Senate Bill No. 281

CHAPTER 345

An act to amend Sections 10110.5, 10232.8, 10271.1, and 10292 of, to add Article 2.1 (commencing with Section 10295) to Chapter 4 of Part 2 of Division 2 of, and to repeal and add Section 10271 of, the Insurance Code, relating to life insurance.

[Approved by Governor September 24, 2013. Filed with Secretary of State September 24, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 281, Calderon. Life insurance: accelerated death benefits.

Existing law governs the business of insurance, and defines various types of insurance for these purposes, including life insurance and disability insurance. Existing law, except as provided, makes the requirements imposed on disability insurance contracts inapplicable to life insurance, endowment, and annuity contracts, or supplemental contracts thereto, that provide additional benefits in case of death or dismemberment or loss of sight by accident, or that operate to safeguard contracts against lapse, or give a special surrender benefit, or a special benefit, as specified. Existing law also provides the language required as part of a provision or supplemental contract governed by these provisions.

This bill would delete the term "special benefit" and replace it with the defined term "accelerated death benefit." The bill would generally revise the phrase "provision or supplemental contract" and replace it with the term "supplemental benefit," as defined. The bill would also revise and recast the required language of the provision or supplemental contract, as prescribed.

Existing law requires a licensed health care practitioner, independent of the insurer, to certify that an insured meets the definition of a "chronically ill individual," as specified by federal law, for purposes of establishing eligibility for benefits under a long-term care policy or certificate that provides home care benefits.

This bill would prohibit an insurer, for purposes of long-term care insurance, from imposing a certification requirement of longer than 90 days.

Existing law authorizes the Insurance Commissioner to adopt reasonable rules and regulations necessary to administer and carry out the purposes of certain provisions relating to the required language in a provision or supplemental contract.

This bill would extend that authorization for the commissioner to adopt reasonable rules and regulations to those provisions relating to supplemental benefits that operate to safeguard life insurance contracts against lapse when

the insured becomes totally disabled and those life insurance contracts with an accelerated death benefit.

Existing law authorizes provisions or supplemental contracts that operate to safeguard life insurance contracts against lapse, in which the insurer waives the premium or monthly deduction for a life insurance contract when the insured becomes totally disabled, and where the waiver continues until the end of the insured's disability, or until the attainment of an age established by the insurer.

This bill would delete the provision regarding attainment of age and would instead authorize the waiver of premiums to continue for a period of time specified in the supplemental benefit. The bill would define "accelerated death benefit" as a policy provision, endorsement, or rider added to a life insurance policy that provides for the advance payment of any part of the death proceeds, payable upon the occurrence of a qualifying event, as defined. The bill would require a life insurance policy with an accelerated death benefit provision to comply with and, if applicable, explain specified requirements, including payment of benefits, commissioner approval of forms and disclosures, and a free look period, and would place limits on advertising and marketing. The bill would prohibit an insurer, broker, agent, or other person from causing a policyholder to unnecessarily replace a long-term care insurance policy with an accelerated death benefit policy, and provide certain notices when a life insurance policy or long-term care insurance policy would be replaced. The bill would prohibit accelerated death benefits from limiting or excluding coverage by type of illness, treatment, medical condition, or accident, except as specified.

This bill would also provide that an insurer that fails to conform to the requirements of the above provisions would be subject to the provisions of existing law that provide for the imposition of a penalty against any person who engages in any unfair method of competition or any unfair or deceptive act or practice in the business of insurance, as provided, including civil penalties as well as a misdemeanor for an insurer intentionally advertising insurance that it will not sell. Because the bill would create a new crime, it would impose a state-mandated local program.

This bill would authorize the commissioner to disapprove any advertising that does not meet the requirements of these provisions, as specified. The bill would also require a policy, certificate, rider, or endorsement to include a provision giving the policyholder or certificate holder the right to appeal to the insurer a decision regarding benefit eligibility.

This bill would delete obsolete provisions and make conforming changes.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 10110.5 of the Insurance Code is amended to read:

10110.5. (a) A policy or endorsement issued by an admitted life and disability insurer may contain a provision for a waiver of premium payments in the event of involuntary unemployment of the insured. Insurers issuing policies or endorsements containing that provision shall establish any additional reserves and file any additional financial reports that the commissioner may require.

(b) A contract or supplemental contract issued by an admitted life and disability insurer may contain a provision for a waiver of surrender charge benefit for a life insurance or annuity contract in the event of voluntary or involuntary unemployment of the owner, insured, or annuitant, as applicable. Insurers issuing contracts or supplemental contracts containing that provision shall establish any additional reserves and file any additional financial reports that the commissioner may require.

SEC. 2. Section 10232.8 of the Insurance Code is amended to read:

10232.8. (a) In every long-term care policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as a provision that the insured will qualify if either one of two criteria are met:

(1) Impairment in two out of seven activities of daily living.

(2) Impairment of cognitive ability.

The policy or certificate may provide for lesser but not greater eligibility criteria. The commissioner, at his or her discretion, may approve other criteria or combinations of criteria to be substituted, if the insurer demonstrates that the interest of the insured is better served.

"Activities of daily living" in every policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits shall include eating, bathing, dressing, ambulating, transferring, toileting, and continence; "impairment" means that the insured needs human assistance, or needs continual substantial supervision; and "impairment of cognitive ability" means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

(b) In every long-term care policy approved or certificate issued after the effective date of the act adding this section, that is intended to be a federally qualified long-term care insurance contract as described in subdivision (a) of Section 10232.1, the threshold establishing eligibility for home care benefits shall provide that a chronically ill insured will qualify if either one of two criteria are met or if a third criterion, as provided by this subdivision, is met:

(1) Impairment in two out of six activities of daily living.

(2) Impairment of cognitive ability.

