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(2) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

b. "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the secretary of the treasury.

c. "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

d. "Qualified long-term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

3. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment.

4. Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection 3 shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

5. Certifications required pursuant to subsection 3 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

6. Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-27. Standard format outline of coverage.

This section implements, interprets, and makes specific the provisions of subsection 2 of North Dakota Century Code section 26.1-45-09 in prescribing a standard format and the content of an outline of coverage.

1. The outline of coverage shall be a freestanding document, using no smaller than ten-point type.

2. The outline of coverage shall contain no material of an advertising nature.

3. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

4. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

5. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY AND STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

   This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified, long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

   O R

   Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified, long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. Terms Under Which the Policy OR Certificate May Be Continued in Force or Discontinued.

a. [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancelable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

b. [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.]

c. [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

a. [Provide a brief description of the right to return - "free look" provision of the policy.]

b. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

a. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

b. [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive,

therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

   a. [Covered services, related deductibles, waiting periods, elimination periods, and benefit maximums.]

   b. [Institutional benefits, by skill level.]

   c. [Noninstitutional benefits, by skill level.]

   d. Eligibility for Payment of Benefits.

   [Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

   [Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should 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 must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

    [Describe:

    a. Preexisting conditions;

    b. Noneligible facilities and provider;

    c. Noneligible levels of care (e.g., unlicensed providers, care, or treatment provided by a family member, etc.);

    d. Exclusions and exceptions; and

    e. Limitations.].

    [This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

    THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

    a. That the benefit level will not increase over time;

    b. Any automatic benefit adjustment provisions;

c. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

d. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and

e. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.].

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[a. State the total annual premium for the policy; and

b. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[a. Indicate if medical underwriting is used; and

b. Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-28. Requirement to deliver shopper's guide.

1. A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

   a. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

   b. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

2. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under North Dakota Century Code section 26.1-45-09.

History: Effective March 1, 2004.

General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-29. Penalties.

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

Appendix A

Rescission Reporting Form

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF _____ FOR THE REPORTING YEAR 20[ ]

Company Name:

Address:

Telephone Number:

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

Signature

Name and title (please type)

Date

Appendix B

Personal Worksheet

Long-Term Care Insurance
Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this [policy] [certificate] [rider] to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this [policy] [certificate] [rider]. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

The premium for the coverage you are considering will be [$ _____per [insert payment interval] **or a total of** [$ _____ per year] [a one-time single premium of $ _____ .]

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this [policy] [certificate] [rider] is in force.

Type of Policy and The Company's Right to Increase Premiums on the Coverage You Choose:

[Noncancellable - The company **cannot** increase your premiums on this [policy] [certificate] [rider].]

[Guaranteed renewable - The company **can** increase your premiums on this [policy] [certificate] [rider] in the future if it increases the premiums for all [policies] [certificates] [riders] like yours in this state.]

[Paid-up - This [policy] [certificate] [rider] will be paid-up after you have paid all of the premiums specified in your [policy] [certificate] [rider].]

Premium Increase History

[Name of company] has sold long-term care insurance since [year] and has sold this [policy] [certificate] [rider] since [year].

[The company has never increased its premiums for any long-term care [policy] [certificate] [rider] it has sold in this state or any other state.]

[The company has not increased its premiums for this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in this state or any other state in the last 10 years.]

[The company has increased its premiums on this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in the last 10 years. A summary of those premium increases follows.]

Questions About Your Income

You do **not** have to answer the questions that follow. They are intended to make sure you have thought about how you'll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?

Current income from employment Current income from investments Other current income

Savings Sell investments Sell other assets Money from my family Other _____

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this [policy] [certificate] [rider] if the premiums will be more than 7% of your income.

Could you afford to keep this [policy] [certificate] [rider] if your spouse or partner dies first?

Yes No Had not thought about it Do not know Does not apply

What would you do if the premiums went up, for example, by 50%?

Pay the higher premium Call the company/agent Reduce benefits
Drop the [policy] [certificate] [rider] Do not know

What is your household annual income from all sources? (check one)

[Less than $10,000] [$10,000-$19,999] [$20,000-$29,999] [$30,000-$50,000]
[More than $50,000]

Do you expect your income to change over the next 10 years? (check one)

No Yes, expect increase Yes, expect decrease

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?

Yes No Do not know

Will you buy inflation protection? (check one)

Yes No

Inflation may increase the cost of long-term care in the future.

If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?

From my income From savings From investments Sell other assets
Money from my family Other

The national average annual cost of long-term care in [insert year] was [insert $ amount], but this figure varies across the country. In 10 years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What [elimination period] [waiting period] [cash deductible] are you considering?
[Number of days_____ in [elimination period] [waiting period]

Approximate cost of care for that period: $ _____
($xxx per day times number of days in [elimination period] [waiting period], where "xxx" represents the most recent estimate of the national daily average cost of long-term care)]

[Cash Deductible $]

How are you planning to pay for your care during the [elimination period] [waiting period] [deductible period]? (check all that apply)

From my income From my savings/investments My family will pay

Questions About Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

[Less than $20,000] [$20,000-$29,999] [$30,000-$50,000] [More than $50,000]

Do you expect your assets to change over the next 10 years? (check one)

No Yes, expect to increase Yes, expect to decrease

If you are buying this [policy] [certificate] [rider] to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

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

I choose not to complete this information.
(Check one.)

I agree that the company and/or its agent (below) has reviewed this worksheet with me, including the premium, premium increase history, and potential for premium increases in the future. I understand the information contained in this worksheet. (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 worksheet to [name of company], along with your application.]

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

Signed:

(Applicant) (Date) _____

Someone from the company may contact you to discuss your answers and the suitability of this [policy] [certificate] [rider] for you.

Appendix C

Disclosure Form

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance". Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Appendix D

Response Letter

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet", which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance". Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

Please check one box and return in the enclosed envelope.

[ ] **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

[ ] **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

Appendix E

Sample Claims Denial Format

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of _____

For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____
_____
Company NAIC Number: _____
Contact Person: _____ Telephone Number:

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

□ Per Claimant - Counts each individual who makes one or a series of claim requests.

□ Per Transaction - Counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable pre-existing condition. It does not include a request for payment that is in excess of the applicable contractual limits.

In-force Data

		State Data	Nationwide Data[1]
1	Total Number of In-force Policies [Certificates] as of December 31st		

Claims and Denial Data

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for		

	Reporting Purposes (line 2 minus line 3 minus line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (line 5 divided by line 1)		
7	Number of Long-Term Care Claims Denied Due to:		
8	Long-Term Care Services Not Covered Under the policy[2]		
9	Provider/Facility Not Qualified Under the Policy[3]		
10	Benefit Eligibility Criteria Not Met[4]		
11	Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

2. Example - Home health care claim filed under a nursing home only policy.

3. Example - A facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

4. Examples - A benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

Appendix F

Potential Rate Increase Disclosure Form

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 approved for an increase [is][are] [on the application] [$].

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 CANNOT 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.)

Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you did not buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here is 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 have 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 at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	**Percentage Increase Over Initial Premium**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%

62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which subdivisions d and f of subsection 4 of section 45-06-05.1-24 are applicable.]

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:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

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:

   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.

Appendix G

Replacement and Lapse Reporting Form

Long-Term Care Insurance
Replacement and Lapse Reporting Form

For the State of _____ For the Reporting Year of

Company Name: _____ Due: June 30 annually

Company Address: _____ Company NAIC Number: ____

Contact Person: _____ Telephone Number: (__)____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percentage of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percentage of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents With the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold by This Agent	Number of Policies Replaced by This Agent	Number of Replacements as Percentage of Number Sold by This Agent

Listing of the 10% of Agents With the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold by This Agent	Number of Policies Replaced by This Agent	Number of Replacements as Percentage of Number Sold by This Agent

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales _____%

Percentage of Replacement Policies Sold to Policies in Force (as of the end of the preceding calendar year) _____%

Percentage of Lapsed Policies to Total Annual Sales _____%

Percentage of Lapsed Policies to Policies in Force (as of the end of the preceding calendar year) _____%

CHAPTER 45-06-17
SELF-INSURANCE HEALTH PLANS

45-06-17-01. Definitions.

1. "Board" means the public employees retirement board created by North Dakota Century Code section 54-52-03.

2. "Commissioner" means the insurance commissioner.

3. "Fiscal year" means a self-insurance health plan's twelve-month fiscal year.

4. "Runoff self-insurance health plan" means a self-insurance health plan that no longer has authority to self-fund but that continues to exist for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the self-insurance health plan provided coverage.

5. "Self-insurance health plan" has the same meaning as provided under North Dakota Century Code section 54-52.1-01.

6. "Service Company" means an entity licensed under North Dakota Century Code chapter 26.1-27 as an administrator of an entity licensed under North Dakota Century Code title 26.1 as an insurance company, health maintenance organization, or nonprofit health service corporation.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-02. Purpose.

