



IIPRC-L-08-LB-I-WMDB

**ADDITIONAL STANDARDS FOR WAIVER OF MONTHLY DEDUCTION BENEFITS
FOR TOTAL DISABILITY OR OTHER QUALIFYING EVENTS**

1. Date Adopted: August 12, 2021
2. Purpose and Scope: The Additional Standards for Waiver of Monthly Deduction Benefits for Total Disability and Other Qualifying Events provide for the waiver of monthly deductions made under an individual life insurance policy in the event that the insured becomes totally disabled or experiences any allowable qualifying event under the terms of the policy. These standards apply to the benefit feature whether added to an individual life insurance policy by rider, endorsement or amendment or by incorporation into a policy form. These standards apply in addition to the general form requirements contained in the Standards for All Benefit Features.
3. Rules Repealed, Amended or Suspended by the Rule: This rule amends the Additional Standards for Waiver of Monthly Deduction Benefits adopted by the IIPRC on February 28, 2007, and amended on August 15, 2014. The amendments add qualifying events as defined under the terms of the form. The amendments apply only to new filings received after the effective date of the amendments. It is not necessary to resubmit previously approved forms to comply with these amendments, or to suspend use of previously approved forms that do not comply with these amendments. See the Transmittal Mem under the Standards History on the Record for a more detailed description of the amendments.
4. Statutory Authority: Among the primary purposes and powers of the Interstate Insurance Product Regulation Commission (“IIPRC”) is to establish reasonable uniform standards for insurance products covered under the Interstate Insurance Product Regulation Compact (“Compact”), specifically pursuant to Article I §2, Article IV § 2 and Article VII § 1 of the Compact, as enacted into law by each IIPRC member state.
5. Required Findings: None
6. Effective Date: November 29, 2021

**ADDITIONAL STANDARDS FOR WAIVER OF MONTHLY DEDUCTION BENEFITS FOR
TOTAL DISABILITY AND OTHER QUALIFYING EVENTS**

Table of Contents

<u>Provision/Section</u>	<u>Page</u>
SCOPE	1
§ 1 ADDITIONAL SUBMISSION REQUIREMENTS	4
A. General	4
B. Variability of Information	4
§ 2 GENERAL REQUIREMENTS	5
A. Cover Page	5
B. Specifications Page	6
§ 3 BENEFIT PROVISIONS	6
A. Benefit	6
B. Conditions for Waiver Benefit Eligibility	9
C. Exclusion	11
D. Filing of Claim	12
E. Effect of Policy Adjustments	13
F. Incontestability	13
G. Nonforfeiture Values	13
H. Preexisting Conditions	14
I. Termination	14

ADDITIONAL STANDARDS FOR WAIVER OF MONTHLY DEDUCTION BENEFITS FOR TOTAL DISABILITY AND OTHER QUALIFYING EVENTS

Scope: These standards apply to waiver of monthly deduction benefits that are built into individual life insurance policy forms or added to such policy forms by rider, endorsement or amendment. The waiver is for monthly deductions made under an individual life insurance policy where monthly deductions are applicable, in the event that the insured becomes totally disabled or experiences any allowable qualifying event under the terms of the form. The waiver can include waiver benefits for one or more benefit triggers and is not required to provide waiver for both total disability and all qualifying events. Products subject to these standards shall not be described as long-term care insurance or as providing long-term care benefits. If the payment of waiver of monthly deduction benefits is contingent upon receipt of long-term care services or supports, these standards shall not apply and such benefit will be subject to the Interstate Insurance Product Regulation Commission standards for individual long-term care insurance.

Mix and Match: These standards are available to be used in combination with State Product Components as described in § 111(b) of the *Operating Procedure for the Filing and Approval of Product Filings*.

Self-Certification: These standards are not available to be filed using the *Rule for the Self-Certification of Product Components Filed with the Interstate Insurance Product Regulation Commission*.

As used in these standards, the following definitions apply:

“Benefit ineligibility period” means the initial period of time during which the insured is ineligible to receive the waiver benefit, whether or not there is a qualifying event. A benefit ineligibility period is only allowed if there is no identifiable charge for the waiver benefit.