Other criteria shall be used in establishing eligibility for benefits if federal law or regulations allow other types of disability to be used applicable to eligibility for benefits under a long-term care insurance policy. If federal law or regulations allow other types of disability to be used, the commissioner shall promulgate emergency regulations to add those other criteria as a third threshold to establish eligibility for benefits. Insurers shall submit policies for approval within 60 days of the effective date of the regulations. With respect to policies previously approved, the department is authorized to review only the changes made to the policy. All new policies approved and certificates issued after the effective date of the regulation shall include the third criterion. No policy shall be sold that does not include the third criterion after one year beyond the effective date of the regulations. An insured meeting this third criterion shall be eligible for benefits regardless of whether the individual meets the impairment requirements in paragraph (1) or (2) regarding activities of daily living and cognitive ability.

(c) A licensed health care practitioner, independent of the insurer, shall certify that the insured meets the definition of "chronically ill individual" as defined under Public Law 104-191. For the purposes of long-term care insurance as defined in Section 10231.2, an insurer shall not impose a certification requirement of longer than 90 days. If a health care practitioner makes a determination, pursuant to this section, that an insured does not meet the definition of "chronically ill individual," the insurer shall notify the insured that the insured shall be entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured. The requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this section and who personally examined the insured. The assessments conducted pursuant to this section shall be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification shall be renewed every 12 months. A licensed health care practitioner shall develop a written plan of care after personally examining the insured. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," or to prepare written plans of care shall not count against the lifetime maximum of the policy or certificate. In order to be considered "independent of the insurer," a licensed health care practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification. It is the intent of this subdivision that the practitioner's assessments be unhindered by financial considerations. This subdivision shall apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract.

(d) "Activities of daily living" in every policy or certificate intended to be a federally qualified long-term care insurance contract as provided by Public Law 104-191 shall include eating, bathing, dressing, transferring, toileting, and continence; "impairment in activities of daily living" means the insured needs "substantial assistance" either in the form of "hands-on

assistance" or "standby assistance," due to a loss of functional capacity to perform the activity; "impairment of cognitive ability" means the insured needs substantial supervision due to severe cognitive impairment; "licensed health care practitioner" means a physician, registered nurse, licensed social worker, or other individual whom the United States Secretary of the Treasury may prescribe by regulation; and "plan of care" means a written description of the insured's needs and a specification of the type, frequency, and providers of all formal and informal long-term care services required by the insured, and the cost, if any.

(e) Until the time that these definitions may be superseded by federal law or regulation, the terms "substantial assistance," "hands-on assistance," "standby assistance," "severe cognitive impairment," and "substantial supervision" shall be defined according to the safe-harbor definitions contained in Internal Revenue Service Notice 97-31, issued May 6, 1997.

(f) The definitions of "activities of daily living" to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

(1) Eating, which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(2) Bathing, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

(3) Continence, which shall mean 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 a catheter or colostomy bag).

(4) Dressing, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(5) Toileting, which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.

(6) Transferring, which shall mean the ability to move into or out of bed, a chair or wheelchair.

The commissioner may approve the use of definitions of "activities of daily living" that differ from the verbatim definitions of this subdivision if these definitions would result in more policy or certificate holders qualifying for long-term care benefits than would occur by the use of the verbatim definitions of this subdivision. In addition, the following definitions may be used without the approval of the commissioner: (1) the verbatim definitions of eating, bathing, dressing, toileting, transferring, and continence in subdivision (g); or (2) the verbatim definitions of eating, bathing, dressing, toileting, and continence in this subdivision and a substitute, verbatim definition of "transferring" as follows: "transferring," which shall mean the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

The definitions to be used in policies and certificates for impairment in activities of daily living, "impairment in cognitive ability," and any third eligibility criterion adopted by regulation pursuant to subdivision (b) shall be the verbatim definitions of these benefit eligibility triggers allowed by federal regulations. In addition to the verbatim definitions, the commissioner may approve additional descriptive language to be added to the definitions, if the additional language is (1) warranted based on federal or state laws, federal or state regulations, or other relevant federal decision, and (2) strictly limited to that language that is necessary to ensure that the definitions required by this section are not misleading to the insured.

(g) The definitions of "activities of daily living" to be used verbatim in policies and certificates that are not intended to qualify for favorable tax treatment under Public Law 104-191 shall be the following:

(1) Eating, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.

(2) Bathing, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.

(3) Dressing, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

(4) Toileting, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

(5) Transferring, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

(6) Continence, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

(7) Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

SEC. 3. Section 10271 of the Insurance Code is repealed.

SEC. 4. Section 10271 is added to the Insurance Code, to read:

10271. (a) Except as set forth in this section, this chapter shall not apply to, or in any way affect, provisions in life insurance, endowment, or annuity contracts, or contracts supplemental thereto, that provide additional benefits in case of death or dismemberment or loss of sight by accident, or that operate to safeguard those contracts against lapse, as described in subdivision (a) of Section 10271.1, or give a special surrender benefit, as defined in subdivision (b) of Section 10271.1, or an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295), in the event that the owner,

insured, or annuitant, as applicable, meets the benefit triggers specified in the life insurance or annuity contract or supplemental contract.

(b) For the purposes of this section, the term "supplemental benefit" means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a).

(c) A supplemental benefit described in subdivision (a) shall contain all of the following provisions. However, an insurer, at its option, may substitute for one or more of the provisions a corresponding provision of different wording approved by the commissioner that is not less favorable in any respect to the owner, insured, or annuitant, as applicable. The required provisions shall be preceded individually by the appropriate caption, or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A life insurance policy or annuity contract that contains a supplemental benefit shall provide that the contract, supplemental contract, and any papers attached thereto by the insurer, including the application if attached, constitute the entire insurance or annuity contract and shall also provide that no agent has the authority to change the contract or to waive any of its provisions. This provision shall be preceded individually by a caption stating "ENTIRE CONTRACT; CHANGES:" or other appropriate caption as the commissioner may approve.

