

KENTUCKY LIFE & HEALTH LAWS



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ALL LICENSING CANDIDATES

DEFINITIONS

Types of Insurer Authority

A **domestic** insurer is one formed under the laws of Kentucky.

A **foreign** insurer is one formed under the laws of any state, other than Kentucky

An **alien** insurer is one formed under the laws of any country other than a state of The United States.

Kind of Insurers

A **stock insurer** is an incorporated insurer with its capital divided into shares and owned by its shareholders.

A **mutual insurer** is an incorporated insurer without permanent capital stock, and the governing body of which is elected by its policyholders or those policyholders specified in its charter, or by any other reasonable method.

A **combined stock and mutual life insurer** is an incorporated insurer with capital divided into shares owned by its shareholders, but which is controlled by the votes both of its stockholders and of its participating policyholder members, to the extent any such rights of membership are granted and specified in the insurer's policies or its articles of incorporation.

A **reciprocal insurer** is an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact common to all subscribers to provide reciprocal insurance among themselves.

A **Lloyd's Plan insurer** is an unincorporated association of persons designated as underwriters who transact an insurance business as insurers in Kentucky through an attorney-in-fact under the name "Lloyd's" or under "Lloyd's Plan" of operation.

A **multiple line insurer** is an insurer which transacts any two or more of the following kinds of insurance: health, property, surety, casualty, marine, and transportation.

INSURANCE COMMISSIONER

The Commissioner is the head of the Kentucky Department of Insurance. The Commissioner is appointed by the Governor with the consent of the Senate, for a term not to exceed 4 years on the basis of his or her merit and fitness to perform the duties of the office. If the Senate is not in session when a term expires, or a vacancy occurs, the Governor makes the appointment to take effect at once, subject to the approval of the Senate when convened. (304.2-020)

Address Change

All persons holding licenses or certificates of authority from the Commissioner must maintain current residence, business, home office and administrative address, as applicable, on file with the Commissioner. Licensees must inform the Commissioner in writing of any change in address or legal name within 30 days of the change. As a condition to holding a license or certificate of authority from the Commissioner, persons holding licenses or certificates of authority are deemed to have consented to service of notices and orders of the Commissioner at their address on file with the Commissioner and any notice or order of the Commissioner mailed or delivered to the address on file with the Commissioner constitutes valid service of notice or order. (304.2-120)

Qualifications for Agent License

An individual applying for an agent license will make application to the Commissioner on the uniform application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the Commissioner must find that the applicant:

- Is at least 18 years of age;
- Has fulfilled the residence requirements or is a nonresident who is not eligible for a nonresident license based on reciprocity;
- Has not committed any act that is a ground for denial, suspension or revocation;
- Is trustworthy, reliable and of good reputation, evidence of which will be determined through an investigation by the Commissioner.
- Is competent to exercise the license and has:
 - Successfully attained a general education level equivalent to that required for graduation for an accredited high school in this state;
 - Except for limited lines licenses, completed a 40-hour pre-licensing classroom course of study for the lines of authority for which the individual has applied;
 - Except for limited line licenses, successfully passed the examinations required by the Commissioner for the lines of authority for which the individual has applied; and
 - Paid the fees
- Is financially responsible to exercise the license and has:
 - Filed with the Commissioner the certificate of an insurer authorized to write legal liability insurance in this state, that the insurer has and will keep in effect on behalf of the person a policy of insurance covering the legal liability of the licensed person as the result of erroneous acts or failure to act in his or her capacity as an insurance agent, and enduring to the benefit of any aggrieved party as the result of a single occurrence in the sum of not less than \$20,000 and \$100,000 in the aggregate for all occurrences within 1 year, and that the policy may not be terminated unless at least 30 days' prior written notice will have been given to the Commissioner; or
 - Deposited with the Commissioner cash, or a cash surety bond execute by an insurer authorized to write business in the Commonwealth, in the sum of \$20,000, which will be subject to the lawful levy of execution by any party to whom the licensee has been found to be legally liable as the result of erroneous acts or failure to act in his or her capacity as an agent.

Qualifications for Consultant License

For the protection of the people of this Commonwealth the Commissioner will not issue any license as consultant except in compliance with this subtitle, or as to any person not qualified therefore as follows:

- Must be an individual of 25 or more years of age;
- Must have had not less than 5 years of actual experience as a licensed agent with respect to the kinds of insurance and contracts to be covered by the license, or other special experience, education or training, all of sufficient content and duration reasonably necessary for competence in fulfilling the responsibilities of a consultant;
- Must have a thorough knowledge of insurance and annuity contracts of the kinds proposed to be covered under the license;
- Must satisfy the Commissioner by written examination, or otherwise of his or her qualification for the license;
- Must be competent, trustworthy under the highest fiduciary standards, financially responsible and of good personal and business reputation;
- Must have filed the bond required by Section 30439-330. **(304.9-320)**

Apprentice Adjuster

An applicant for an adjuster's license who meets all the requirements except the experience, special education or training requirement may be issued a temporary license as an apprentice adjuster for up to 12 months without passing the written examination.