“Benefit eligibility date” means the date the benefit ineligibility period ends. If there is no benefit ineligibility period, the benefit eligibility date is the waiver benefit issue date.

“Monthly deduction” includes the actual cost of insurance charges, expense charges, and costs of charges for any benefits added to the policy by rider, endorsement, or amendment, and which are specified in the policy to be deducted from the account value.

“Preexisting condition” means an injury or sickness beginning, commencing, originating, occurring, sustained or manifesting or first manifesting itself before the waiver benefit issue date, which may or may not be the cause of a qualifying event.

“Qualifying event” means any of the following, as long as the event meets the requirements of this standard:

- (1) Diagnosis of limited life expectancy or life-threatening condition;
- (2) Diagnosis of cognitive impairment;
- (3) Assessment by qualified professional establishing inability to perform certain activities of daily living;
- (4) Receipt of care from a health care facility;
- (5) Disability other than total disability; or
- (6) Unemployment.

“Waiting period” means the period of time that must elapse after a qualifying event before the owner can receive the waiver benefit. If the qualifying event occurs during the benefit ineligibility period, the waiting period may begin on the benefit eligibility date.

“Waiver benefit” means a waiver of the monthly deductions made under an individual life insurance policy where monthly deductions are applicable.

In addition to the applicable policy Uniform Standards, the following provisions, as applicable apply:

§ 1 ADDITIONAL SUBMISSION REQUIREMENTS

A. GENERAL

The following additional filing submission requirements shall apply:

- (1) A statement of the types of policy forms with which this benefit will be offered, any underwriting restrictions involving face amount or age, and whether the benefit is intended for use with new issues and/or in force business.
- (2) A description of the waiver benefit for all types of forms with which the benefit will be used.
- (3) The formulae, if any, used to determine the benefit, including any limitations on the amount of the benefit and sample calculations for representative issue ages, including issue age 35 if within the issue age range.
- (4) If a waiver benefit is based on a specific condition or situation subject to underwriting, a statement that the application shall include pertinent questions to determine if the condition or situation is present at the time of application.

B. VARIABILITY OF INFORMATION

- (1) The following items shall only be changed upon prior approval:
 - (a) Definition of health care facility; and
 - (b) Exclusions applicable to qualifying events.
- (2) The company may also identify waiver benefit specifications that may be changed without prior notice or approval, as long as the Statement of Variability presents reasonable and realistic ranges for the item. These items include:
 - (a) Life expectancy (no less than six months);
 - (b) Period of time required to meet the definition of total and permanent disability or to meet the definition of any other disability allowed under the standards (no greater than 12 months);
 - (c) Number of “activities of daily living” (no more than two);

- (d) Period of time for which monthly deductions are waived;
 - (e) Benefit ineligibility period if no identifiable charge (no greater than one year from the waiver benefit issue date);
 - (f) Maximum age for initial eligibility for the waiver benefit, if no identifiable charge;
 - (g) Period of time within which insured must enter a health care facility after discharge from an institutional confinement (no less than 30 days) and period of original confinement (no greater than three days);
 - (h) Period of time for which confinement in a health care facility is required to be eligible for a waiver benefit for home care or hospice care (no greater than 30 days);
 - (i) Waiting period for other than total disability (no greater than 90 days);
 - (j) Period of time before application of new waiting period to recurrent condition (no less than 30 days after receiving services/treatment or disability);
 - (k) Period of time for company to provide claim forms (no greater than ten days);
 - (l) Period of time for submitting proof of claim (no less than 90 days after receiving services or treatment, or after unemployment or disability begins);
 - (m) Period of time within which to apply for waiver benefit;
 - (n) Expiry age for termination of the waiver benefit; and
 - (o) Identifiable charge, if any.
- (3) A zero entry in a range for any benefit is unacceptable, and any change to a range requires a refiling for prior approval.

§ 2 GENERAL REQUIREMENTS

A. COVER PAGE

- (1) If a waiver benefit is provided by attachment to the policy by rider, endorsement or amendment, the following shall be included on the cover page:
 - (a) At least one signature of a company officer if the waiver benefit form is added after the date of issue of a policy.
 - (b) A statement to the effect that the waiver benefit form is made a part of the policy and that its provisions apply in lieu of any policy provisions to the contrary.