(2) The supplemental benefit shall provide that reinstatement of the supplemental benefit shall be on the same or more favorable terms as reinstatement of the underlying life insurance policy or annuity contract. Following reinstatement, the insured and insurer shall have the same rights under reinstatement as they had under the supplemental benefit immediately before the due date of the defaulted premium, subject to any provisions endorsed in the rider or endorsement or attached to the rider or endorsement in connection with the reinstatement. This reinstatement provision shall be preceded individually by a caption stating "REINSTATEMENT:" or other appropriate caption as the commissioner may approve.

(3) A supplemental benefit subject to underwriting shall include an incontestability statement that provides that the insurer shall not contest the supplemental benefit after it has been in force during the lifetime of the insured for two years from its date of issue, and that the supplemental benefit may only be contested based on a statement made in the application for the supplemental benefit, if the statement is attached to the contract and if the statement was material to the risk accepted or the hazard assumed by the insurer. This provision shall be preceded individually by a caption stating "INCONTESTABILITY:" or other appropriate caption as the commissioner may approve.

(4) The supplemental benefit shall provide either that the insurer may accept written notice of claim at any time or that the insurer may require that written notice of claim be submitted by a due date that is no less than 20 days after an occurrence covered by the supplemental benefit, or commencement of any loss covered by the supplemental benefit, or as soon after the due date as is reasonably possible. Notice given by or on behalf of

the insured or the beneficiary, as applicable, to the insurer at the insurer's address or telephone number, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This provision shall be preceded individually by a caption stating "NOTICE OF CLAIM:" or other appropriate caption as the commissioner may approve.

(5) The supplemental benefit shall provide that the insurer, upon receipt of a notice of claim, shall furnish to the claimant those forms as are usually furnished by it for filing a proof of occurrence or a proof of loss. If the forms are not furnished within 15 days after giving notice, the claimant shall be deemed to have complied with the requirements of the supplemental benefit as to proof of occurrence or proof of loss upon submitting, within the time fixed by the supplemental benefit for filing proof of occurrence or proof of loss, written proof covering the character and the extent of the occurrence or loss. This provision shall be preceded individually by a caption stating "CLAIM FORMS:" or other appropriate caption as the commissioner may approve.

(6) The supplemental benefit shall provide that the insurer may require that the insured provide written proof of occurrence or proof of loss no less than 90 days after the termination of the period for which the insurer is liable, and, in the case of claim for any other occurrence or loss, within 90 days after the date of the occurrence or loss. Failure to furnish proof within the time required shall not invalidate or reduce the claim if it was not reasonably possible to give proof within the time, provided proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. This provision shall be preceded individually by a caption stating "PROOF OF LOSS:" or other appropriate caption as the commissioner may approve.

(7) The supplemental benefit shall provide that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as the insurer may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law. This provision shall be preceded individually by a caption stating "PHYSICAL EXAMINATIONS:" or other appropriate caption as the commissioner may approve.

(d) The commissioner shall not approve any contract or supplemental contract for insurance or delivery in this state if the commissioner finds that the contract or supplemental contract does any of the following:

(1) Contains any provision, label, description of its contents, title, heading, backing, or other indication of its provisions that is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the supplemental benefit is offered, delivered, or issued.

(2) Constitutes fraud, unfair trade practices, or insurance economically unsound to the owner, insured, or annuitant, as applicable.

(3) Contains any actuarial information that is materially incomplete, incorrect, or inadequate.

(e) A supplemental benefit described in subdivision (a) shall not contain any title, description, or any other indication that would describe or imply that the supplemental benefit provides long-term care coverage.

(f) Commencing two years from the date of the issuance of the supplemental benefit, no claim for loss incurred or disability, as defined by the supplemental benefit, may be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date on the coverage of the supplemental benefit.

(g) With regard to supplemental benefits set forth in subdivision (a), the supplemental benefit shall specify any applicable exclusions, which shall be limited to the following:

(1) Condition or loss caused or substantially contributed to by any attempt at suicide or intentionally self-inflicted injury, while sane or insane.

(2) Condition or loss caused or substantially contributed to by war or an act of war, as defined in the exclusion provisions of the contract.

(3) Condition or loss caused or substantially contributed to by active participation in a riot, insurrection, or terrorist activity.

(4) Condition or loss caused or substantially contributed to by committing or attempting to commit a felony.

(5) Condition or loss caused or substantially contributed to by voluntary intake of either:

(A) Any drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions.

(B) Poison, gas, or fumes, unless they are the direct result of an occupational accident.

(6) Condition or loss in consequence of the insured being intoxicated, as defined by the jurisdiction where the condition or loss occurred.

(7) Condition or loss caused or substantially contributed to by engaging in an illegal occupation.

(h) If the commissioner notifies the insurer, in writing, that the filed form or actuarial information does not comply with the requirements of law and specifies the reasons for his or her opinion, it is unlawful for an insurer to issue any policy in that form.

SEC. 5. Section 10271.1 of the Insurance Code is amended to read:

10271.1. (a) (1) Supplemental benefits that operate to safeguard life insurance contracts against lapse are defined as a waiver of premium benefit or a waiver of monthly deduction benefit, as applicable, in which the insurer waives the premium or monthly deduction for a life insurance contract when the insured becomes totally disabled, as defined by the supplemental benefit, and where the waiver continues until the end of the insured's disability, or for the period specified by the supplemental benefit, consistent with paragraph (5).