Controlled Business

The purpose of a license issued under this subtitle to an insurance producer is to authorize and enable the licensee actively and in good faith to engage in the business of insurance with respect to the general public, and to facilitate the public supervision of such activities in the public interest, and not for the purpose of enabling the licensee to receive a rebate of premium in the form of "commission" or other compensation upon his or her own interest or upon those of other persons with whom he or she is closely associated in capacities other than as an insurance producer.

The Commissioner will not grant, renew, continue or permit to exist any license of an insurance producer if he or she find that the license has been, is being or will probably be used by the applicant or licensee principally for the purpose of writing "controlled business," that is:

- Insurance on his or her own interest or those of his or her family or of his or her employer; or
- Insurance or annuity contracts covering himself or herself or members of his or her family, or the officers, directors, stockholders, partners, employees or debtors of a partnership, association, or corporation of which he or she or a member of his or her family is an officer, director, stockholder, partner, associate, or employee.

Continuing Education for Agents

This section applies to individuals who hold licenses or lines of authority requiring continuing education. This section does not apply to:

- Limited lines of authority under agent licenses, as exempted by the Commissioner;
- Licensees not licensed for 1 full year prior to the end of the applicable continuing education biennium;
- Licensees holding nonresident licenses who have met the continuing education requirements of their home state and whose home state gives credit to Kentucky resident licensees on the same basis; or

- Licensees maintaining their licenses for the sole purpose of receiving renewals or deferred commissions and providing the Department with a supporting affidavit.

Licensees who are not exempt must satisfactorily complete a minimum of 24 hours of continuing education courses: Six (6) hours must be related to any one (1) active line of authority and three (3) hours must pertain to ethics.

Temporary Licenses

The Commissioner may issue a temporary license for a period not to exceed 180 days without requiring an examination or pre-licensing course of study if the Commissioner deems that a temporary license is necessary for the servicing of an insurance business in the following cases:

- To the surviving spouse or court-appointed personal representative of a licensed agent who dies or becomes mentally or physically disabled, to allow adequate time for the:
 - Sale of the insurance business owned by the agent;
 - Recovery or return of the agent to the business; or
 - Training and licensing of new personnel to operate the agent's business.
- To a member or employee of a business entity licensed as an agent, upon the death or disability of the sole individual designated in the business entity application or the license;
- To the designee of a licensed agent entering upon active service in the armed forces of the United States; or
- In any other circumstance where the Commissioner deems that the public interest will best be served by the issuance of this license.

Record Retention

Every individual and business entity issued a license with Kentucky as its home state must have and maintain a place of business in Kentucky accessible to the public and where the licensee principally conducts transactions. This does not prohibit maintaining a place of business in an insurer's office or in the licensee's residence.

The licenses of the licensee must be conspicuously displayed in a part of the place of business customarily open to the public.

The licensee must keep at his or her place of business complete records of transaction under his or her license. For an insurance producer, the records must show, as to each insurance policy or contract placed or countersigned by or through the licensee, the names of the insurer and insured, the number and expiration date and premium payable as to, the policy or contract, and such other information as the Commissioner may reasonably require. The records must be kept available for inspection by the Commissioner for a period of at least 5 years after completion of the respective transactions. **(304.9-390)**

Revocation or Suspension of License

The Commissioner may place on probation, suspend, or may impose conditions upon the continuance of a license for not more than 12 months, revoke, or refuse to issue or renew any license issued under this section or any surplus lines broker license, or may levy a civil penalty, or any combination of actions for any one or more of the following causes:

- Providing incorrect, misleading, incomplete, or materially untrue information in the license application;
- Violating any insurance laws, violating any administrative regulations, subpoena, or order of the Commissioner or of another state's Insurance Commissioner;
- Obtaining or attempting to obtain a license through misrepresentation or fraud;
- Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing insurance business;

- Intentionally misrepresenting the terms of an actual or proposed insurance contract or application of insurance;
- Having been convicted of any felony
- Having admitted or been found to have committed any unfair insurance trade practice or insurance fraud;
- Using fraudulent, coercive, or dishonest practices; or demonstrating incompetence, untrustworthiness, or financial irresponsibility; or being a source of injury or loss to the public in the conduct of business in this state or elsewhere;
- Having any insurance license or its equivalent, denied, suspended or revoked in any other state, province, district or territory;
- Surrendering or otherwise terminating any other license issued by this state or by any other jurisdiction, under threat of disciplinary action, or denial, or refusal of the issuance of or renewal of any other license issued by this state or by any other jurisdiction; or revocation or suspension of any other license held by the licensee issued held by the licensee issued by this state or by any other jurisdiction;
- Forgery in relation to insurance;
- Knowingly accepting insurance business from an individual who is not licensed, but who is required to be licensed under this section;
- Failing to comply with an administrative or court order imposing child support obligation;
- Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax;
- Having been convicted of a misdemeanor for which restitution is ordered in excess of \$300, or of any misdemeanor involving dishonesty, breach of trust, or moral turpitude; or
- Any other cause for which issuance of the license could have been refused, had it then existed and been known to the Commissioner.