The provisions in this chapter are intended to ensure the financial integrity and the competent and equitable administration of the self-insurance health plan.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-03. Scope.

This chapter shall apply to all self-insurance health plans established by the Board as set forth in North Dakota Century Code chapter 54-52.1.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-04. Ending self-insurance health plan.

1. **Termination.** The board may terminate its self-insurance health plan as set forth in North Dakota Century Code chapter 54-52.1. The board must notify the commissioner of its decision to terminate within ninety days of its decision to terminate.

2. **Runoff Self-Insurance Health Plan.** A self-insurance health plan must continue to exist as a runoff self-insurance health plan after its authority to self-fund has ended, for the purpose of paying claims, preparing reports, and administering transactions associated with the period during which the self-insurance health plan provided coverage. A runoff self-insurance health plan must continue to comply with this chapter and with other applicable North Dakota laws and rules.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-05. Administration.

1. **Service company.** The board may contract with one or more service companies for services necessary to conduct the day-to-day operations of the self-insurance health plan. The service company or companies must have expertise in and be licensed for the services provided to the self-insurance health plan. Subject to the oversight of the board, the service company or companies may, directly or through subcontractors, provide services directly related to the administration of coverage.

2. **Recordkeeping and examination authority.** A self-insurance health plan must maintain all records necessary to verify the accuracy and completeness of all reports submitted to the commissioner under section 45-06-17-07. The commissioner may examine the self-insurance health plan's records in order to verify the self-insurance health plan's compliance with this chapter and with other statutes and rules. The provisions of North Dakota Century Code chapter 26.1-03 apply to the commissioner's examination. All records concerning claims, reserves, financial transactions, and other matters necessary for the self-insurance health plan's operations are the self-insurance health plan's property and shall be retained for the current year plus the previous five years.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-06. Reserves.

A reserve must be established for all charges, claims, costs, and expenses of the self-insurance health plan. This reserve must be set at a level to cover between two and four months of expected charges, claims, costs and expenses. The reserve must be adjusted as new information becomes available.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-07. Reporting.

1. **Financial statements.** A self-insurance health plan must prepare annual financial statements containing a balance sheet; a statement of revenues, expenses, and surplus; a statement of changes in financial position; and a schedule of investments. The statements must be prepared on forms and according to instructions prescribed by the commissioner. The financial statements must be filed with the commissioner no later than one hundred eighty days after the end of the self-insurance health plan's fiscal year. In lieu of self-prepared financial statements, a self-insurance health plan may submit audited financial statements prepared by an independent certified public accountant. Said auditor's report must be submitted no later than thirty days after completion of audit.

2. **Quarterly reports.** If the commissioner determines that a self-insurance health plan's financial integrity is such that the self-insurance health plan's ability to meet obligations promptly and in full will be significantly impaired, the commissioner may require that the self-insurance health plan file quarterly reports with the commissioner no later than thirty days after the end of the first, second, and third quarters of each fiscal year. The commissioner may remove the requirement to file quarterly reports when the self-insurance health plan's financial integrity is restored. A quarterly report must contain statements of the self-insurance health plan's:

    a. Current total cash on hand and on deposit, and total investment;

    b. Current total reserve for outstanding losses reported and unreported;

    c. Gross premiums written during the quarter;

    d. Losses paid during the quarter;

    e. Current total members; and

    f. Any other information that the commissioner requests.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-08. Trade practices.

Self-insurance health plans are subject to the provisions of the unfair trade practices act found at North Dakota Century Code section 26.1-04-03.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

45-06-17-09. Disclosure.

Each policy issued by a self-insurance health plan must contain, in at least ten-point type on the front page and declaration page, the following notice:

NOTICE

This policy is issued by a self-insurance health plan. A self-insurance health plan may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-insurance health plan.

History: Effective April 1, 2021
General Authority: NDCC 26.1-36.6
Law Implemeted: NDCC 26.1-36.6

CHAPTER 45-07-01.1
CONSUMER CREDIT INSURANCE

45-07-01.1-01. Definitions.

As used in this chapter:

1. "Affiliate" has the same meaning as defined in North Dakota Century Code section 26.1-10-01.

2. "Control" has the same meaning as defined in North Dakota Century Code section 26.1-10-01.

3. "Evidence of individual insurability" means a statement furnished by the debtor, as a condition of insurance becoming effective, that relates specifically to the health status or to the health or medical history of the debtor.

4. "Loss ratio" means incurred claims divided by earned premiums.

5. "Preexisting condition" means any condition for which the insured debtor received medical advice, consultation, or treatment within six months before the effective date of coverage.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-02. Rights and treatment of debtors.

1. **Termination of group consumer credit insurance policy.**

   a. If a debtor is covered by a group consumer credit insurance policy providing for the payment of single premiums to the insurer, or any other premium payment method which prepays coverage beyond one month, then provision shall be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under the policy shall be continued for the entire period for which the premium has been paid.

   b. If a debtor is covered by a group consumer credit insurance policy providing for the payment of premiums to the insurer on a monthly basis, then the policy shall provide that, in the event of termination of the policy, termination notice shall be given to the insured debtor at least thirty days prior to the effective date of termination except when replacement of the coverage by the same or another insurer in the same or greater

amount takes place without lapse of coverage. The insurer shall provide or cause to be provided this required information to the debtor.

2. **Remittance of premiums.** If the creditor adds identifiable insurance charges or premiums for consumer credit insurance to the debt, and any direct or indirect finance, carrying, credit, or service charge is made to the debtor on the insurance charges or premiums, the creditor must remit and the insurer shall collect the premium within sixty days after it is added to the debt.

3. **Refinancing of the debt.** If the debt is discharged due to refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the refinanced debt. In all cases of termination prior to scheduled maturity, a refund of all unearned premium or unearned insurance charges paid by the debtor shall be paid or credited to the debtor as provided in section 45-07-01.1-08. In any refinancing of the debt, the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy with respect to the debt which was refinanced, at least to extent of the amount and term of the debt outstanding at the time of refinancing of the debt.

4. **Maximum aggregate provisions.** A provision in an individual policy or group certificate which sets a maximum limit on total claim payments must apply only to that individual policy or group certificate.

5. **Prepayment of debt.** If a debtor prepays the debt in full, then any consumer credit insurance covering the debt shall be terminated and an appropriate refund of the consumer credit insurance premium shall be paid or credited to the debtor in accordance with section 45-07-01.1-08. However, if the prepayment is a result of death or any other lump sum consumer credit insurance payment, no refund shall be required for the coverage under which the lump sum was paid. If a claim under credit accident and health coverage or credit unemployment coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit accident and health benefits are payable or during any period of unemployment for which credit unemployment benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period or at the end of the unemployment period.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-03. Determination of reasonableness of benefits in relation to premium charge.

1. Benefits provided by consumer credit insurance policies must be reasonable in relation to the premium charged. Premium rates charged for credit life or disability satisfy this requirement if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than forty-five percent. With the exception of deviations approved under section 45-07-01.1-10, the rates shown in sections 45-07-01.1-04 and 45-07-01.1-05, as adjusted pursuant to section 45-07-01.1-09, shall be presumed to satisfy this standard. Anticipated losses that develop or are expected to develop a loss ratio of not less than forty-five percent shall be presumed reasonable. Any insurer filing a deviation in accordance with section 45-07-01.1-10 must satisfy the sixty percent loss ratio standard on its total consumer credit insurance business, including that of affiliated insurers, for each type of insurance defined in North Dakota Century Code section 26.1-37-02 for which the deviation is being filed.

2. Premium rates charged for credit unemployment or credit property satisfy this requirement if anticipated losses are expected to develop a loss ratio of no less than forty-five percent.

3. Nonstandard coverage. If any insurer files for approval of any form providing coverage different than that described in sections 45-07-01.1-04 through 45-07-01.1-06, the insurer shall demonstrate to the satisfaction of the commissioner that the premium rates to be charged for such coverage are:

   a. Reasonably expected to develop a loss ratio of not less than sixty percent; or

   b. Actuarially consistent with the rates used for standard coverages.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-04. Credit life insurance rates.

1. **Premium rate.** Subject to the conditions and requirements in subsection 2 and section 45-07-01.1-10, the prima facie rates shown below are considered to meet the requirements of section 45-07-01.1-03 and may be used without filing additional actuarial support.

   a. Monthly outstanding balance basis: Sixty-two cents per month per one thousand dollars of outstanding insured debt on single life insurance and one dollar five cents per month per one thousand dollars of outstanding insured debt on joint life insurance if premiums are payable on a monthly outstanding balance basis.

   b. Single premium basis: If the premium is charged on a single premium basis, the rate shall be computed according to the following formula or according to a formula approved by the commissioner which produces rates substantially the same as those produced by the following formula:

$$S_p = \left(\frac{{}_nO_p}{10} \times \frac{I_t}{I_i} \times (v_{t-1})\right)$$

$$v = \frac{1}{1 + (dis)}$$

$$S_p = \sum_{t=1}^{n} \left(\frac{O_p}{10} \times \frac{I_t}{I_i} \times (v_{t-1})\right)$$

$$v = \frac{1}{1 + (dis)}$$

S_p = Single premium per one hundred dollars of initial consumer credit life insurance coverage.