(2) For purposes of this subdivision, total disability shall not be less favorable to the insured than the following:

(A) During the first 24 months of total disability, the insured is unable to perform with reasonable continuity the substantial and material duties of his or her job due to sickness or bodily injury.

(B) After the first 24 months of total disability, the insured, due to sickness or bodily injury, is unable to engage with reasonable continuity in any other job in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, experience, station in life, or physical and mental capacity.

(3) The definition of total disability may also include presumptive total disability, such as the insured's total and permanent loss of sight of both eyes, hearing of both ears, speech, the use of both hands, both feet, or one hand and one foot.

(4) The insurer may require total disability to continue for an uninterrupted period of time specified by the supplemental benefit, or the insurer may allow separate periods of disability to be combined.

(5) The waiver of premium or monthly deduction benefit shall continue for the period specified by the supplemental benefit, but shall not be less favorable to the insured than the following:

(A) If the insured's total disability begins before the insured attains 60 years of age, the insurer shall waive all premiums or monthly deductions due for the period of the total disability, and if the total disability extends to the insured's attainment of 65 years of age, the insurer shall waive all further premiums or monthly deductions due.

(B) If the insured's total disability begins after the age specified in subparagraph (A), the insurer shall waive all premiums or monthly deductions due for the period that the insured continues to be totally disabled up to 65 years of age.

(6) In addition to the permissible exclusions listed in subdivision (g) of Section 10271, the insurer may exclude a total disability occurring after the policy anniversary or supplemental contract anniversary, as applicable and as defined by the supplemental benefit, on which the insured attains a specified age of no less than 65 years.

(b) "Special surrender benefit" is defined as a "waiver of surrender charge benefit" wherein the insurer waives the surrender charge usually charged for a withdrawal of funds from the cash value of a life insurance contract or the account value of an annuity contract if the owner, insured, or annuitant, as applicable, meets any of the following criteria:

(1) Develops any medical condition where the owner's, insured's, or annuitant's life expectancy is expected to be less than or equal to a limited period of time that shall not be restricted to a period of less than 12 months or greater than 24 months.

(2) Is receiving, as prescribed by a physician, registered nurse, or licensed social worker, home care or community-based services, as defined in subdivision (a) of Section 10232.9, or is confined in a skilled nursing facility, convalescent nursing home, or extended care facility, which shall not be defined more restrictively than as in the Medicare program, or is confined in a residential care facility or residential care facility for the elderly, as

defined in the Health and Safety Code. Out-of-state providers of services shall be defined as comparable in licensure and staffing requirements to California providers.

(3) Has any medical condition that would, in the absence of treatment, result in death within a limited period of time, as defined by the supplemental benefit, but that shall not be restricted to a period of less than six months.

(4) Is totally disabled, as follows:

(A) During the first 24 months of total disability, the owner, insured, or annuitant, as applicable, is unable to perform with reasonable continuity the substantial and material duties of his or her job due to sickness or bodily injury.

(B) After the first 24 months of total disability, the owner, insured, or annuitant, as applicable, due to sickness or bodily injury, is unable to engage with reasonable continuity in any other job in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, experience, station in life, or physical and mental capacity.

(C) The definition of total disability may also include presumptive total disability, such as the insured's total and permanent loss of sight of both eyes, hearing of both ears, speech, the use of both hands, both feet, or one hand and one foot.

(D) The insurer may require the total disability to continue for an uninterrupted period of time specified by the supplemental benefit, or the insurer may allow separate periods of disability to be combined.

(5) Has a chronic illness as defined pursuant to either subparagraph (A) or (B):

(A) Either of the following:

(i) Impairment in performing two out of seven activities of daily living, as set forth in subdivisions (a) and (g) of Section 10232.8, meaning the insured needs human assistance, or needs continual substantial supervision.

(ii) The insured has an impairment of cognitive ability, meaning a deterioration or loss of intellectual capacity due to mental illness or disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

(B) Either of the following:

(i) Impairment in performing two out of six activities of daily living as described in subdivisions (b), (d), (e), and (f) of Section 10232.8 due to a loss of functional capacity to perform the activity.

(ii) Impairment of cognitive ability, meaning the insured needs substantial supervision due to severe cognitive impairment, as described in subdivisions (b), (d), and (e) of Section 10232.8.

(6) Has become involuntarily or voluntarily unemployed.

(c) The term "supplemental benefit" means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a) of Section 10271.

SEC. 6. Section 10292 of the Insurance Code is amended to read:

10292. (a) A supplemental benefit described in subdivision (a) of Section 10271 shall not be delivered or issued for delivery to any person in this state until a copy of the form thereof is submitted to, and approved by, the commissioner. If the supplemental benefit is an integral part of a contract of life insurance or annuity, the entire contract shall be submitted to the commissioner, but his or her power of approval or disapproval, unless it is otherwise authorized, is limited to the supplemental portion and any other portions that relate to the supplemental portion.

(b) A supplemental benefit described in subdivision (a) of Section 10271 shall be considered an integral part of a contract for purposes of this section. To facilitate the review of a supplemental benefit, the insurer shall submit, for informational purposes, a sample copy of the life insurance or annuity contract with which the supplemental benefit will be used. To facilitate the location of the required provisions as stated in subdivision (c) of Section 10271, the insurer shall provide the sample copy page reference for the provisions that appear in the contract.

(c) The commissioner may adopt reasonable rules and regulations as are necessary to administer and carry out the purposes of Sections 10271 and 10271.1, Article 2.1 (commencing with Section 10295), and this section.

SEC. 7. Article 2.1 (commencing with Section 10295) is added to Chapter 4 of Part 2 of Division 2 of the Insurance Code, to read:

Article 2.1. Accelerated Death Benefits

10295. (a) An accelerated death benefit, as described in this section, shall not be offered, sold, issued, or marketed as health, accident, or long-term care insurance. An accelerated death benefit shall not reimburse or provide specific coverage for any health, accident, or long-term care insurance benefits.