The license of a business entity may be suspended, revoked or refused for any such causes as relate to an individual designated in or registered as to the license to exercise its powers if the individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the firm or corporation and the violation was not reported to the insurance department, nor was corrective action taken. In such cases, the applicant or licensee may request a hearing on the matter from the Commissioner.

The Commissioner has the authority to enforce the provisions and penalties of the insurance law against any individual or business entity who is under investigation for or charged with a violation, even if the individual's or business entity's license has been surrendered or has lapsed by operation of law. **(304.9-440)**

The Commissioner has the authority to immediately suspend or place conditions on licenses if:

- The licensee is indicted for fraud, dishonest or breach of trust;
- The Department receives a sworn consumer complaint against the licensee showing evidence of misappropriation of premium in excess of \$300; or
- The agent has a suspended or revoked license in Kentucky or elsewhere.

An agent may appeal the order to immediately suspend his or her license. The appeal must be filed within 60 days of the date of the order. A hearing on the appeal must be held within 10 days from the date the appeal is filed. **(304.9-465)**

Premium Tax

Every unauthorized insurer must pay a premium tax of 2% of gross premiums charged for insurance on subject's resident, located, or to be performed in this state. The tax is payable to the Secretary of Revenue annually before March 1st following the calendar year in which the insurance was so effectuated, continued or renewed. **(304.11-050)**

HIV Testing

In the underwriting of an insurance contract regarding human immuno-deficiency virus infection and health conditions derived from such infection, the insurer must utilize medical tests which are reliable predictors of risk. Only a test which is recommended by the Centers for Disease Control or by the Food and Drug Administration is deemed to be reliable for the purposes of this section. If a specific Centers for Disease Control or Food and Drug Administration recommended test indicated the existence or possible existence of human immuno-deficiency virus infection or a health condition related to the human immuno-deficiency virus infection, before relying on a single test to deny issuance of an insurance contract, limit coverage under an insurance contract or to establish the premium for an insurance contract, the insurer must follow the applicable Centers for Disease Control or Food and Drug Administration recommended follow-up test or series of tests to confirm the indication.

Prior to testing, the insurer must disclose in writing its intent to test the applicant for the human immuno-deficiency virus infection or for a specific health condition derived there from and must obtain the applicant's written informed consent to administer the test.

Written informed consent must include a fair explanation of the test, including its purpose, potential uses and limitations, the meanings of its results, and the right to confidential treatment of information.

An applicant must be notified of a positive test result by a physician designated by the applicant, or, in the absence of such designation, by the Cabinet for Human Resources.

A medical test for HIV infection or for a health condition derived from the infection may only be required for an insurance contract on the basis of the applicant's health condition or health history, on the basis of the amount of insurance applied for, or if the test is required of all applicants.

An insurer may ask whether an applicant for an insurance contract has tested positive for HIV infection or other health conditions derived from such infection. Insurers may not inquire whether the applicant has been tested for or has received a negative result from a specific test for HIV infection or for a health condition derived from such infection.

Insurers must maintain strict confidentiality of the results of tests for HIV infection or a specific health condition derived from HIV infection. Information regarding specific test results may be disclosed only as required by law or pursuant to a written request or authorization by the applicant.

An insurance contract may not exclude coverage for HIV infection and may not contain benefit provisions, terms or conditions which apply to HIV infection differently than those that apply to any other health condition.

A health insurance contract may not be cancelled or nonrenewed solely because a person covered by the contract has been diagnosed as having or has been treated for HIV infection. Sexual orientation may not be used in the underwriting process or in the determination of which applicants shall be tested for exposure to the HIV infection.

This subsection does not prohibit the issuance of accident only or specified disease insurance contracts. **(304.12-013)**

Advertising Files; Reporting Requirements

Every insurer must maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of individual policies and typical printed, published or prepared advertisements of blanket, franchise and group policies disseminated in any state, with a notation attached to each advertisement indicating the manner and extent of distribution and the form number of any policy advertised. The file is subject to regular and periodic inspection by the Department of Insurance. All advertisements must be maintained in the file for at least 3 years.

Each insurer required to file an annual statement and which is subject to the advertisement regulations must file with the Department together with its annual statement, a certificate executed by an authorized officer of the insurer stating that to the best of his or her knowledge, information and belief the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws of Kentucky.