O_p = Sixty-two cents, the prima facie consumer credit life insurance premium rate for monthly outstanding balance coverage from subdivision a.

I_t = The scheduled amount of insurance for month t.

I_i = Initial amount of insurance. For a net insurance policy, I_i equals the initial principal balance of the loan.

dis = .0028, representing an annual discount rate of three percent for interest plus four-tenths percent for mortality.

n = The number of months in the term of the insurance.

c. If the benefits provided are other than those described in the introduction to this subsection, premium rates for such benefits shall be actuarially consistent with the rates provided in subdivisions a and b.

d. If life coverage is sold on a joint basis involving two people, the factor for calculating the rate is 1.7.

2. **Conditions and requirements.**

a. Coverage may exclude death resulting from:

(1) War or any act of war;

(2) Suicide within one year after the effective date of the coverage;

(3) A preexisting condition that causes or substantially contributes to death within twelve months of the effective date of coverage; or

(4) Terminal illness with a life expectancy of twelve months or less which was diagnosed prior to the effective date of coverage.

b. The effective date of coverage for that part of the insurance attributable to a different advance or a charge to the plan account is the date on which the advance or charge occurs.

c. An age restriction may be included provided coverage continues until at least age seventy.

d. Guaranteed issue amount. An insurer must issue an amount up to five thousand dollars without regard to a debtor's or creditor's health status. An amount in excess of five thousand dollars may be denied based upon the company's underwriting

determination. An insurer may apply the exclusions set forth in subdivision a to the entire amount.

History: Effective January 1, 2003; amended effective April 1, 2021.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-05. Credit accident and health insurance rates.

1. Premium rate. Subject to the conditions and requirements in subsection 5 and section 45-07-01.1-10, the prima facie rates shown below are considered to meet the requirements of section 45-07-01.1-03 and may be used without filing additional actuarial support.

   a. If premiums are payable on a single premium basis for the duration of the coverage, the prima facie rate per one hundred dollars of initial insured debt for single accident and health insurance is as set forth in the table below (rates for monthly periods other than those listed shall be interpolated or extrapolated):

Number of Equal Monthly Installments	After Fourteenth Day of Disability, Retroactive to Fire Day of Disability	After Fourteenth Day of Disability	After Thirtieth Day of Disability, Retroactive to First Day of Disability	After Thirtieth Day of Disability
6	$1.31	$.83	$1.05	$.55
12	1.88	1.30	1.51	.94
24	2.54	1.85	2.03	1.39
36	3.01	2.23	2.38	1.70
48	3.40	2.56	2.65	1.94
60	3.74	2.83	2.89	2.16
72	4.00	3.06	3.06	2.32
84	4.17	3.24	3.18	2.43
96	4.30	3.38	3.27	2.51
108	4.40	3.50	3.34	2.58
120	4.47	3.60	3.40	2.62

b. If premiums are paid on the basis of a premium rate per month per thousand of outstanding insured gross debt, these premiums shall be computer according to the following formula or according to a formula approved by the commissioner which produces rates actuarially consistent with the single premium rates in subdivision a of subsection 1:

~~$$OP_n = \frac{10\ SP_n}{\sum_{t=1}^{n} \{(v_{t-1} \times (n-t+1))\}}$$~~

~~where $v = \frac{1}{1 + (dis)}$~~

$$OP_n = \frac{10\ SP_n}{\sum_{t=1}^{n} \{(v_{t-1} \times (n-t+1))\}}$$

where $v = \frac{1}{1 + (dis)}$

Where SP_n = Single premium rate per one hundred dollars of initial insured debt repayable in n equal monthly installments as shown in subdivision a.

OP_n = Monthly outstanding balance premium rate per one thousand dollars.

n = The number of months in the term of the insurance.

dis = .0025, representing an annual discount rate of three percent for interest.

c. If the coverage provided is a constant maximum indemnity for a given period of time, the actuarial equivalent of subdivisions a and b shall be used.

d. If the coverage provided is a combination of a constant maximum indemnity for a given period of time after which the maximum indemnity begins to decrease in even amounts per month, an appropriate combination of the premium rate for a constant maximum indemnity for a given period of time and the premium rate for a maximum indemnity which decreases in even amounts per month shall be used.

e. The outstanding balance rate for credit accident and health insurance may be either a term-specified rate or may be a single composite term outstanding balance rate.

2. Subject to the conditions and requirements in subsection 5 and section 45-07-01.1-10, the prima facie rates for credit accident and health insurance shown below are considered to meet the requirements of section 45-07-01.1-03 in the situation where the insurance is written on an open-end loan. These prima facie rates and the formulae used to calculate them may be used without filing additional actuarial support. Other formulae to convert from a closed-end credit rate to an open-end credit rate may be used if approved by the commissioner.

   a. If the maximum benefit of the insurance equals the net debt on the date of disability, the term of the loan is calculated according to the formula: 1/(minimum payment percent). The prima facie rate is determined by applying the calculated term to the rates shown in subsection 1. A composite minimum payment percentage may be used in place of the minimum payment percentage for a specific credit transaction.

   b. If the maximum benefit of the insurance equals the outstanding balance of the loan on the date of disability plus any interest accruing on that amount during disability, the term of the insurance (n) is estimated by using the following formula:

~~n = 1n{1-(1000i/x)}/1n(v)~~

n = ln{1-(1000i/x)}/ln(v)

where:

i = interest rate on the account or a composite interest rate used for the type of policy;

x = monthly payment per one thousand dollars of coverage consistent with the term calculated above; and

v = 1/(1 + i).

The calculated value of the term is used to look up an initial rate in subsection 1. The final prima facie rate is calculated by multiplying the initial rate by:

the adjustment n/an

where:

n is the term calculated above; and

$$a_{n} = (1 - v^{n})/i.$$

3. If the accident and health coverage is sold on a joint basis involving two people, the factor for calculating the rate is 1.8.

4. If the benefits provided are other than those described in subsection 1 or 2, rates for those
benefits shall be actuarially consistent with rates provided in subsections 1 and 2.

5. The premium rates in subsection 1 shall apply to contracts providing credit accident and health insurance and that contain the provisions below:

   a. Coverage may be excluded for disabilities resulting from:

      (1) Normal pregnancy;

      (2) War or any act of war;

      (3) Elective surgery;

      (4) Intentionally self-inflicted injury;

      (5) Sickness or injury caused by or resulting from the use of alcoholic beverages or narcotics, including hallucinogens, unless they are administered on the advice of and taken as directed, by a licensed physician other than the insured;

      (6) Flight in any aircraft other than a commercial scheduled aircraft; or

      (7) A preexisting condition from which the insured debtor becomes disabled within six months after the effective date of coverage.

   b. For the preexisting condition exclusion above, the effective date of coverage for that part of the insurance attributable to a different advance or a charge to the plan account may be the date on which the advance or charge occurs.

   c. A definition of disability providing that for the first twelve months of disability, total disability shall be defined as the inability to perform the essential functions of the insured's own occupation. Thereafter, it shall mean the inability of the insured to perform the essential functions of any occupation for which the insured is reasonably suited by virtue of education, training, or experience.

   d. No employment requirement more restrictive than one requiring that the debtor be employed full time on the effective date of coverage and for at least twelve consecutive months prior to the effective date of coverage. "Full time" means a regular workweek of not less than thirty hours.

e. An age restriction providing that no insurance will become effective on debtors on or after the attainment of age sixty-six and that all insurance will terminate upon attainment by the debtor of age sixty-six.

f. A daily benefit of not less than one-thirtieth of the monthly benefit payable under the policy.

g. Guaranteed issue. An insurer must issue a benefit amount up to five thousand dollars without regard to a debtor's or creditor's health status. A credit accident and health insurance benefit amount in excess of five thousand dollars may be denied based upon the company's underwriting determination. The benefit amount for credit accident and health insurance is defined as the monthly disability payment times the maximum number of payments payable.

History: Effective January 1, 2003; amended effective April 1, 2021.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-06. Credit unemployment insurance rates.

1. Each insurer filing rates for credit unemployment insurance shall include in its rate filing with the commissioner the appropriate rate formula upon which its rates are based, including a provision for anticipated losses. Anticipated losses that develop or are expected to develop a loss ratio of not less than forty-five percent shall be presumed reasonable. Anticipated losses may include an amount for fluctuation in loss due to catastrophe based on the experience of at least the latest nine policy years or as long as the company has been writing this line of business. If coverage is sold on a joint basis involving two people, the factor for calculating the rate is 1.8.