(b) (1) For the purposes of this article, an "accelerated death benefit" means a provision, endorsement, or rider added to a life insurance policy that provides for the advance payment of any part of the death proceeds, payable upon the occurrence of a qualifying event in accordance with Section 10295.1.

(2) For the purposes of this article, "qualifying event" means that subparagraph (A) or (B) applies.

(A) The insured has a medical condition that would, in the absence of treatment, result in death within a limited period of time, as defined by the supplemental benefit, but that shall not be restricted to a period of less than six months.

(B) (i) The insured has a chronic illness as defined in subparagraph (B) of paragraph (5) of subdivision (b) of Section 10271.1.

(ii) For policies intended to be federally tax qualified, the insurer shall require that a licensed health care practitioner, independent of the insurer, certifies that the insured meets the definition of "chronically ill individual"

as defined under the federal Health Insurance Portability and Accountability Act (Public Law 104-191).

(I) If a health care practitioner makes a determination, pursuant to this clause, that an insured does not meet the definition of "chronically ill individual," the insurer shall notify the insured that the insured shall be entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured. The requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this clause and who personally examined the insured.

(II) The assessments conducted pursuant to this clause shall be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification shall be renewed every 12 months.

(III) The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," shall not count against the lifetime maximum of the policy or certificate.

(IV) In order to be considered "independent of the insurer," a licensed health care practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification.

(V) It is the intent of the Legislature in enacting this clause that the practitioner's assessments be unhindered by financial considerations.

(VI) This clause shall apply only to a policy or certificate intended to be federally tax qualified.

(3) For the purposes of this article, "applicant" means any of the following:

(A) In the case of an individual life insurance policy with an accelerated death benefit, the person who seeks to contract for benefits.

(B) (i) In the case of a group life insurance policy with an accelerated death benefit, the proposed certificate holder.

(ii) "Certificate" means any certificate issued under a group life insurance policy that includes an accelerated death benefit.

(4) For the purposes of this article, the term "supplemental benefit" means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a) of Section 10271.

(c) A life insurance policy that accelerates death benefits if the insured is chronically ill and requires that the insured receives long-term care services described in Section 10231.2, shall not be considered an accelerated death benefit for the purposes of this article.

(d) Nothing in this subdivision shall be construed as prohibiting an insurer from including other riders to a life insurance policy, such as a terminal illness rider, that are not subject to this article.

10295.1. (a) An accelerated death benefit as defined in paragraph (1) of subdivision (b) of Section 10295 shall comply with, and shall explain all of, the following:

(1) That the accelerated death benefit is fixed at the time the insurer approves the request for the accelerated death benefit.

(2) That the payment of the accelerated death benefit is not conditioned on the receipt of long-term care or medical services.

(3) That the insured shall have the option to take the accelerated death benefit in a lump sum on the occurrence of a qualifying event, as well as an option to receive the benefit in periodic payments is provided for a certain period only.

(4) That the accelerated death benefit may not restrict the insured's use of the proceeds.

(5) That the payment of the accelerated death benefit is due immediately upon receipt of the due written proof of eligibility.

(6) That, prior to the payment of the accelerated death benefit, the insurer is required to obtain from an assignee or irrevocable beneficiary, if any, a signed acknowledgment of concurrence for payout. If the insurer making the accelerated death benefit is itself the assignee under the policy, the acknowledgment is not required.

(7) That if any death benefit remains after payment of an accelerated death benefit, the accidental death benefit provision, if any, in the policy shall not be affected by the payment of the accelerated death benefit.

(b) The accelerated death benefit shall also provide for all of the following:

(1) A maximum amount that may be accelerated.

(2) An explanation that the insured may accelerate more than once on a qualifying event up to the maximum amount.

(3) An explanation that the insured may accelerate on more than one of the qualifying events specified in the supplemental provision up to the maximum amount.

(4) A statement that the policy, rider, endorsement, or certificate pays proceeds that are or are not intended for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C. Sec. 101(g)), if applicable.

(c) The insurer shall advise the policyholder or certificate holder that there may be tax consequences of accepting an amount above the amount that would be tax qualified under the Internal Revenue Code.

(d) The accelerated death benefit shall not contain any preexisting condition limitation and shall not contain any requirement that acceleration be conditioned on a prior hospitalization or institutionalization.

(e) The accelerated death benefit shall contain an explanation of how the insured will pay for the accelerated death benefit, whether by paying a portion of the premium for the life insurance policy, by paying a fee at the time of the acceleration, by paying the cost of insurance charge, or by paying the administrative expense charge, together with an illustration. If there is a premium or cost of insurance charge, or a charge imposed upon the

acceleration, a generic illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens shall suffice for this purpose.

(f) (1) Every accelerated death benefit that pays proceeds intended for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C. Sec. 101(g)) shall be identified as such by prominently displaying and printing that intention on page one of the accelerated benefit policy provision, rider, endorsement, or certificate.

(2) Every accelerated death benefit that pays proceeds that are not intended for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C. Sec. 101(g)) shall be identified as such by prominently displaying and printing that intention on page one of the accelerated death benefit policy provision, rider, endorsement, or certificate.

10295.2. A life insurance contract with an accelerated death benefit or an accelerated death benefit in the form of a rider or endorsement shall be submitted for the approval of the commissioner in the same manner as required under Section 10292 and shall be submitted with the following additional information:

(a) The term "accelerated death benefit" shall be included in the descriptive title of the filing.

(b) A statement of the specific policy forms with which this accelerated death benefit will be offered, any underwriting restrictions involving face amount or age, and whether the accelerated death benefit is intended for use with new issues or in force business, or both.