The use of advertising materials previously filed with and approved by the Department does not subject the filer to any disciplinary action or penalty by the Department, as long as the prior approval remains in effect. **(Reg 806.12-010.8)**

Defamation

No person shall make, publish, disseminate or circulate directly or indirectly, or aid, abet or encourage making, publishing, dissemination or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, or of an organization proposing to become an insurer, and which is calculated to injure any person engaged or proposing to engage in the business of insurance. **(304.12-060)**

Illegal Inducements

No insurance producer may, as an inducement to insurance, or in connection with any insurance transaction, provide in any policy for, or offer, sell, buy, or offer or promise to buy, sell, give, promise, or allow to the insured or prospective insured or to any other person on his or her behalf in any manner whatsoever:

- Any employment
- Any shares of stock or other securities issued or at any time to be issued or any interest therein or rights thereto
- Any advisory board contract, or any similar contract, agreement or understanding, offering, providing for, or promising any profits or special returns or special dividends
- Any prizes, goods, wares, merchandise, or property of an aggregate value in excess of \$25. **(304.12-110)**

Life and Health - Unfair Claims Settlement Practices

Every insurer upon receiving due notice of a claim, must within 15 days of notification, provide necessary claims forms, instructions and reasonable assistance so the insured can properly comply with the filing requirements.

Upon receipt of proof of loss from a claimant, the insurer shall begin any necessary investigation of the claim within 15 days.

The insurer shall affirm or deny any liability on any claim within a reasonable time and shall offer payment within 30 days of receipt of due proof of loss.

With each claim payment, the insurer shall provide an explanation of benefits which must include the name of the provider of health care services covered, dates of services and a reasonable explanation of the computation of benefits.

If a claim remains unresolved for 30 days from receipt of due proof of loss, the insurer must provide a written explanation of the delay.

If a claim is denied, the insurer must provide a written explanation for the denial within 15 days of the determination. The notice must refer to specifics of the policy.

Each insurer's claims files are subject to examination by the Commissioner. The insurer must:

- Maintain claim data that are accessible and retrievable for examination.
- Maintain documentation for each claim file for reconstruction purposes; and
- Maintain dates received, dates process and dates mailed for each claim file.
- Claim files must be maintained for the current year and the 5 preceding years. (Reg. 806.12-092)

THE INSURANCE CONTRACT

Insurable Interest - Person

An employer or the employer's trustee may procure and effect an insurance contract upon the life or body of an employee for the purposed of funding a pension or other benefit plan established for the employee of the employer.

Any individual of competent legal capacity may procure or affect an insurance contract upon his own life or body for the benefit of any person. No person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under the contract are payable to the individual insured or his personal representatives, or to a person having, at the time when the contract was made, an insurable interest in the individual insured.

If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits accruing upon the death, disablement or injury of the individual insured, the individual insured or his executor or administrator, as the case may be, may maintain an action to recover the benefits from the person so receiving them.

"Insurable interest" as to personal insurance means that every individual has an insurable interest in the life, body and health of himself, and of other persons as follows:

- In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;
- In the case of other persons, a lawful and substantial economic interest in having the life, health or bodily safety of the individual insured continue, as distinguished for an interest which would arise only by, or would be enhance in value by, the death, disablement or injury of the individual insured;
- An individual heretofore or hereafter party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a close corporation or of an interest in the shares, has an insurable interest in the life, health or bodily safety of each individual party to the contract for the purpose of the contract only, in addition to any insurable interest which may otherwise exist as to the individual; and
- Any domestic or foreign corporation which provides its active or retired employees with benefits under a retirement or other employee benefit plan has an insurable interest in the life, health or bodily safety of any active retired employee of the corporation or of any of its subsidiaries who is covered by a plan, and any trustee of a trust established by the corporation for the sole benefit of the corporation has the same insurable interest in the employee as the corporation itself.

Power to Contract Insurance; Purchase by Minors

Any person of competent legal capacity may contract for insurance.

Any minor not less than 15 years of age may, notwithstanding his or her minority, contract for or own annuities, or insurance upon his or her own life, body, healthy, property, liabilities or other interests, or on the person of another in whom the minor

has insurable interest. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under:

- Any contract for annuity or for insurance upon his or her own life, body or health, or
- Any contract such minor effected upon his or her own property, liabilities, or other interests, or
- Any contract effect or owned by the minor on the person of another, as might be exercised by a person of full legal age, and may at any time surrender his or her interest in any such contract and give valid discharge for any benefit accruing or money payable there under. Such a minor shall not, by reasons of his or her minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege there under, except that such a minor not otherwise emancipated, shall not be bound by any unperformed agreement to pay by promissory note or otherwise, any premium on any such annuity or insurance contract.