2. Credit unemployment insurance policies must contain benefits at least as favorable to insureds as the provisions below:

   a. Coverage for unemployment for any reason, except that coverage may be excluded for:

      (1) Voluntary forfeiture of salary, wage, or other employment income;

      (2) Resignation;

      (3) Retirement;

      (4) General strike;

      (5) Illegal walkout;

      (6) War;

      (7) Separation from the military;

      (8) Willful misconduct or criminal misconduct or unlawful behavior; and

      (9) Disability caused by injury, sickness, or pregnancy.

b. For credit unemployment insurance which provides for a monthly benefit in the event of unemployment, benefits must start after a waiting period of not longer than thirty days but need not be retroactive to the first day of unemployment and must have a maximum benefit period that is no shorter than six months.

3. Credit unemployment insurance policies may not contain eligibility requirements more restrictive than the restrictions below:

   a. Exclusion from qualification for coverage:

      (1) Self-employed individuals;

      (2) Workers in seasonal or temporary jobs, defined as jobs designed to last six consecutive months or less; and

      (3) Debtors who have been notified either orally or in writing of any layoff or of employment termination either now or within the next sixty days.

      This exclusion must be disclosed to all prospective insureds.

   b. No employment requirement more restrictive than one requiring that the debtor be employed full time on the effective date of coverage for at least twelve consecutive months prior to the effective date of coverage. "Full time" means a regular workweek of not less than thirty hours.

   c. An age restriction providing that no insurance will become effective on debtors on or after the attainment of age sixty-six and that all insurance will terminate upon attainment by the debtor of age sixty-six.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-07. Credit property insurance rates.

1. Each insurer filing rates for credit property insurance shall include in its rate filing with the commissioner the appropriate rate formula upon which its rates are based, including a provision for anticipated losses. Anticipated losses that develop or are expected to develop a loss ratio of no less than forty-five percent shall be presumed to be reasonable. Anticipated losses may include an amount for fluctuation in loss due to catastrophe.

2. Credit property rates must provide for at a minimum the following coverages found in the standard fire policy and extended coverage endorsement: fire, lightning, riot, riot attending a strike, civil commotion, smoke, aircraft and vehicle damage, windstorm, hail, and explosion.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-08. Refund formulas.

1. In the event of termination, no charge for consumer credit insurance may be made for the first fifteen days of a month and a full month may be charged for sixteen days or more of a month.

2. The requirements of the consumer credit insurance law that refund formulas be filed with the commissioner shall be considered fulfilled if the refund formulas are set forth in the individual policy or group certificate filed with the commissioner.

3. No refund of five dollars or less need be made.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-09. Experience reports and adjustment of prima facie rates.

1. The commissioner will, on a triennial basis, beginning January 1, 2006, review the loss ratio standards set forth in section 45-07-01.1-03 and the prima facie rates set forth in sections 45-07-01.1-04 and 45-07-01.1-05 and determine therefrom the rate of expected claims on a statewide basis, compare such rate of expected claims with the rate of actual claims for the preceding three years determined from the incurred claims and earned premiums at prima facie rates reported in the annual statement supplement or other available source, and publish the adjusted actual statewide prima facie rates to be used by insurers during the next triennium. The rates will reflect the difference between:

   a. Actual claims based on experience; and

   b. Expected claims based on the loss ratio standards set forth in section 45-07-01.1-03 applied to the prima facie rates set forth in sections 45-07-01.1-04 and 45-07-01.1-05.

2. The commissioner will, on a triennial basis, review the discount rates for interest included in the formulae in subsection 1 of section 45-07-01.1-04 and subsection 1 of section 45-07-01.1-05 and has the discretion to adjust those discount rates.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-10. Use of rates.

1. **Use of prima facie rates.** An insurer that files rates or has rates on file that are equivalent to the prima facie rates shown in sections 45-07-01.1-04 and 45-07-01.1-05, to the extent adjusted pursuant to section 45-07-01.1-09, may use those rates without further proof of their reasonableness.

2. **Use of rates higher than prima facie rates.** An insurer may file for approval of and use rates that are higher than the prima facie rates shown in sections 45-07-01.1-04 and 45-07-01.1-05, to the extent adjusted pursuant to section 45-07-01.1-09, as long as the filed rates are consistent with the provisions of section 45-07-01.1-03.

   If rates higher than the prima facie rates shown in sections 45-07-01.1-04 and 45-07-01.1-05, to the extent adjusted pursuant to section 45-07-01.1-09, are filed for approval, the filing shall specify the account or accounts to which the rates apply. The rates may be:

   a. Applied uniformly to all accounts of the insurer;

   b. Applied on an equitable basis approved by the commissioner to only one or more accounts of the insurer for which the experience has been less favorable than expected; or

   c. Applied according to a case-rating procedure on file with the commissioner.

3. **Approval period of deviated rates.**

   a. A rate that deviates from a prima facie rate will be in effect for a period of time not longer than the experience period used to establish the rate, i.e., one year, two years, or three years. An insurer may file for a new rate before the end of a rate period but not more often than once during any twelve-month period.

   b. Notwithstanding the provision of subsection 1, if an account changes insurers, the rate approved to be used for the account by the prior insurer is the maximum rate that may be used by the succeeding insurer for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on the account, if sooner.

4. **Use of rates lower than filed rates.** An insurer may at any time use a rate for an account that is lower than its filed rate without notice to the commissioner.

5. **Glossary of terms and definitions.**

   a. "Experience" means "earned premiums" and "incurred losses" during the experience period.

   b. "Experience period" means the most recent period of time for which earned premiums and incurred losses are reported but not for a period longer than three full years.

   c. "Incurred losses" means total claims paid during the experience period, adjusted for the change in claim reserve.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-11. Supervision of consumer credit insurance operations.

1. Each insurer transacting credit insurance in this state shall be responsible for conducting a thorough periodic triennial review of creditors with respect to their credit insurance business with such creditors to assure compliance with the insurance laws of this state and the regulation promulgated by the commissioner.

2. Written records of such reviews shall be maintained by the insurer for review by the commissioner.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-12. Prohibited transactions.

The following practices, when engaged in by insurers in connection with the sale or placement of credit insurance, or as an inducement thereto, shall constitute unfair methods of competition and shall be subject to the Unfair Trade Practices Act of this state.

1. The offer or grant by an insurer to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than the payment of agent's commissions;

2. Agreement by an insurer to deposit with a bank or financial institution money or securities of the insurer with the design or intent that the same shall affect or take the place of a deposit of money or securities which otherwise would be required of the creditor by the bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement; and

3. Deposit by an insurer of money or securities without interest or at a lesser rate of interest than is currently being paid by the creditor, bank, or financial institution to other depositors of like amounts for similar durations. This subsection shall not be construed to prohibit the maintenance by an insurer of such demand deposits or premium deposit accounts as are reasonably necessary for use in the ordinary course of the insurer's business.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

45-07-01.1-13. Severability.

If any provision or clause of this chapter or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared severable.

History: Effective January 1, 2003.
General Authority: NDCC 26.1-37-15
Law Implemented: NDCC 26.1-37

CHAPTER 45-09-01

SURPLUS LINES INSURANCE

Section

45-09-01-01. Definitions.

Unless otherwise defined, or made inappropriate by context, all words used in this chapter have meanings given to them under North Dakota Century Code chapters 26.1-02, 26.1-26, and 26.1-44.

History: Effective January 1, 1982.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44

45-09-01-02. Surplus lines insurance producer application.

The insurance commissioner will not issue a resident surplus lines insurance producer's license until the applicant has met the requirements of North Dakota Century Code section 26.1-26-17, has completed and filed with the commissioner a completed application for a surplus lines insurance producer license, and paid the license fee. An applicant for a nonresident surplus lines insurance producer license must hold an active resident surplus lines insurance producer license in the applicant's home state and must complete and file with the commissioner an application for a nonresident surplus lines insurance producer license and pay the license fee.

History: Effective January 1, 1982; amended effective December 1, 2001; January 1, 2008; July 1, 2012.
General Authority: NDCC 26.1-26-49, 26.1-44-09
Law Implemented: NDCC 26.1-26-17, 26.1-26-20

45-09-01-03. Surplus lines insurance producer must conduct search.

The licensed surplus lines insurance producer seeking the placement of nonadmitted insurance must conduct a diligent search to ascertain whether the insurance, indemnity contract, or surety bond can be procured from a company authorized to do business in this state. The surplus lines insurance producer may rely on a diligent search done by a licensed insurance producer or the insured if the surplus lines insurance producer deems it sufficient. ~~Within sixty days after~~ After the placing of any surplus lines insurance, the surplus lines insurance producer must complete and file with the commissioner a surplus lines affidavit confirming such a search has been done no later than March first for the quarter ending the

preceding December thirty-first, June first for the quarter ending the preceding March thirty-first, September first for the quarter ending the preceding June thirtieth, and December first for the quarter ending the preceding September thirtieth of each year. The affidavit is not required if the insured is an exempt commercial purchaser as defined in North Dakota Century Code section 26.1-44-02.