(c) An insurer that requires certification that a chronic illness is expected to last longer than 90 days shall include in its filing a legal memorandum from outside tax counsel that the certification would allow for preferable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C. Sec. 101(g)).

10295.3. (a) A written disclosure, as set forth below, shall be included with the filing for the commissioner's approval, and shall be given to each applicant. The same written disclosure shall be attached to the policy or certificate delivered to the insured.

(b) The required written disclosure shall be in the following form:

"IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS"

"The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility."

(c) In the case of agent-solicited life insurance, the agent shall provide the disclosure form to the applicant prior to, or concurrently with, the application. Acknowledgment of the applicant's receipt of the disclosure shall be signed by the applicant and the writing agent.

(d) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant together with the application. A notice that a full premium refund shall be provided to the insured if the policy is returned to the company within the free look period, pursuant to Section 10295.8.

(e) In the case of group insurance policies, the disclosure form shall be delivered together with the application for the certificate, or with the certificate of coverage or any related document furnished by the insurer for the certificate holder.

10295.4. An insurer shall file with the commissioner an actuarial memorandum prepared, dated, and signed by a member of the American Academy of Actuaries that includes all of the following information:

(a) A description of the accelerated death benefit, including the effects of payment of the accelerated death benefit on all life insurance policy benefits and any subsequent accelerated death benefits, premium payments, cost of insurance rates, and values, including any outstanding loan, if applicable, for all types of forms with which the accelerated death benefit will be used.

(b) A description of, and justification for, expense charges associated with the accelerated death benefit and the maximum expense charges.

(c) A description of the interest rate or interest rate methodology used in any present value calculation or in accruing interest on the amount of the accelerated death benefit, which shall not exceed the greater of the current yield on 90-day treasury bills, or a variable rate determined in accordance with the National Association of Insurance Commissioners (NAIC) Model Policy Loan Interest Rate Bill No. 590.

(d) A description of the mortality basis and methodology, including the period of time applicable to any mortality discount, used in any present value calculation of the accelerated death benefit.

(e) A description of the mortality and morbidity basis and methodology used in the determination of any separate premium or costs of insurance for the accelerated death benefit.

(f) The formula used to determine the accelerated death benefit, including any limitations on the amount of the benefit, and the formula used to

determine the postacceleration premium for the accelerated death benefit as well as the life insurance policy.

(g) A sample calculation of the accelerated death benefit. If the life insurance policy contains a loan provision, the example shall assume that there is an outstanding loan on the date of acceleration. All policy and accelerated death benefit benefits, premium payments, cost of insurance charges and values, including the outstanding loan, if applicable, immediately before and immediately after acceleration shall be shown in the example.

(h) If an accelerated death benefit will be paid in installments, the actuarial memorandum shall explain the basis used in the calculation of the minimum periodic payment for the payment period and a sample calculation of a minimum periodic payment, and the basis used, and a sample calculation of the lump sum payable if the insured dies before all periodic payments for the payment period are made.

(i) (1) For any accelerated death benefit subject to this article, a certification that the value and premium of the accelerated death benefit is 10 percent or less of the total value of the benefits over the life of the policy. These values shall be measured as of the date of issue.

(2) The certification shall be in the following form:

"I,_____of _____ am a Member in good standing of the American Academy of Actuaries and am qualified to provide this Certification with respect to the accelerated death benefit described in the Actuarial Memorandum to which this Certification is attached.

I certify that:

(1) The value of the benefits provided, on an aggregated basis, in respect of the filed accelerated death benefit, determined according to the formula below applied over a range of underwriting classes and plans at which the benefit is being made available, is not in any case greater than 10%.

(NSP2 – NSP1) / NSP1

Where:

(a) NSP1 and NSP2 are determined using an effective annual interest rate of 6%.

(b) NSP1 is the net single premium for the base policy benefits assuming there is no accelerated death benefit.

(c) NSP2 is the net single premium for the base policy benefits assuming that the full death benefit is paid at time of death or the occurrence of the non-death accelerated death benefit trigger.

(2) In developing the assumptions, other than the interest assumption, used in calculating NSP1 and NSP2, I have complied with all applicable laws, regulations, and Actuarial Standards of Practice (ASOPs). The assumptions used represent anticipated experience factors, as defined in actuarial literature and by generally accepted actuarial practice.

(3) The assumptions, other than the interest assumption, used in calculating NSP1 and NSP2 will be reviewed at least annually by the Company to ensure that the value of the accelerated death benefit provided,

as defined in (1) above, continues to be incidental. If, after such review and while this accelerated death benefit is being actively issued, the value of the benefits provided by this benefit are no longer incidental based on then current anticipated experience factors, the Company will discontinue offering the accelerated death benefit which is no longer incidental.

(4) If a separate premium or cost of insurance (COI) charge is being charged for the accelerated death benefit provided, the ratio of the present value of the accelerated death benefit premiums or COI charges over the life of the policy to the present value of the policy premiums or COI charges exclusive of any riders, does not exceed 10%. The present values in this item (4) are determined using an effective annual interest rate of 6%."

10295.5. (a) Applications, if any, or forms supporting an application, if any, for accelerated death benefits shall contain clear, unambiguous, short, and simple questions designed to ascertain the health condition of the applicant. Each question shall contain only one health status inquiry and shall require only a "yes" or "no" answer, except that the application may include a request for the name of any prescribed medication and the name of the prescribing physician. If the application requests the name of any prescribed medication or the prescribing physician, then any mistake or omission shall not be used as a basis for the denial of a claim or the rescission of the accelerated death benefit or life insurance policy or certificate.

(b) The following warning shall be printed conspicuously and in close conjunction with the applicant's signature block:

"Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage."