B. SPECIFICATIONS PAGE

- (1) The specifications page of the policy or waiver benefit form shall include the following information, when applicable, and the respective waiver benefit provisions shall direct the insured to the specifications page:
 - (a) The name, age, sex and premium class for each insured, as applicable;
 - (b) Period of time for which monthly deductions are waived (including any maximum benefit amount);
 - (c) Any applicable identifiable charges. In this regard, an identifiable charge is recognized as a separate monthly deduction or an administrative fee or charge;
 - (d) The benefit eligibility date; and
 - (e) The expiry date or age, if any, for the termination of the waiver benefit.

These items may be considered as variable items and marked to denote variability.

C. FAIRNESS

- 1) The form shall not contain provisions that unfairly discriminate among insureds with differing qualifying events covered under the form, or among insureds with similar qualifying events covered under the form.

§ 3 BENEFIT PROVISIONS

A. BENEFIT

- (1) A waiver benefit form that includes a waiver of monthly deduction as a result of total disability shall describe the total disability conditions that shall be met to be eligible for the waiver benefit. The conditions shall comply with the following:
 - (a) The definition of total disability shall not be less favorable than the following:
 - (i) **During the first 24 months of total disability**, the insured is unable to perform the substantial and material duties of their job due to sickness or accidental bodily injury; and
 - (ii) **After the first 24 months of total disability**, the insured, due to sickness or accidental bodily injury, is unable to perform any of the substantial and material duties of their job, or any other job for which they become reasonably suited by education, training or experience.

Drafting Note: At the discretion of the company, the form may provide for more favorable or additional definitions of total disability such as for full-time students and homemakers.

- (b) The form may expand the definition of total disability to include presumptive total disability such as the insured's total and permanent loss of: sight of both eyes; hearing of both ears; speech; or the use of both hands, both feet or one hand and one foot;
- (c) The form shall describe the monthly deductions that will be waived. All monthly deductions under the policy shall be waived, except asset-based charges may be excluded at the option of the company.
- (d) The form shall state that, if the waiver benefit is in effect, all benefits included under the policy shall continue in force, subject to the investment performance of any separate account included as part of the account value and the policy loan provisions.
- (e) The form shall state that the insured's total disability shall begin while the form is in effect;
- (f) The form shall state the period of time required for the total disability to continue, such as a consecutive period of six months, before the company will approve a claim for the waiver benefit. The form shall also state that until the company approves the claim, monthly deductions shall continue when due as provided in the policy. If the company approves the claim for the waiver benefit after the specified period of time, the company shall credit to the policy's account value an amount equal to the waived monthly deductions taken after the first of the benefit month on or following the date the insured's total disability began, and the account value will be adjusted accordingly.
- (g) The form may base the type of waiver benefit available on the insured's age on the date disability begins, but shall not do so on terms less favorable than the following:
 - (i) **If the insured's total disability begins before the benefit anniversary on which the insured attains age 60**, the form shall state that the company shall waive all monthly deductions which it would have taken under the policy for the period that the insured continues to be totally disabled. If such period extends to the benefit anniversary on which the insured attains age 65, the form shall state that the company shall waive all further monthly deductions due for the insured under the policy;-and
 - (ii) **If the insured's total disability begins after the benefit anniversary on which the insured attains the age specified in item (i) for when total disability begins**, the form shall state that the company shall waive all monthly deductions which it would have taken under the policy for the period that the insured continues to be totally disabled, but only up to the benefit anniversary on which the insured attains age 65;
- (h) The form shall state that monthly deductions waived by the company shall not be taken from the policy proceeds.
- (i) The form shall state that if total disability begins during a grace period, sufficient funds will be required to be added to the account value to ensure that any overdue monthly

deductions can be taken to avoid a lapse of insurance before the company approves the claim for the waiver benefit.