History: Effective January 1, 1982; amended effective December 1, 2001; July 1, 2012, April 1, 2021.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-04. Presumption - Diligent search.

A presumption that a diligent search has been made and that the insurance producer was unable to procure the insurance, indemnity contract, or surety bond desired from a company authorized to do business in this state is created when the insurance, contract, or bond is written in one of the categories set out in Appendix I.

History: Effective January 1, 1982; amended effective December 1, 2001; January 1, 2008; July 1, 2012.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-05. Other acceptable lines of coverage.

The categories designated in Appendix I are not to be considered as the only lines of coverage in which unauthorized insurers may be used. Other categories of coverage not listed may be acceptable because of special underwriting considerations, i.e., losses, high exposure, etc. Any exceptions must be fully explained on the surplus lines report of placement. The securing of advantage as to lower premium rates or as to the terms of the insurance contract do not constitute justification nor are they special underwriting considerations sufficient to allow the surplus lines broker to use an unauthorized company nor lines of coverage other than those designated in Appendix I.

History: Effective January 1, 1982; amended effective December 1, 2001; January 1, 2008; July 1, 2012.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-06. Surplus lines affidavit - Time for filing.

Repealed effective July 1, 2012.

45-09-01-07. Surplus lines affidavit - Limits on availability.

Repealed effective July 1, 2012.

45-09-01-08. Additional policy endorsement requirement.

Repealed effective July 1, 2012.

45-09-01-09. Statement of taxable premiums.

Repealed effective July 1, 2012.

APPENDIX I

Categories of Acceptable Surplus Lines Coverage

The following categories of surplus lines coverage are not the only lines which may be written in North Dakota. Other lines of coverage not on this list may be acceptable because of special underwriting considerations. Any exceptions must be fully explained on the surplus lines report of placement.

If the coverage written is in an approved category, there is a presumption that after diligent search the insurance, indemnity contract, or surety bond desired cannot be procured from a company authorized to do business in this state.

These categories may be changed from time to time at the discretion of the insurance commissioner subject to provisions of North Dakota Century Code chapter 28-32, the Administrative Agencies Practice Act.

1. Fiduciary liability.
2. Professional liability (E & O) except for hospitals.
3. Directors and officers.
4. Ocean marine cargo, liability and hull.
5. Hazardous cargo and short-term trip transit.
6. Bridges (large).
7. Heavy woodworking property (unprotected, high-value sawmills).
8. Product liability (hazardous).
9. Ski lifts and tows' liability.
10. Fireworks, ammunition, fuse, cartridges, power, nitroglycerine, explosive gases.
11. Environmental impairment - pollution.
12. Kidnap ransom.
13. Oil and gas liability and marine.
14. Livestock mortality (high values and unusual).
15. Short tail (hole-in-one, 300 bowling score, etc.).
16. Large utilities (generation, transmission).
17. Building demolition and moving.
18. Mono line liquor legal liability.
19. Surcharged fire and allied lines excluding uncontrolled marine.

20. High-value substandard private passenger automobile.

21. Commercial automobile physical damage coverage in excess of rating organizations' filed rates.

22. Any excess liability coverages.

23. Day care liability insurance coverages.

History: Amended effective February 1, 1983; November 1, 1987; December 1, 2001; January 1, 2008; July 1, 2012.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

ARTICLE 45-11
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

CHAPTER 45-11-01
NOTICE TO POLICY OWNERS

45-11-01-01. Required notice to policy owners.

A document that describes the general purposes and current limitations of the North Dakota life and health insurance guaranty association as required by subsections 2 and 3 of section 26.1-38.1-16 of the North Dakota Century Code must be in the form and contain the language printed in the notice shown in exhibit A.

History: Effective September 1, 1990; amended effective January 1, 2000; July 1, 2012; April 1, 2021.
General Authority: NDCC 26.1-38.1-16
Law Implemented: NDCC 26.1-38.1-16

(Exhibit A cannot be accurately reproduced for publication. Users should contact the Insurance Commissioner to obtain a correct copy)

EXHIBIT A

NOTICE OF PROTECTION PROVIDED BY THE

NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the North Dakota Life and Health Insurance Guaranty Association (" ~~the~~ Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs).)

The protections provided by the Association are based on contract obligations up to the following amounts:

1. Life Insurance

    a. $300,000 in death benefits

    b. $100,000 in cash surrender or withdrawal values

2. Health Insurance

    a. $500,000 ~~in hospital, medical and surgical insurance benefits~~ for health benefit plans (see definition below)

    b. $300,000 in disability income insurance benefits

    c. $300,000 in long-term care insurance benefits

    d. $100,000 in other types of health insurance benefits

3. Annuities

    a. $250,000 in ~~withdrawal and cash values~~ the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to ~~hospital, medical, and surgical insurance benefits~~ health benefit plans.

“Health benefit plan” is defined in North Dakota Century Code section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Benefits provided by a long-term care (LTC) rider to a life insurance policy of annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life and Health Insurance Guaranty Association

North Dakota Insurance Department

P.O. Box 2422	600 East Boulevard Avenue, Dept. 401
Fargo, ND 58108	Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

CHAPTER 45-14-01
PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION

45-14-01-01. Authority.

This rule is adopted under North Dakota Century Code section 26.1-02-27.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-02. Purpose and scope.

1. **Purpose.** This chapter governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the state insurance department. This chapter:

a. Requires a licensee to provide notice to individuals about its privacy policies and practices;

b. Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

c. Provides methods for individuals to prevent a licensee from disclosing that information.

2. **Scope.** This chapter applies to:

a. Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family, or household purposes from licensees. This chapter does not apply to information about companies or about individuals who obtain products or services for business, commercial, or agricultural purposes; and

b. All nonpublic personal health information.

3. **Compliance.** A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or rules that meet the requirements of title V of the Gramm-Leach-Bliley Act [Pub. L. 102-106] may nonetheless be deemed to be in compliance with title V of the Gramm-Leach-Bliley Act in the other state.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-03. Rule of construction.

The examples in this chapter and the sample clauses in appendix A are not exclusive. Compliance with an example or use of sample clause, to the extent applicable, constitutes compliance with this chapter.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-04. Definitions.

As used in this chapter, unless the context requires otherwise:

1. "Affiliate" means a company that controls, is controlled by, or is under common control with another company.

2. a. "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

b. Examples:

(1) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

(a) Presents the information in the notice in clear, concise sentences, paragraphs, and sections;

(b) Uses short explanatory sentences or bullet lists whenever possible;

(c) Uses definite, concrete, everyday words and active voice whenever possible;

(d) Avoids multiple negatives;

(e) Avoids legal and highly technical business terminology whenever possible; and

(f) Avoids explanations that are imprecise and readily subject to different interpretations.

(2) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

(a) Uses a plain-language heading to call attention to the notice;

(b) Uses a typeface and type size that are easy to read;

(c) Provides wide margins and ample line spacing;

(d) Uses boldface or italics for key words; and

(e) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(3) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site such as text, graphics, hyperlinks, or sound do not distract attention from the notice, and the licensee either:

(a) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(b) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature, and relevance of the notice.

3. "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

4. "Commissioner" means the insurance commissioner of the state.

5. "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization.

6. a. "Consumer" means an individual who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative.

b. Examples:

(1) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment, or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(2) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(3) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(4) An individual is a licensee's consumer if:

(a) [1] The individual is a beneficiary of a life insurance policy underwritten by the licensee;

[2] The individual is a claimant under an insurance policy issued by the licensee;

[3] The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

[4] The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(b) The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under sections 45-14-01-14, 45-14-01-15, and 45-14-01-16.

(5) Provided that the licensee provides the initial, annual, and revised notices under sections 45-14-01-05, 45-14-01-06, and 45-14-01-09 to the plan sponsor, group or blanket insurance policyholder, or group annuity contract holder, and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under sections 45-14-01-14, 45-14-01-15, and 45-14-01-16, an individual is not the consumer of the licensee solely because the individual is:

(a) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary; or

(b) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(6) (a) The individuals described in subparagraphs a and b of paragraph 5 are consumers of a licensee if the licensee does not meet all the conditions of paragraph 5.

(b) In no event shall the individuals, solely by virtue of the status described in subparagraphs a and b of paragraph 5, be deemed to be customers for purposes of this rule.

(7) An individual is not a licensee's consumer solely because the individual is a beneficiary of a trust for which the licensee is a trustee.

(8) An individual is not a licensee's consumer solely because the individual has designated the licensee as trustee for a trust.

7. "Consumer reporting agency" has the same meaning as in section 603(f) of the federal Fair Credit Reporting Act [15 U.S.C. 1681a(f)].

8. "Control" means:

a. Ownership, control, or power to vote twenty-five percent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

b. Control in any manner over the election of a majority of the directors, trustees, or general partners, or individuals exercising similar functions, of the company; or

c. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

9. "Customer" means a consumer who has a customer relationship with a licensee.