Any annuity contract or policy of life or health insurance procured by or for a minor shall be made payable either to the minor or his or her state or to a person having an insurable interest in the life of the minor. (304.14-070)

INSURANCE FRAUD

A person convicted of a violation of this section shall be guilty of a misdemeanor where the aggregate of the claim, benefit or money referred to in this section is less than or equal to \$500, and shall be punished by:

1. Imprisonment for not more than 1 year;
2. A fine, per occurrence, of not more than \$1,000 per individual nor \$5,000 per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or
3. Both imprisonment and a fine set forth in this paragraph.

Where the claim, benefit or money referred to in this section exceed an aggregate of \$300, a person convicted of a violation of this section shall be guilty of a felony and shall be punished by:

1. Imprisonment for not less than 1 nor more than 5 years;
2. A fine, per occurrence, of not more than \$10,000 per individual nor \$100,000 per corporation or twice the amount of gain receive as a result of the violation, whichever is greater; or
3. Both imprisonment and a fine set forth in this paragraph.

Any person, with the purpose to establish or maintain a criminal syndicate, or to facilitate any of it activities is guilty of engaging in organized crime, a Class B felony, and shall be punished by:

1. Imprisonment for not less than 10 nor more than 20 years;
2. A fine, per occurrence, of not more than \$10,000 per individual nor \$100,000 per corporation or twice the amount of gain receive as a result of the violation, whichever is greater; or
3. Both imprisonment and a fine set forth in this paragraph.

PENALTIES FOR VIOLATIONS

Consultants

If any consultant or agent is found by the commissioner, after a hearing, to be in violation, the commissioner may, in addition to any applicable suspension, revocation or refusal to continue the consultant's or agent's license, impose a fine in the amount of the consultant's or agent's fees or commissions associated with the sale of the product which is the subject of the violation. (304.99-025)

**UNIT TWO
LIFE AND HEALTH
INSURANCE CANDIDATES**

**KENTUCKY LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION**

Purpose of Subtitle

The purpose of this subtitle is to protect policy owners, insureds, beneficiaries, annuitants, payees and assignees of certain life insurance policies, health insurance policies and annuity contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the insurer issuing such policies or contracts. To provide this protection:

- An association of insurers is created to enable the guaranty of payment of benefits and continuation of coverages;
- Members of the association are subject to assessment to provide funds to carry out the purpose of this subtitle. (304.42-020)

Creation of Association

There is created a nonprofit legal entity to be known as the Kentucky Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The Association shall exercise its powers through a board of directors. For the purpose of administration and assessment, the Association shall maintain 3 accounts:

1. The Health Insurance Account;
2. The Life Insurance Account; and
3. The Annuity Account.

The Association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state. (304.42-060)

Scope of Coverage

The Association provides coverage for **direct, nongroup life, health or annuity policies or contracts and supplemental contracts** to any of these, and for certificates issued under direct group policies and contracts. There are many specific exclusions from coverage. *Some* of the exclusions include the following:

- Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner
- Any policy of contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract.
- Any portion of a policy or contract to the extent that the rate of interest on which it is based
 - Averaged over the period of 4 years prior to the date on which the association become obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average averaged for that same 4 year period or for such lesser period if the policy or contract was issued less than 4 years before the association became obligated; and
 - On and after the date on which the association becomes obligated with respect to the policy or contract, exceed the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as most recently available;

- Any portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health, or annuity benefits to its employees, members or others to the extent that such plan or program is self-funded or uninsured
- Any policy or contract issued in Kentucky by a member insurer at a time when it did not have a certificate of authority to issue such policy or contract in this state.
- Any unallocated annuity contract
- A portion of a policy or contract to the extent that the assessments required by **KRS 304.42-090** with respect to the policy or contract are preempted by federal or state law
- A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee which in each case is not an affiliate of the member insurer.

Also excluded is any obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, such as:

- Claims based on marketing materials
- Claims based inside letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements
- Misrepresentation regarding policy benefits
- Extra contractual claims
- Claims for penalties or consequential or incidental damages

Limitations on Association Obligation

The benefits the Association is obligated to cover are limited to the lesser of the contractual obligation for which the insurer is liable or would have been liable, if it were not an impaired or insolvent insurer or the following for any one life, regardless of the number of policies or contracts:

- \$300,000 in life insurance death benefits, but no more than \$100,000 net cash surrender and net cash withdrawal values for life insurance
- \$100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values
- \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, except for each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, \$250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values.