- (j) The form shall describe the initial and subsequent due proof requirements for total disability. To initialize a claim, the form may require written notice and proof of total disability while the insured is alive and totally disabled, or as soon as reasonably possible. During a specified period of time after the company approves the claim for the waiver benefit, not to exceed 24 months, the form may require proof of continued total disability not more frequently than once every 30 days. After such specified period of time, the form shall state that the company shall not require proof more than once in any 12-month period. The form may also state that as part of the due proof requirement, the company at its expense may have its designated physician examine the insured.
- (2) A waiver benefit may be triggered by the occurrence of a qualifying event. The qualifying event shall be described in the waiver benefit form and may include:
- (a) The insured is receiving care from a health care facility designated in the waiver benefit form. A health care facility may include, but is not limited to, the following facilities: skilled nursing, extended care, intermediate care, convalescent care, personal care, home care or hospice care.
 - (b) Due to any medical condition of the insured, the insured's life expectancy is expected to be less than or equal to a limited period of time. The period of time shall not be restricted to a period of less than six months.
 - (c) The insured has any medical condition that would in the absence of treatment result in death within a limited period of time. The period of time shall not be restricted to a period of less than six months.
 - (d) The insured is unable to perform a certain number of "activities of daily living" as defined in Items (i) through (vi). Requirements for the qualifying event shall not be more restrictive than the insured's inability to perform not more than two of the activities of daily living.
 - (i) "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
 - (ii) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
 - (iii) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
 - (iv) "Eating" means feeding oneself by food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

- (v) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- (vi) "Transferring" means moving into or out of a bed, chair or wheelchair.
- (e) The insured is determined to have a cognitive impairment, requiring substantial supervision. "Cognitive impairment" is defined as a deficiency in a person's short or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
- (f) The insured becomes involuntarily or voluntarily unemployed.
- (3) A waiver benefit form may specify more than one qualifying event. The waiver benefit form shall not require that a waiver will be provided only if all qualifying events specified are satisfied.
- (4) The waiver benefit form shall state that if the waiver benefit is in effect, all benefits included under the policy, excluding optional benefits that are issued as attachments to the policy, shall continue in force. Any such optional benefits that will not continue in force shall be disclosed in the form;
- (5) The waiver benefit form shall state that monthly deductions waived by the company shall not be deducted from the policy proceeds;
- (6) The waiver benefit form shall state that if total disability or a qualifying event begins during a grace period, sufficient funds will be required to be added to the account value to ensure that any overdue monthly deductions can be taken to avoid a lapse of insurance before the company approves the claim for the waiver benefit;
- (7) A waiver benefit form shall not restrict the qualifying event to one or more specific medical conditions.
- (8) A waiver benefit form shall not limit a qualifying event to sickness only or injury only; it shall provide for both.
- (9) A waiver benefit form shall specify the status of the waiver benefit should the insured become eligible for additional occurrences of the same qualifying event.
- (10) A waiver benefit form shall uniquely define the terms used. For example, if a waiver benefit provision requires that the care from a health care facility must be medically necessary, the waiver benefit provision shall define "medically necessary."
- (11) If a waiver benefit built into the policy is not described in a separate appropriately captioned provision of the policy, then the reference to the waiver benefit by name in the policy and any specified time period restrictions or limitations shall be in prominent print.