(c) If an insurer does not complete medical underwriting for the accelerated death benefit separate from underwriting for the life insurance policy and resolve all reasonable questions arising from information submitted on or with an application before issuing the accelerated death benefit, then the insurer may only rescind the accelerated death benefit or life insurance policy or certificate or deny an otherwise valid claim upon clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant. The evidence shall do all of the following:

(1) Pertain to the condition for which benefits are sought.

(2) Involve a chronic condition or involve dates of treatment before the date of application.

(3) Be material to the acceptance for coverage.

(d) An accelerated death benefit may not be field issued.

(e) The contestability period for a life insurance policy or certificate that contains an accelerated death benefit shall comply with paragraph (3) of subdivision (c) of Section 10271.

(f) A copy of the completed application shall be delivered to the insured at the time of delivery of the life insurance policy or certificate that contains an accelerated death benefit.

10295.6. (a) When a policyholder or certificate holder requests an acceleration of death benefits, the insurer shall send a statement to the policyholder or certificate holder and irrevocable beneficiary showing any effect that the payment of the accelerated death benefit would have on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. The statement shall disclose that receipt of accelerated death benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of an accelerated death benefit payment may be taxable and assistance should be sought from a personal tax adviser. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policyholder or certificate holder and irrevocable beneficiary.

(b) The accelerated death benefit shall be effective not more than 30 days following the effective date of the policy provision, rider, endorsement, or certificate.

(c) If the insurer charges a separate premium for the accelerated death benefit, then the insurer may also offer a waiver of premium benefit as defined in subdivision (a) of Section 10271.1. At the time the waiver of the accelerated death benefit premium benefit is claimed, the insurer shall explain any continuing premium requirement to keep the underlying policy in force.

(d) An insurer shall not unfairly discriminate among insureds with different qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy. An insurer shall not apply further conditions on the payment of the accelerated death benefits other than those conditions specified in the accelerated death benefit.

(e) The insurer shall provide the policyholder or certificate holder with a report, at least monthly, of any accelerated death benefits paid out during the prior month, an explanation of any changes to the policy or certificate, death benefits, and cash values on account of the benefits being paid out, and the amount of the remaining benefits that can be accelerated at the end of the prior month. The insurer may use a calendar month or policy or certificate month.

(f) The conversion benefit available to group certificate holders on termination of employment pursuant to paragraph (2) of subdivision (a) of Section 10209 shall include a benefit comparable to the accelerated death benefit. This requirement may be satisfied by an individual policy or certificate. This requirement, subject to the approval of the commissioner, may be satisfied by arrangement with another insurer to provide the required coverage.

(g) When payment of an accelerated death benefit results in a pro rata reduction in cash value, the payment may be applied toward repaying a portion of the loan equal to a pro rata portion of any outstanding policy

loans if disclosure of the effect of acceleration upon any remaining death benefit, cash value or accumulation account, policy loan, and premium payments, including a statement of the possibility of termination of any remaining death benefit, is provided to the policyholder or certificate holder. The policyholder or certificate holder shall provide written consent authorizing any other arrangement for the repayment of outstanding policy loans.

10295.7. (a) The insurer may require a premium charge or cost of insurance charge for the accelerated death benefit. This charge shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be reflected in the experience rating.

(b) (1) The insurer may pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum required in Section 10295.4. The maximum interest rate used shall be no greater than the greater of one of the following:

(A) The current yield on 90-day treasury bills.

(B) The current maximum statutory adjustable policy loan interest rate.

(2) The interest rate accrued on the portion of the lien that is equal in amount to the cash value of the life insurance policy at the time of the supplemental benefit acceleration shall be not more than the policy loan interest rate stated in the contract.

(c) (1) Except as provided in paragraph (2), when an accelerated death benefit is payable, there shall not be more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated death benefit payment.

(2) Alternatively, the payment of accelerated death benefits, any administrative expense charges, any future premiums, and any accrued interest can be considered a lien against the death benefit of the life insurance policy and access to the cash value of the life insurance policy may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans may also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

(d) When payment of an accelerated death benefit results in a pro rata reduction in the cash value of the life insurance policy, the payment shall not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

10295.8. (a) An applicant for an accelerated death benefit shall have the right to return the accelerated death benefit policy or certificate by first-class United States mail 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. If the accelerated death benefit is purchased as an endorsement or rider at the same time as the base life insurance policy, then the endorsement or rider may be returned within 30

days. The underlying life insurance policy shall be otherwise subject to this code.

(b) The return of a life insurance policy or certificate that contains an accelerated death benefit, or the return of an accelerated death benefit rider or endorsement, shall void the life insurance policy, certificate, rider, or endorsement from the beginning, and the parties shall be in the same position as if no policy, certificate, rider, or endorsement had been issued. All premiums paid and any policy fee paid for the accelerated death benefit shall be fully refunded directly to the applicant by the insurer within 30 days after the policy, rider, endorsement, or certificate is returned.

(c) Policies, certificates, riders, or endorsements to which this section applies shall have a notice prominently printed, or attached thereto, stating in substance the conditions described in subdivisions (a) and (b).

10295.9. (a) Application forms for accelerated death benefits shall include a question designed to elicit information as to whether the accelerated death benefit is intended to replace any long-term care insurance presently in force. A supplementary application or other form to be signed by the applicant containing that question may be used.

(b) (1) An insurer, broker, agent, or other person shall not cause a policyholder to replace a long-term care insurance policy unnecessarily. This section shall not be construed to allow an insurer, broker, agent, or other person to cause a policyholder to replace a long-term care insurance policy or life insurance policy subject to this section that will result in a decrease in benefits and an increase in premium.