In no event is the Association obligated to cover more than:

- A total of \$300,000 in benefits with respect to any one life, or
- With respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than \$1,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

CREDIT LIFE AND HEALTH INSURANCE

Policy Types and Benefits

Credit life insurance and credit health insurance may only be issued in the following forms:

1. Individual policies of life insurance issued to debtors on the term plan
2. Individual policies of health insurance issued to debtors on a term plan or disability benefit provision in individual policies of credit life insurance
3. Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan
4. Group policies of health insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

The initial amount of credit life insurance must not exceed the total amount repayable under the contract of indebtedness. Where an indebtedness is repayable in substantially equal installments, the amount of insurance must not ever exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater; however, in the case of a group policy the amount of insurance may be reduced annually or at more frequent intervals, by a level percentage.

Joint Lives

No agent or insurer may deliver or issue for delivery in this state any policy of credit life or health insurance or any certificate in the case of such a policy of group insurance, which insures the life or health of more than one individual, except in the case of the debtor's spouse who is co-signer to the credit or finance transaction. When a husband and wife are insured under this provision, **the premium rate charged must not exceed 150% of the rate permissible for a single life.**

Not more than one individual credit life insurance policy and one credit health insurance policy may be issues as security for a single indebtedness. (Reg. 806.19-060)

FRATERNAL BENEFIT SOCIETIES

Definitions

'Fraternal Benefit Society' means any incorporated society, order or supreme lodge, without capital stock, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a Lodge System with ritualistic form of work, having a representative form of government and which provides benefits in accordance with this subtitle.

"Lodge System" denotes a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and rituals. Subordinate lodges are required by the laws of the society to hold regular meetings are least once in each month in furtherance of the purposes of the society.

"Benefit Member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

"Laws" means the society's articles of incorporation, constitution, any bylaws, however designated. (304.29-011,021, and 041)

Powers of the Society

A society must operate for the benefit of the member and their beneficiaries by:

1. Providing benefits as specified in Section 304.29-161; and
2. Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others. The purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

Every society has the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend the laws and rules and shall have other powers necessary and incidental to carrying into effect the objects and purposes of the society. **(304.29-051)**

Membership

If benefits are provided on the lives of children, the age requirement for adult membership may not be less than 15 years of age nor may it be greater than 21 years of age. **(304.29-061)**

UNIT THREE LIFE INSURANCE CANDIDATES

Premium Payments; “Free Look” Provision

There shall be a provision relating to the time and place of payment of premiums.

There shall be a provision which shall state in substance that the policy may be returned by the policy owner to the company, within a period of not less than 10 days after its receipt to the company or to the agent through whom it was purchased. Immediately upon any such delivery, or mailing, of the policy to the company or agent, the policy will be deemed void from its inception and any premium paid for such policy shall be promptly returned to the policy owner by the company. This subsection shall not apply to policies of credit life insurance and policies issued under tax qualified pension plans. (304.15-050)

Policy Reinstatement

There shall be a provision that, unless the policy has been surrendered for its cash surrender value, or its cash surrender value has been exhausted, the policy will be reinstated at any time within 3 years (or 2 years in the case of industrial life insurance policies) from the date of premium default upon written application, therefore, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears and the payment or reinstatement of any other indebtedness to the insurer upon the policy, all with interest at the rate specified. (304.15-130)

Definition of Industrial Life Insurance

Industrial Life Insurance is that form of life insurance written under policies of **face amount of \$3,000 or less issued** on the basis of an industrial mortality table, and under which premiums are payable monthly or more often.

Wholesale Life Insurance is that plan of life insurance, other than salary savings life insurance or pension trust insurance and annuities, under which individual policies are issued to the employees of any employer and where such policies are issued on the lives of not less than 4 employees at date of issued. Premiums for such policies shall be paid either wholly from the employer’s funds or funds contributed by him or her, or partly from such funds and partly from fund contributed by the insured employees.

LIFE INSURANCE REPLACEMENT

Replacements; Purpose of Regulations

A replacement is any transaction in which new life insurance is to be purchased and as a result of that transaction; existing life insurance has been or is to be:

- lapsed, forfeited, surrendered or otherwise terminated; or
- converted to reduced paid-up insurance, continued as extended term insurance or otherwise reduced in value by the use of non-forfeiture benefits or other policy values; or
- amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid; or
- reissued with any reduction in cash value; or
- pledged as collateral or subjected to borrowing over a period of time for amounts in the aggregate exceeding 25% of the loan value set forth in the policy. (304.12-030.1)

GROUP LIFE

Group Life Insurance policies may be issued to the following groups:

- employer groups
- debtor groups
- labor union groups
- trustee groups
- public employee groups
- association groups
- credit union groups (304.16-030 through 090)

Conversion of Policy on Termination of Eligibility

If the insurance, or any portion of it, on an individual covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the individual is entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits. Application for the individual policy must be made, and the first premium paid to the insurer, within 31 days after the termination of eligibility. The individual policy must, at the option of such individual, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for.