10. a. "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes.

b. Examples:

(1) A consumer has a continuing relationship with a licensee if:

(a) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(b) The consumer obtains financial, investment, or economic advisory services relating to an insurance product or service from the licensee for a fee.

(2) A consumer does not have a continuing relationship with a licensee if:

(a) The consumer applies for insurance but does not purchase the insurance;

(b) The licensee sells the consumer travel insurance in an isolated transaction;

(c) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(d) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(e) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(f) The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

(g) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(h) For the purposes of this chapter, the individual's last-known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the

postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

11. a. "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 [12 U.S.C. 1843(k)].

b. Financial institution does not include:

(1) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the commodity futures trading commission under the Commodity Exchange Act [U.S.C. 1 et seq.];

(2) The federal agricultural mortgage corporation or any entity charged and operating under the Farm Credit Act of 1971 [12 U.S.C. 2001 et seq.]; or

(3) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales, including sales of servicing rights, or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

12. a. "Financial product or service" means a product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under section 4(k) of the Bank Holding Company Act of 1956 [12 U.S.C. 1843(k)].

b. Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

13. "Health care" means:

a. Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests, or counseling that:

(1) Relates to the physical, mental, or behavioral condition of an individual; or

(2) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

b. Prescribing, dispensing, or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

14. "Health care provider" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law, or a health care facility.

15. "Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

a. The past, present, or future physical, mental, or behavioral health or condition of an individual;

b. The provision of health care to an individual; or

c. Payment for the provision of health care to an individual.

16. a. "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

b. Insurance service includes a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

17. a. "Licensee" means all licensed insurers, producers, and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the insurance law of this state and health maintenance organizations holding a certificate of authority pursuant to North Dakota Century Code chapter 26.1-18.1. As used herein, the term "licensee" does not include either of the following:

(1) North Dakota life and health insurance guaranty association created pursuant to North Dakota Century Code chapter 26.1-38; or

(2) North Dakota insurance guaranty association created pursuant to North Dakota Century Code chapter 26.1-42.1.

b. A licensee is not subject to the notice and authorization requirements for nonpublic personal financial information set forth in this chapter if the licensee is an employee, agent, or other representative of another licensee ("the principal") and:

(1) The principal otherwise complies with, and provides the notices required by, the provisions of this chapter; and

(2) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates unless in a manner permitted by this chapter.

c. (1) Subject to paragraph 2, "licensee" also includes an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to North Dakota Century Code chapter 26.1-44.

(2) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and authorization requirements for nonpublic personal financial information set forth in this rule provided:

(a) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under section 45-14-01-14, except as permitted by section 45-14-01-15 or 45-14-01-16; and

(b) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in sixteen-point type:

PRIVACY NOTICE

"Neither the U.S. brokers that handled this insurance nor the insurers that have underwritten this insurance will disclose nonpublic personal information concerning the buyer to nonaffiliates of the brokers or insurers except as permitted by law."

18. a. "Nonaffiliated third party" means any person except:

(1) A licensee's affiliate; or

(2) A person employed jointly by a licensee and any company that is not the licensee's affiliate, but nonaffiliated third party includes the other company that jointly employs the person.

b. Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the federal Bank Holding Company Act [12 U.S.C. 1843(k)(4) (H) and (I)].

19. "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

20. a. "Nonpublic personal financial information" means:

(1) Personally identifiable financial information; and

(2) Any list, description, or other grouping of consumers, and publicly available information pertaining to them, that is derived using any personally identifiable financial information that is not publicly available.

b. Nonpublic personal financial information does not include:

(1) Health information;

(2) Publicly available information, except as included on a list described in paragraph 2 of subsection a; or

(3) Any list, description, or other grouping of consumers, and publicly available information pertaining to them, that is derived without using any personally identifiable financial information that is not publicly available.

c. Examples of lists:

(1) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(2) Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

21. "Nonpublic personal health information" means health information:

a. That identifies an individual who is the subject of the information; or

b. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

22. a. "Personally identifiable financial information" means any information:

(1) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(2) About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(3) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

b. Examples:

(1) Information included. Personally identifiable financial information includes:

(a) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(b) Account balance information and payment history;

(c) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(d) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(e) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(f) Any information the licensee collects through an internet cookie, an information-collecting device from a web server; and

(g) Information from a consumer report.

(2) Information not included. Personally identifiable financial information does not include:

(a) Health information;

(b) A list of names and addresses of customers of an entity that is not a financial institution; and

(c) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names, or addresses.

23. a. "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(1) Federal, state, or local government records;

(2) Widely distributed media; or

(3) Disclosures to the general public which are required to be made by federal, state, or local law.

b. Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(1) That the information is of the type that is available to the general public; and

(2) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

c. Examples:

(1) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(2) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper, or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(3) Reasonable basis.

(a) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(b) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed the licensee that the telephone number is not unlisted.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-05. Initial privacy notice to consumers required.

1. **Initial notice requirement.** A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

a. Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subsection 5; and

b. Consumer. A consumer, when the licensee requests authorization to disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by sections 45-14-01-15 and 45-14-01-16.

2. **When initial notice to a consumer is not required.** A licensee is not required to provide an initial notice to a consumer under subdivision b of subsection 1 if:

a. The licensee does not request authorization to disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by sections 45-14-01-15 and 45-14-01-16, and the licensee does not have a customer relationship with the consumer; or

b. A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

3. **When the licensee establishes a customer relationship.**

a. General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

b. Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

(1) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(2) Agrees to obtain financial, economic, or investment advisory services relating to insurance products or services for a fee from the licensee.

4. **Existing customers.** When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, the licensee satisfies the initial notice requirements of subsection 1 as follows:

a. The licensee may provide a revised policy notice, under section 45-14-01-09, that covers the customer's new insurance product or service; or

b. If the initial, revised, or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subsection 1.

5. Exceptions to allow subsequent delivery of notice.

a. A licensee may provide the initial notice required by subdivision a of subsection 1 within a reasonable time after the licensee establishes a customer relationship if:

(1) Establishing the customer relationship is not at the customer's election; or

(2) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

b. Examples of exceptions:

(1) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(2) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(3) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

6. **Delivery.** When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to section 45-14-01-10. If the licensee uses a short-form initial notice for noncustomers according to subsection 4 of section 45-14-01-07, the licensee may deliver its privacy notice according to subdivision c of subsection 4 of section 45-14-01-07.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-06. Annual privacy notice to customers required.

1. a. General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

   b. Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year one, the licensee shall provide an annual notice to that customer by December 31 of year two.

2. Exception to General Rule. A licensee that provides nonpublic personal information to nonaffiliated third parties only in accordance with Sections 45-14-01-14, 45-14-01-15, or 45-14-01-16 and has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent notice sent to consumers in accordance with this section or Section 45-14-01-05 shall not be required to provide an annual notice under this section until such time as the licensee fails to comply with any criteria described in this paragraph.

3. a. Termination of customer relationship. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

   b. Examples:

      (1) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

      (2) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

      (3) For the purposes of this rule, a licensee no longer has a continuing relationship with an individual if the individual's last-known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

      (4) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

4. Delivery. When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to section 45-14-01-10.

History: Effective December 1, 2001; Amended Effective April 1, 2021.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-07. Information to be included in privacy notices.

1. **General rule.** The initial, annual, and revised privacy notices that a licensee provides under sections 45-14-01-05, 45-14-01-06, and 45-14-01-09 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

   a. The categories of nonpublic personal financial information that the licensee collects;

   b. The categories of nonpublic personal financial information that the licensee discloses;

   c. The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under sections 45-14-01-15 and 45-14-01-16;

   d. The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under sections 45-14-01-15 and 45-14-01-16;

   e. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under section 45-14-01-14, and no other exception in sections 45-14-01-15 and 45-14-01-16 applies to that disclosure, a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

   f. An explanation of the consumer's right under subsection 1 of section 45-14-01-11 to authorize or not to authorize the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

   g. Any disclosures that the licensee makes under section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act [15 U.S.C. 1681a(d)(2)(A)(iii)] (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

   h. The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

   i. Any disclosure that the licensee makes under subsection 2.

2. **Description of parties subject to exceptions.** If a licensee discloses nonpublic personal financial information as authorized under sections 45-14-01-15 and 45-14-01-16, the licensee is not required to list those exceptions in the initial or annual privacy notices required by sections 45-14-01-05 and 45-14-01-06. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

3. Examples:

   a. Categories of nonpublic personal financial information that the licensee collects. A licensee

satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(1) Information from the consumer;

(2) Information about the consumer's transactions with the licensee or its affiliates;

(3) Information about the consumer's transactions with nonaffiliated third parties; and

(4) Information from a consumer reporting agency.

b. Categories of nonpublic personal financial information a licensee discloses.

(1) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in subdivision a, as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(a) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address, and social security number;

(b) Transaction information, such as information about balances, payment history, and parties to the transaction; and

(c) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(2) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(3) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

c. Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(1) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(2) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking, or securities brokerage.