(2) It shall be presumed that any third or greater policy sold to a policyholder in any 12-month period is unnecessary within the meaning of this section. This section shall not apply to those instances in which a policy is replaced solely for the purpose of consolidating policies with a single insurer.

(c) Upon determining that a sale will involve a replacement of a life insurance policy subject to this section or replacement of a long-term care insurance policy, an insurer or its agent shall furnish the applicant, prior to issuance or delivery of a policy, certificate, rider, or endorsement, a notice regarding replacement of life insurance that includes an accelerated death benefit, or long-term care insurance coverage with a life insurance policy or certificate that contains an accelerated death benefit. One copy of this 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 form:

"NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG-TERM CARE INSURANCE OR LIFE INSURANCE INCLUDING ACCELERATED DEATH BENEFITS

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by (company name) Insurance Company. Your

new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and it is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

(1) Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax adviser.

(2) Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. 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.

If, after due consideration, you still wish to terminate your present coverage 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 coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

(Date)

(Applicant’s Signature)”

(d) The replacement notice shall include the following statement except when the replacement coverage is group insurance:

"COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

____ Additional or different benefits

(please specify) _____.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ Other (please specify) _____.

(Signature of Agent and Name of Insurer)

(Signature of Applicant)

(Date)

(e) In recommending the purchase or replacement of any policy or certificate issued under this section, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(f) The replacing policy or certificate shall not contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

10295.10. An insurer may not:

(a) Cancel, nonrenew, or otherwise terminate an accelerated death benefit on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

(b) Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.

10295.11. (a) An accelerated death benefit shall not be advertised or marketed as long-term care insurance, nursing home insurance, or home care insurance. Any advertisement, description, comparison, marketing material, or illustration shall state in bold type:

"This is a life insurance benefit that also gives you the option to accelerate some or all of the death benefit in the event that you meet the criteria for a qualifying event described in the policy. This policy or certificate does not provide long-term care insurance subject to California long-term care insurance law. This policy or certificate is not a California Partnership for Long-Term Care program policy. This policy or certificate is not a Medicare supplement (policy or certificate)."

An insurer shall also include in any advertisement or marketing materials for these insurance policies all of the following:

(1) A statement that the policy or certificate pays proceeds that are or are not intended to receive favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C. Sec. 101(g)).

(2) A description of the accelerated death benefits provided by the policy, including a description of the acceleration of the death benefit to pay an

unrestricted cash benefit when the insured has become chronically ill or otherwise eligible for benefits from a qualified event.

(3) A comparison between the benefits provided by life insurance policies, riders, or endorsements that contain accelerated death benefits and the benefits provided by long-term care insurance.

(b) Advertising for term life insurance policies or certificates that contain an accelerated death benefit to be attached to an existing term life policy shall include a prominent statement that the accelerated death benefit will terminate with the policy.

(c) On or after January 1, 2014, every insurer offering accelerated death benefits shall file with the commissioner copies of all printed advertising for accelerated death benefits that the insurer proposes to disseminate in the state prior to use of that material. The commissioner shall have the authority to disapprove any advertising that does not meet the requirements of this code. If the commissioner disapproves the advertising, the insurer shall not use and shall stop using the disapproved advertising. Nothing in this subdivision shall be construed as requiring prior approval of advertising prior to dissemination in this state.

10295.12. (a) Insurers shall ensure that agents offering, marketing, or selling accelerated death benefits on their behalf are able to describe the differences between benefits provided under an accelerated death benefit and benefits provided under long-term care insurance, as follows:

(1) The difference between the benefits afforded to an insured through an accelerated death benefit and a long-term care insurance policy or rider.

(2) The differences between benefit eligibility criteria.

(3) Whether an elimination period applies to either an accelerated death benefit or long-term care insurance and a description of the elimination period.

(4) The benefits under the accelerated death benefit or long-term care insurance if benefits are never needed.

(5) The benefits under the accelerated death benefit or long-term insurance if benefits are needed.

(6) Restrictions on benefit amounts.

(7) Tax treatment of benefits.

(8) Income and death benefit considerations.

(b) Completion of California agent education or continuing education for long-term care insurance shall meet the requirements of this section.

10295.13. In addition to other unfair trade practices described in this code, the following acts and practices in the sale of insurance under this article 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 that 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.

10295.14. (a) Accelerated death benefits shall comply with the provisions in Sections 10113.71 and 10113.72.

(b) Every insurer offering term life insurance with accelerated death benefits or any rider that provides for accelerated death benefits described in Section 10295 shall also offer a waiver of premium benefit for the life insurance premium and any premium charged for the accelerated death benefit as described in Section 10271.1.

(c) Every insurer offering a cash value life insurance policy or rider offering accelerated death benefits described in Section 10295 shall disclose all premium default protection options in the policy and at the time of the application, including waiver of premium options available under Section 10271.1 and automatic premium loans.

10295.15. (a) Except at the request of the policyholder or contractholder, all accelerated death benefit provisions or supplemental contracts shall be renewable for the life of the underlying life insurance policy, provided the premiums are timely paid. The statement shall be prominently displayed on the first page of the accelerated death benefit policy or rider.

(b) Term life insurance policies shall also include a prominent statement on page one that the accelerated death benefit terminates with the policy.

10295.16. Termination of an accelerated death benefit shall not prejudice the payment of benefits for any qualifying event that occurred while the accelerated death benefit was in force.

10295.17. An insurer that fails to conform to the requirements provided under this article shall be subject to Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1.

10295.18. Accelerated death benefits shall not limit or exclude coverage by type of illness, treatment, medical condition, or accident, except under the circumstances described in paragraphs (1) to (4), inclusive, of subdivision (g) of Section 10271.

10295.19. A policy, certificate, rider, or endorsement shall include a provision giving the policyholder or certificate holder the right to appeal to the insurer a decision regarding benefit eligibility.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

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