The individual policy must be in an amount not in excess of the amount of life insurance which ceases because of the termination less the amount of any life insurance for which such person is or becomes eligible within 31 days after the termination under any other group policy. Any amount of insurance which has matured on or before the date of the termination as an endowment payable to the individual insured must not be included in the amount which is considered to cease because of the termination.

The premium on the individual policy must be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which the individual then belongs, and to his or her age attained on effective date of the individual (converted) policy. (304.16-190)

Conversion of Policy at Policy Termination

There shall be a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured individuals, every individual insured there under at the date of such termination, whose insurance terminates and who has been so insured for at least 5 years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided in section 304.16-190, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller or

- the amount of the individual's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days of such termination; and
- **\$10,000** (304.16-200)

UNIT FOUR HEALTH INSURANCE CANDIDATES

PROHIBITED DISCRIMINATION

Use of Genetic Testing

In the case of benefits consisting of medical care in connection with a group or individual health benefit plan, the plan or insurer may not deny, cancel or refuse to renew the benefits or coverage, or vary the premiums, terms or conditions for the benefits or coverage, for any participants or beneficiary under the plan on the basis:

- Of a genetic test for which symptoms have not manifested, or
- That the participant or beneficiary has requested or received genetic services

A group or individual health benefit plan or insurer offering health insurance in connection with health benefit plan or an insurer offering a disability income plan may not request or require an applicant, participant or beneficiary to disclose to the plan or insurer any genetic test about the participant, beneficiary or applicant.

A group or individual health benefit plan or insurer offering health insurance in connection with a health benefit plan may not disclose any genetic test about a participant or beneficiary without prior authorization by the participant. The authorization is required for each disclosure. **(304.12-085.2)**

Coverage for Infants from Birth

All individual health insurance policies providing coverage on an expense-incurred basis, regardless of whether the policies are issued for nonfamily or family coverage, must provide that the health insurance benefits shall be payable with respect to a newly born child of the insured from the moment of birth.

The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. **(304.17-042)**

Policyholder's Right to Examine and Return Policy

Except as to nonrenewable accident policies, every individual health insurance policy shall contain a provision therein or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to such person and have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. If the provision is not printed on the face page or filing back of the policy, notice of the provision should be printed or stamped on the face page or filing back of the policy.

The policy may be returned to the insurer at its principal or branch office or to the agent through whom it was applied for, and shall be void from the beginning and as if the policy had not been issued. **(304.17-170)**

Policy Provisions; Generally

Except for permitted preexisting condition clauses, no policy may be advertised, solicited or issued for delivery in Kentucky as a Medicare supplement policy if it contains limitations or exclusions on coverage that are more restrictive than those of Medicare. Medicare supplement policies are also subject to these restrictions:

- No Medicare supplement policy may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.
- No Medicare supplement policy may contain a probationary or elimination period
- No Medicare supplement policy in force in Kentucky may contain benefits that duplicate benefits provided by Medicare (**Reg. 806-17-390.4**)

A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

A Medicare supplement policy must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amounts and co-payment percentage factors. Premiums may be modified to correspond with such changes. (**Reg. 806.17-390.6**)

Free Look

Medicare supplement policies must have a notice prominently printed on the first page of the policy or attached thereto stating that the applicant has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. (**Reg. 806.17-390.9.g**)

Guaranteed Issue for Eligible Persons

Coverage must be made available on a guaranteed issue basis to an “eligible person” who applies to enroll no later than 63 days after the date of termination of enrollment in prior coverage and who submit evidence of the date and termination or dis-enrollment with the application for Medicare supplement insurance.

Eligible persons under this provision include anyone who is:

- Enrolled under an employee welfare benefit plan that provides health benefits that supplement Medicare, if the plan terminates or ceases to provide all those supplemental health benefits to the person.
- Enrolled under a Medicare supplement policy, if the enrollment ceases because of the insolvency of the issuer, bankruptcy of the non-issuer organization, or any other involuntary termination of coverage
- Enrolled under a Medicare Select plan, if the enrollment ceases because of a change in the individual’s place of residence

Individuals who are enrolled in Medicare+Choice plans or with Program of All-Inclusive Care for the Elderly (PACE) providers and whose coverage terminates may also be eligible persons in some cases.