B. CONDITIONS FOR WAIVER BENEFIT ELIGIBILITY

- (1) If there is an identifiable charge for the waiver benefit:
 - (a) A benefit ineligibility period shall not be required; and
 - (b) Other than for total disability, the insured shall not be required to be younger than a specified age in order to be initially eligible for the waiver benefit.
- (2) If there is no identifiable charge for the waiver benefit:
 - (a) The waiver benefit form may require a benefit ineligibility period, that shall not exceed one year;
 - (b) The insured may be required to be younger than a specified age in order to be initially eligible for the waiver benefit; and
 - (c) A disclosure describing the benefit ineligibility period or the initial age limit shall be included at the top or beginning of the conditions for waiver benefit eligibility.
- (3) The form shall describe the initial and subsequent due proof requirements for total disability. To initialize a claim, the form may require written notice and proof of total disability while the insured is alive and totally disabled, or as soon as reasonably possible. During a specified period of time after the company approves the claim for the waiver benefit, not to exceed 24 months, the form may require proof of continued total disability not more frequently than once every 30 days. After such specified period of time, the form shall state that the company shall not require proof more than once in any 12-month period. The form may also state that as part of the due proof requirement, the company at its expense may have its designated physician examine the insured.
- (4) A waiver benefit form may include a requirement that the health care services be provided, or the diagnosis of limited life expectancy, impairment, disability, or unemployment occur, after the waiver benefit issue date. Such waiver benefit form shall not require that the qualifying event occur after the benefit eligibility date.
- (5) If a waiver benefit form requires that the insured enter a health care facility within a period of time from discharge from an institutional confinement, the period of time from discharge shall be at least 30 days. The original institutional confinement shall not be required to be greater than three days.
- (6) If there is a waiver benefit for home health care or hospice care, and the waiver benefit requires that the insured be confined in a health care facility to establish eligibility for the home health care or hospice care, the period of confinement shall not be required to be greater than 30 days.
- (7) If a waiver benefit form requires the insured experiencing a qualifying event to receive services, receive treatment, be disabled other than total disability or be unemployed for a period of time (waiting period) prior to the waiver of premium, the waiting period shall not exceed 90 days. For qualifying events that occur during the benefit ineligibility period, the 90 days may be measured

from the later of the date of the qualifying event or the benefit eligibility date. The waiver benefit form shall not require that a new waiting period be applied to services received, treatment received or disability due to the same cause as a previously covered service, treatment or disability, or due to a cause related to the cause of a previously covered service, treatment or disability, unless the services received, treatment received or disability occurs at least 30 days after the previously-covered service, treatment or disability.

- (8) A waiver benefit for limited life expectancy shall not require that the condition causing the limited life expectancy be diagnosed after the waiver benefit issue date.
- (9) A waiver benefit for health care facility confinement shall not require that the confinement begin after the benefit eligibility date or exclude confinements beginning during the benefit ineligibility period. Confinements that begin before the benefit issue date may be excluded.
- (10) If a waiver benefit form provides for unemployment (voluntary or involuntary) as a qualifying event with an identifiable charge for the waiver benefit, the waiver benefit form shall specify a means for an insured who is self-employed or otherwise could not qualify for unemployment compensation to prove unemployment as an alternative to unemployment compensation qualification.
- (11) A waiver benefit form shall not provide for the accumulation or pooling of values or the aggregation of policies or values in the determination of a waiver benefit.

C. EXCLUSIONS

- (1) The form shall specify any exclusion applicable to the waiver benefit. The exclusions shall be limited to the following:
 - (a) Total disability or a qualifying event caused or contributed to by:
 - (i) Any attempt at suicide, or intentionally self-inflicted injury, while sane or insane;
 - (ii) “War” or “act of war,” as defined in the standards for the exclusions provision of the individual life policy;
 - (iii) Active participation in a riot, insurrection or terrorist activity;
 - (iv) Committing or attempting to commit a felony;
 - (v) Voluntary intake or use by any means of any drug, unless prescribed or administered by a physician and taken in accordance with the physician’s instructions, or poison, gas or fumes, unless a direct result of an occupational accident;
 - (vi) Intoxication as defined by the jurisdiction where the total disability occurred;

- (vii) Caused or materially contributed to by participation in an illegal occupation or activity; and/or
 - (viii) Any condition disclosed in the application and explicitly excluded in a form attached to the policy.
- (2) Total disability occurring before the insured reaches a specified age, such as age 5;
 - (3) Total disability occurring after the benefit anniversary on which the insured attains a specified age no less than age 65;
 - (4) A waiver benefit form for qualifying events or total disability shall not include the following exclusions and restrictions as a basis of waiver claim denial by the company:
 - (a) Denial due to the insured's financial resources, income or need;
 - (b) Denial if there is not a reasonable expectation that a significant improvement will occur in the insured's condition;
 - (c) Denial if services are provided by a health care facility for the insured less often than on a daily basis;
 - (d) Denial if services are not provided in the least costly setting;
 - (e) Denial if the health care facility does not accommodate a minimum number of persons;
 - (f) Denial if services are provided by a health care facility that predominantly provides care and treatment of the mentally ill or drug addicts;
 - (g) Denial if services are provided by a health care facility that does not have surgical facilities or access to such facilities;
 - (h) Denial if reimbursement for services is provided by another company; or
 - (i) Denial if the insured is not confined to a health care facility with the expectation that he or she will remain in the facility for a lifetime (until death).