(3) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

d. Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in section 45-14-01-14 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subdivision e of subsection 1 if it:

(1) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subdivision b of subsection 1, as applicable; and

(2) States whether the third party is:

(a) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(b) A financial institution with whom the licensee has a joint marketing agreement.

e. Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under sections 45-14-01-15 and 45-14-01-16, the licensee may simply state that fact, in addition to the information it shall provide under subdivisions a, h, and i of subsection 1 and subsection 2.

f. Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(1) Describes in general terms who is authorized to have access to the information; and

(2) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

4. Short-form initial notice regarding request for authorization for noncustomers.

a. A licensee may satisfy the initial notice requirements in subdivision b of subsection 1 of section 45-14-01-05 and subsection 3 of section 45-14-01-08 for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers a notice regarding request for authorization as required in section 45-14-01-08.

b. A short-form initial notice shall:

(1) Be clear and conspicuous;

(2) State that the licensee's privacy notice is available upon request; and

(3) Explain a reasonable means by which the consumer may obtain that notice.

c. The licensee shall deliver its short-form initial notice according to section 45-14-01-10. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to section 45-14-01-10.

d. Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(1) Provides a toll-free telephone number that the consumer may call to request the notice; or

(2) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

5. **Future disclosures.** The licensee's notice may include:

   a. Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

   b. Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

6. **Sample clauses.** Sample clauses illustrating some of the notice content required by this section are included in appendix A.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-08. Notice to consumers regarding request for authorization.

1. a. Form of notice. If a licensee is required to provide notice under subsection 1 of section 45-14-01-11, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to authorize disclosures under that section. The notice shall state:

   (1) That the licensee may only disclose nonpublic personal financial information about its consumer to a nonaffiliated third party if the licensee first obtains authorization from the consumer; and

   (2) That the consumer has the right to authorize or not to authorize that disclosure.

   b. Examples: Adequate notice. A licensee provides adequate notice that the consumer has the right to authorize or not to authorize the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

   (1) Identifies all of the categories of nonpublic personal financial information that it will disclose if authorization is obtained, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in subdivisions b and c of subsection 1 of section 45-14-01-07, and states that the consumer has the right to authorize or not to authorize the disclosure of that information; and

   (2) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the authorization would apply.

2. Same form as initial notice permitted. A licensee may provide the request for authorization together with or on the same written or electronic form as the initial notice the licensee provides in accordance with section 45-14-01-05.

3. Initial notice required when request for authorization delivered subsequent to initial notice. If a licensee provides the notice to consumers regarding request for authorization later than required for the initial notice in accordance with section 45-14-01-05, the licensee shall also include a copy of the initial notice with the notice regarding request for authorization in writing or, if the consumer agrees, electronically.

4. Joint relationships:

   a. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single notice to the joint consumers. The licensee's notice shall explain how the licensee will treat an authorization by a joint consumer, as explained in subdivision b.

   b. Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may:

      (1) Send a single authorization notice to John's address.

      (2) Permit John and Mary to make different authorizations, provided if John provides authorization and Mary does not, the licensee may only disclose nonpublic personal financial information about John, but not about Mary and not about John and Mary jointly.

5. Duration of consumer's authorization. An authorization must specify the length of time for which the authorization is valid.

6. Delivery. When a licensee is required to deliver a notice by this section, the licensee shall deliver it according to section 45-14-01-10.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-09. Revised privacy notices.

1. **General rule.** Except as otherwise authorized in this rule, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under section 45-14-01-05, unless:

   a. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

   b. The licensee has provided a new notice to the consumer regarding requests for authorization and a new authorization; and

   c. The licensee has obtained authorization from the consumer whose nonpublic personal financial information is sought to be disclosed.

2. **Examples.**

   a. Except as otherwise permitted by sections 45-14-01-14, 45-14-01-15, and 45-14-01-16, a licensee shall provide a revised notice if it requests authorization to disclose:

      (1) A new category of nonpublic personal financial information to any nonaffiliated third party;

      (2) Nonpublic personal financial information to a new category of nonaffiliated third party; or

      (3) Nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not authorized the disclosure.

b. A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

3. **Delivery.** When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to section 45-14-01-10.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-10. Delivery.

1. How to provide notices. A licensee shall provide any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

2. a. Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(1) Hand delivers a printed copy of the notice to the consumer;

(2) Mails a printed copy of the notice to the last-known address of the consumer separately, or in a policy, billing, or other written communication;

(3) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service; or

(4) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

b. Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(1) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(2) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

3. Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

a. The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

b. The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

4. Oral description of notice insufficient. A licensee may not provide any notice required by this rule solely by orally explaining the notice, either in person or over the telephone.

5. Retention or accessibility of notices for customers.

   a. For customers only, a licensee shall provide the initial notice required by subdivision a of subsection 1 of section 45-14-01-05, the annual notice required by subsection 1 of section 45-14-01-06, and the revised notice required by section 45-14-01-09 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

   b. Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

      (1) Hand delivers a printed copy of the notice to the customer;

      (2) Mails a printed copy of the notice to the last-known address of the customer; or

      (3) Makes its current privacy notice available on a web site or a link to another web site for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

6. Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee may also provide a notice on behalf of another financial institution.

7. Joint relationships. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual, and revised notice requirements of subsection 1 of section 45-14-01-05, subsection 1 of section 45-14-01-06, and subsection 1 of section 45-14-01-09, respectively, by providing one notice to those consumers jointly.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-11. Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties.

1. a. Conditions for disclosure. Except as otherwise authorized in this rule, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

      (1) The licensee has provided to the consumer an initial notice as required under section 45-14-01-05;

      (2) The licensee has provided to the consumer a notice as required in section 45-14-01-08; and

      (3) An authorization is obtained from the consumer whose nonpublic personal information is sought to be disclosed.

   b. A valid authorization to disclose nonpublic personal information pursuant to section 45-14-01-11 shall be in written or electronic form separate from that used for any other purpose and shall contain all of the following:

      (1) The identity of the consumer or customer who is the subject of the nonpublic personal information;

      (2) A specific description of the types of nonpublic personal information to be disclosed;

(3) Specific descriptions of the parties to whom the licensee discloses nonpublic personal information, the purpose of the disclosure, and how the information will be used;

(4) The signature of the consumer or customer who is the subject of the nonpublic personal information or the individual who is legally empowered to grant authority and the date signed; and

(5) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

2. Application to all consumers and all nonpublic personal financial information.

a. A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

b. Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the authorization from the consumer.

3. Partial authorization. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to authorize disclosure.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-12. Limits on redisclosure and reuse of nonpublic personal financial information.

1. a. Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in section 45-14-01-15 or 45-14-01-16, the licensee's disclosure and use of that information is limited as follows:

(1) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(2) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(3) The licensee may disclose and use the information pursuant to an exception in section 45-14-01-15 or 45-14-01-16, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

b. Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

2. a. Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an

exception in section 45-14-01-15 or 45-14-01-16, the licensee may disclose the information only:

(1) To the affiliates of the financial institution from which the licensee received the information;

(2) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(3) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

b. Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in section 45-14-01-15 or 45-14-01-16:

(1) The licensee may use that list for its own purposes; and

(2) The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, and the licensee may disclose the list in accordance with an exception in section 45-14-01-15 or 45-14-01-16, such as to the licensee's attorneys or accountants.

3. Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in section 45-14-01-15 or 45-14-01-16, the third party may disclose and use that information only as follows:

a. The third party may disclose the information to the licensee's affiliates;

b. The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

c. The third party may disclose and use the information pursuant to an exception in section 45-14-01-15 or 45-14-01-16 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

4. Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in section 45-14-01-15 or 45-14-01-16, the third party may disclose the information only:

a. To the licensee's affiliates;

b. To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

c. To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-13. Limits on sharing account number information for marketing purposes.

1. **General prohibition on disclosure of account numbers.** A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

2. **Exceptions.** Subsection 1 does not apply if a licensee discloses a policy number or similar form of access number or access code:

   a. To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

   b. To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

   c. To a participant in an affinity or similar program when the participants in the program are identified to the customer when the customer enters into the program.

3. **Examples.**

   a. Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

   b. Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-14. Exception to authorization requirements for disclosure of nonpublic personal financial information for service providers and joint marketing.

1. **General rule.**

   a. The notice and authorization requirements in sections 45-14-01-08 and 45-14-01-11 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee provides the initial notice in accordance with section 45-14-01-05 and enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in section 45-14-01-15 or 45-14-01-16 in the ordinary course of business to carry out those purposes.

   b. Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of subdivision a if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an

exception in section 45-14-01-15 or 45-14-01-16 in the ordinary course of business to carry out that joint marketing.

2. **Service may include joint marketing.** The services a nonaffiliated third party performs for a licensee under subsection 1 may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

3. **Definition of joint agreement.** For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse, or sponsor a financial product or service.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-15. Exceptions to notice and authorization requirements for disclosure of nonpublic personal financial information for processing and servicing transactions.