With respect to an eligible person, an issuer of Medicare supplement insurance may not:

- Deny or condition the issuance of effectiveness of a Medicare supplement policy that is offered and is available for issuance to new enrollees
- Discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of healthcare or medical condition
- Impose an exclusion of benefits based on a preexisting condition

At the time of an event that causes an individual to lose coverage or benefits due to the termination of a contract or plan, or when an individual's enrollment ceases for any reason, the issuer or organization terminating or offering the coverage, or the administrator of the plan, must notify the individual in writing of his or her rights under this section. The notice must be communicated at the same time as notification of termination if the plan is terminated, or within 10 working days of the issuer receiving notification of a person's disenrollment. **(Reg. 806.17-400.3)**

Guaranteed Renewal of Policies

All Medicare supplement policies must be guaranteed renewable. An insurer may not cancel or non-renew a policy for any reason other than non-payment of the premium or material misrepresentation and may not cancel or non-renew a policy based solely on the individual's health status. A policy may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for the termination of coverage of the insured (other than nonpayment of the premium). **(Reg. 806.17-390.6)**

Permitted Compensation Arrangements

The first year commission for the sale of a Medicare supplement policy may not be more than 200% of the commission paid for selling or servicing the policy in the second year. The commission provided in the subsequent (renewal) years must be the same as that provided in the second year and must be provided for no fewer than 5 renewal years.

If an existing policy is replaced, an insurer may not provide compensation to its agents or other representatives greater than the compensation which would have been payable had the existing policy been renewed. **(Reg. 806-17-400.5)**

Limitations on Terminology

The terms *guaranteed* and *noncancelable* cannot be used in any long-term care insurance policy without further explanations in regard to the disclosure requirements of this regulation.

- Long-Term Care Insurance policies cannot contain renewal provisions other than *guaranteed renewable* or *noncancelable*
- The term *guaranteed renewable* may only be used when the insured has the right to continue the long-term care insurance by timely payment of premiums, and when the insurer has no right to make any changes in provisions while insurance is in force, and cannot decline to renew. Rates may be revised on a class basis.
- The term *noncancelable* can only be used when the insured has the right to continue long-term care insurance by timely payment of premiums and the insurer has no right to make any changes in any provisions or in the premium rates.
- The term *level premium* may only be used if the insurer does not have the right to change the premium.

In addition to the other requirements of this section, a qualified long-term care insurance contract must be guaranteed renewable within the meaning of federal law. **(Reg. 806.17-081.3.2)**

Limitations and Exclusions

A long-term care policy cannot be delivered or issued for delivery if it limits or excludes coverage by type of illness, treatment, medical condition, or accident **except** as follows:

- Preexisting conditions or diseases;
- Mental or nervous disorders (not including Alzheimer's disease);
- Alcoholism or drug addiction;

- Illness, treatment or medical condition arising out of:
 1. war or act of war (declared or undeclared)
 2. participation in a felony, riot or insurrection;
 3. service in the armed forces or auxiliary units;
 4. suicide (insane or sane), attempted suicide or self-injury);
 5. aviation (this exclusion applies only to non-fare paying passengers).
- Treatment provided in a government facility (unless required by law), services which are covered by Medicare or other government program (except Medicaid), any state or federal workers compensation, employer's liability, or occupational disease law; services provided by the covered person's immediate family, services for which no charge is normally made in the absence of insurance.

The requirements of this subsection are not intended to prohibit exclusions and limitations by type of provider or territorial limitations. **(Reg. 806-17-081.3.2)**

Requirement to Offer Inflation Protection

An insurer cannot 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 buy a policy that provides for benefit levels to increase with benefit maximums; or a policy that provides for an increase in the period of coverage which meets anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer, at the time of purchase, the option to buy a policy with an inflation protection feature no less favorable than one of the following:

- Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%.
- Guarantees the insured 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 be declined. The amount of the additional benefit can be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.
- Covers a specified percentage of actual or reasonable charges and does not include a maximum specified reimbursement.

Minimum Benefits Under a Converted Policy

A converted policy issued according to the conversion privilege contained in a group policy providing hospital or surgical expense insurance must provide a lifetime maximum benefit of at least \$500,000. The Commissioner will establish minimum benefits for a converted policy issued according to the conversion privilege contained in a group health policy. **(304.18-120)**

Rates Quotes; Policy Refusals

Any health insurer that fails to issue a premium rate quote to an individual within 30 days of receiving a properly completed application requesting a quote must issue coverage to that individual and may not impose any preexisting conditions exclusion on that individual with respect to coverage.

Every health insurer offering individual health insurance coverage in Kentucky that refuses to issue a health benefit plan to an applicant or insured with a disclosed high-cost condition or for any reason, must provide the individual with a denial letter within 20 working days of the request for coverage. The letter must include the name and title of the person making the decision, a statement setting forth the basis for refusing to issue a policy, a description of Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access. **(304.17A-250.12)**

Pre-existing Conditions-Group Coverage

A group health plan and a health insurer offering group health insurance coverage may impose a pre-existing condition exclusion with respect to a participant or beneficiary only if:

- The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date.
- The exclusion extends for no more than 12 months (18 months in the case of a late enrollee) after the enrollment, and
- The period of that pre-existing condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date

A group health plan and a health insurance insurer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of:

- An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage, or
- A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the 20-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. (This does not apply to coverage before the date of the adoption or placement for adoption.)