D. FILING OF CLAIM

- (1) A waiver benefit form shall disclose any claim requirements for filing a claim. The waiver benefit form shall not include requirements more restrictive than the following:
 - (a) If the waiver benefit form requires the filing of a proof of claim form, the waiver benefit form shall state that the claim form shall be provided by the company within ten working days of the waiver request to the owner. If the claim form is not furnished within ten working days, it is considered that the claimant complied with the claim requirements if

the claimant submits written proof covering the occurrence, the character and the extent of the occurrence for which claim is made.

- (b) If the company requires that proof of claim be provided within a certain time frame, the waiver benefit form shall state that the proof will not be required to be supplied sooner than 90 days after receiving services or treatment, or after unemployment or other qualifying event or total disability begins. Provision shall be made for the situation where it can be shown that it was not reasonably possible to provide proof within the required period of time and that the proof was given as soon as possible; however, in no event, except in the absence of legal capacity may the required proof be provided later than one year after proof is otherwise required. For a limited life expectancy waiver benefit, the waiver benefit form shall not require a time frame within which proof of claim must be provided.
 - (i) During a specified period of time, not to exceed 24 months after the company approves a claim for a waiver benefit as a result of total disability, the form may require proof of continued total disability not more frequently than once every 30 days. After such specified period of time, the form shall state that the company shall not require proof more than once in any 12-month period.
- (c) The waiver benefit form shall state if the company has the right to require a physical exam as proof of claim.
- (d) The waiver benefit form shall state that any requirements for a second or third medical opinion to confirm proof of claim shall be at the company's expense. The waiver benefit form shall state which opinion rules in the event of conflict.

E. EFFECT OF POLICY ADJUSTMENTS

- (1) The form shall describe the effect of policy adjustments, such as increases in face amount, may have on the coverage provided by the waiver benefit. The form may state that, unless otherwise stated, an application to increase the face amount of the policy may be deemed to be an application to increase the coverage provided by the benefit waiver.

F. INCONTESTABILITY

- (1) If the form is issued as an attachment to the policy, the form may state that the company shall not contest the form after it has been in force during the lifetime of the insured for two years from the date of issue of the form, excluding any period when the insured is totally disabled, except for fraud in the procurement of the form, when permitted by applicable law in the state where the policy is delivered or issued for delivery. With respect to statements made in an application for the waiver benefit, the waiver benefit is incontestable after it has been in force during the insured's lifetime for two years beginning with the day of issuance. The contestable period is based only on statements in the waiver benefit application, unless the original contestable period has not yet expired. The waiver benefit may include an exception to the incontestability provision for fraud in the procurement of the waiver benefit when permitted by applicable law in the state where the policy is delivered or issued for delivery.

G. NONFORFEITURE VALUES

- (1) If the form is issued as an attachment to the policy, the form shall state that it does not have cash values or loan values.

H. PREEXISTING CONDITIONS

- (1) A waiver benefit form shall not exclude disability, services, treatment or diagnosis caused by a preexisting condition. Therefore, the waiver benefit form shall not require that disability or need for services, treatment or diagnosis be caused by injury or sickness beginning, commencing, originating, occurring, sustained or manifesting or first manifesting itself after the waiver benefit issue date.

I. TERMINATION

- (1) The form shall include the following termination conditions:
 - (a) Upon written request from the owner;
 - (b) Upon termination of the policy; or
 - (c) The insufficiency of the account value to allow monthly deductions, in accordance with the provisions of the form or the policy.
- (2) The form may also include the following termination conditions:
 - (a) The benefit anniversary on which the insured attains a specified age, no less than age 65;
 - (b) The date the policy lapses or is continued as extended term or paid-up insurance under the nonforfeiture provisions;
 - (c) If the policy is an endowment policy, on the date of endowment, regardless if the endowment date is deferred; and/or
 - (d) If the policy is a limited-payment policy, on the date the policy becomes fully paid-up.