1. Exceptions for processing transactions at consumer's request. The requirements for initial notice in subdivision b of subsection 1 of section 45-14-01-05, for notice and authorization in sections 45-14-01-08 and 45-14-01-11 and for service providers and joint marketing in section 45-14-01-14 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with:

   a. Servicing or processing an insurance product or service that a consumer requests or authorizes;

   b. Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

   c. A proposed or actual securitization, secondary market sale, including sales of servicing rights, or similar transaction related to a transaction of the consumer;

   d. Reinsurance or stop-loss or excess loss insurance;

   e. Informing a policyholder or the policyholder's producer or broker with respect to a claim asserted by, or paid to, a consumer under the policy and servicing and processing such claim; or

   f. Maintaining or servicing a customer's account as authorized by the customer, orally or otherwise, or as necessary to replace an insurance product or service that is nonrenewed as a result of the withdrawal of an insurer from a market.

2. "Necessary to effect, administer, or enforce a transaction" means that the disclosure is:

   a. Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

   b. Required, or is a usual, appropriate, or acceptable method:

      (1) To carry out the transaction or the product or service business of which the transaction is a part, and record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(2) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(3) To provide a confirmation, explanation, statement, or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's producer or a policyholder or the policyholder's agent, producer, or broker with respect to a claim asserted by, or paid to, a consumer under a policy;

(4) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(5) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance or the policyholder's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation; processing premium payments; processing, adjusting, paying, and, settling insurance claims; administering insurance benefits including utilization review activities; participating in research projects; or as otherwise required or specifically permitted by federal or state law; or

(6) In connection with:

(a) The authorization, settlement, billing, processing, clearing, transferring, reconciling, or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other payment card, check or account number, or by other payment means;

(b) The transfer of receivables, accounts, or interests therein; or

(c) The audit of debit, credit, or other payment information.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-16. Other exceptions to notice and authorization requirements for disclosure of nonpublic personal financial information.

1. **Exceptions to authorization requirements.** The requirements for initial notice to consumers in subdivision b of subsection 1 of section 45-14-01-05, for notice and authorization in sections 45-14-01-08 and 45-14-01-11 and for initial notice in paragraph 1 of subdivision a of subsection 1 of section 45-14-01-14 do not apply when a licensee discloses nonpublic personal financial information:

a. With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

b. (1) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction;

(2) To protect against or prevent actual or potential fraud or unauthorized transactions;

(3) For required institutional risk control or for resolving consumer disputes or inquiries;

(4) To persons holding a legal or beneficial interest relating to the consumer; or

(5) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

c. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants, and auditors;

d. To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 [12 U.S.C. 3401 et seq.], to law enforcement agencies, including the federal reserve board, office of the comptroller of the currency, federal deposit insurance corporation, office of thrift supervision, national credit union administration, the securities and exchange commission, the secretary of the treasury, with respect to 31 U.S.C. chapter 53, subchapter II (records and reports on monetary instruments and transactions) and 12 U.S.C. chapter 21 (financial recordkeeping), a state insurance authority, and the federal trade commission, self-regulatory organizations, or for an investigation on a matter related to public safety;

e. (1) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act [15 U.S.C. 1681 et seq.]; or

(2) From a consumer report reported by a consumer reporting agency;

f. In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

g. (1) To comply with federal, state, or local laws, rules, and other applicable legal requirements;

(2) To comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state, or local authorities; or

(3) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; or

h. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or a workers' compensation plan.

2. **Revocation of authorization.** A consumer may revoke authorization by subsequently exercising the right at any time by informing the licensee in writing of the revocation.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-17. When authorization required for disclosure of nonpublic personal health information.

1. A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

2. Nothing in this section shall prohibit, restrict, or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee or its affiliate: claims administration; claims adjustment and management; detection, investigation, or reporting of actual or potential fraud, misrepresentation, or criminal activity; underwriting; policy placement or issuance; loss control;

ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical, or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; data base security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers' compensation policy or program; activities in connection with a sale, merger, transfer, or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the United States department of health and human services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process. Additional insurance functions may be added with the approval of the commissioner to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-18. Authorizations.

1. A valid authorization to disclose nonpublic personal health information pursuant to sections 45-14-01-17 through 45-14-01-21 shall be in written or electronic form and shall contain all of the following:

   a. The identity of the consumer or customer who is the subject of the nonpublic personal health information;

   b. A general description of the types of nonpublic personal health information to be disclosed;

   c. General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure, and how the information will be used;

   d. The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

   e. Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

2. An authorization pursuant to sections 45-14-01-17 through 45-14-01-21 shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four months.

3. A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to sections 45-14-01-17 through 45-14-01-21 at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

4. A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-19. Authorization request delivery.

A request for authorization and an authorization form may be delivered to a consumer or a customer pursuant to section 45-14-01-10, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to subsection 1 of section 45-14-01-17.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-20. Relationship to federal rules.

Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the United States department of health and human services [45 CFR subtitle A, subchapter C, part 160] (the "federal rule"), if a licensee complies with all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of sections 45-14-01-17 through 45-14-01-21.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-21. Relationship to state laws.

Nothing in this rule shall preempt or supersede existing state law related to medical records, health, or insurance information privacy.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-22. Protection of Fair Credit Reporting Act.

Nothing in this rule shall be construed to modify, limit, or supersede the operation of the federal Fair Credit Reporting Act [15 U.S.C. 1681 et seq.], and no inference shall be drawn on the basis of the provisions of this rule regarding whether information is transaction or experience information under section 603 of that Act.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-23. Nondiscrimination.

1. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of the person's nonpublic personal financial information pursuant to the provisions of this regulation.

2. A licensee shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of the person's nonpublic personal health information pursuant to the provisions of this rule.

3. Usual, appropriate, or acceptable insurance underwriting methods are not discriminatory practices for the purposes of this section.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-24. Severability.

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

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-25. Effective date.

This chapter shall become effective November 1, 2004. As of that date, nonpublic personal information, regardless as to when the information was collected by a licensee, may not be shared with a nonaffiliated third party except as authorized by the consumer or customer, or except as permitted under subsection 2 of section 45-14-01-13 or section 45-14-01-14, 45-14-01-15, or 45-14-01-16. An initial privacy notice or an annual privacy notice issued after November 1, 2004, must comply with the revised privacy notice requirements of this chapter.

History: Effective December 1, 2001; amended effective November 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

APPENDIX A
SAMPLE CLAUSES

The examples in this rule and the sample clauses in this appendix are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this rule.

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to authorize disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffilated third parties.

A-1-Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision a of subsection 1 of section 45-14-01-07 to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from a consumer reporting agency.

A-2-Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of subdivision b of subsection 1 of section 45-14-01-07 to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in sections 45-14-01-14, 45-14-01-15, and 45-14-01-16.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as **[provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"]**;
- Information about your transactions with us, our affiliates, or others, such as **[provide illustrative examples, such as "your policy coverage, premiums, and payment history"]**; and
- Information we receive from a consumer reporting agency, such as **[provide illustrative examples, such as "your creditworthiness and credit history"]**.

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described **[describe location in the notice, such as "above" or "below"]**.

A-3-Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of subdivisions b, c, and d of subsection 1 of section 45-14-01-07 to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in sections 45-14-01-15 and 45-14-01-16.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4-Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision c of subsection 1 of section 45-14-01-07 to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in sections 45-14-01-14, 45-14-01-15, and 45-14-01-16, as well as when permitted by the exceptions in sections 45-14-01-15 and 45-14-01-16.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as **[provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents"]**;
- Nonfinancial companies, such as **[provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]**; and
- Others, such as **[provide illustrative examples, such as "nonprofit organizations"]**.

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5-Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of subdivision e of subsection 1 of section 45-14-01-07 related to the exception for service providers and joint marketers in section 45-14-01-14. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as **[provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"]**;

- ° Information about your transactions with us, our affiliates, or others, such as **[provide illustrative examples, such as "your policy coverage, premium, and payment history"]**; and

- ° Information we receive from a consumer reporting agency, such as **[provide illustrative examples, such as "your creditworthiness and credit history"]**.

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6-Explanation of authorization right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision f of subsection 1 of section 45-14-01-07 to provide an explanation of the consumer's right to authorize the disclosure of nonpublic personal information to nonaffiliated third parties, including the methods by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in sections 45-14-01-14, 45-14-01-15, and 45-14-01-16.

Sample Clause A-6:

We will not disclose nonpublic personal information about you to nonaffiliated third parties (other than as permitted by law), unless you authorize us to make those disclosures. Your authorization must be in writing or, if you agree, in electronic form. If you wish to authorize disclosures to nonaffiliated third parties, you may **[describe a reasonable means of authorization, such as "call the following toll-free number: (insert number)"]**.

A-7-Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision h of subsection 1 of section 45-14-01-07 to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to **[provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]**. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.