**Section 2001.120 Construction of Accident and Health Insurance Policy Forms**

a) Section 356a − Form of Policy

Each policy form of a domestic company that is issued for delivery to a person residing in another state must be approved by the Director unless that policy form is subject to approval or disapproval by the other state.

b) Section 357.1 − Accident and Health Policy Provisions Required

1) In order to expedite departmental action on policies submitted for approval, it is requested that companies adhere to the statutory wording and order of the required provisions. Policies submitted that include variations from the statutory words and order must be accompanied by a complete list of all variations and a justification for each. Extensive variations, without adequate justification, will only result in delay in the processing of the policies. The companies' cooperation in keeping variations to a minimum is essential.

2) Each provision of Sections 357.2 through 357.113 of the Code must be preceded by a caption and, if the captions differ in any respect from the captions appearing in the law, changes must be clearly indicated and justified pursuant to subsection (b)(1).

3) Numbering of the "Required Provisions" will not be required.

c) Section 359a − Application

1) When an Industrial Accident and Health policy is issued upon signed application of the person to be insured, the application shall conform with Section 359a of the Code.

2) The Application

A) When changes are made on the application for administrative purposes only, the changes must be clearly indicated.

B) When the application is subject to being changed for administrative purposes by the insurer, the application shall clearly indicate that any changes are not to be ascribed to the applicant.

d) Section 361a − Age Limit

Any policy form containing an "age limit" shall contain in substance a provision setting forth the limitations of Section 361a of the Code.

e) Section 362a − Non-Application to Certain Policies

Section 362a(3) of the Code does not apply to group accident and health insurance provided for under Section 356a(1)(c) of the Code.

f) Section 368 − Industrial Accident and Health Insurance

The Department will require Industrial Accident and Health policy forms to be of the same form and content as other accident and health insurance policy forms required to be filed pursuant to Section 355 of the Code, except Industrial Accident and Health Policies shall be issued on a weekly premium basis and contain the words "Industrial Policy" printed on each form.

g) Accident and Health Insurance

1) Accident and health insurance may only be defined as insurance against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age and every insurance appertaining thereto.

2) Terms such as "external" and "violent" in connection with the definition of accident and health insurance are not acceptable.

h) The information required in Section 356a(1)(a) and (b) of the Code must appear in the policy form itself or on its schedule page and cannot be added to the policy by rider, endorsement or supplement. Although riders, endorsements and supplements, when attached to the policy form, become a part of the contract, it is evident the law intends that the information required by Section 356a(1)(a) and (b) be made a part of the policy form itself, since this Section specifically refers to the policy and distinguishes between the policy forms, riders and endorsements.

i) Funeral benefits will not be permitted in accident and health contracts.

j) If hospitals are defined in accident and health contract forms presented for use in this State, then an appropriate definition must be used. A term such as "legally operated hospital", or any other definition that is definite and applicable in this State, will be accepted.

k) Waiting period provisions in accident and health insurance contracts that stipulate the contract must be maintained in "continuous force" or "in force for (a specified number of) months after the effective date of the policy" or "in force for (a specified number of) months prior to the date of the loss" will not be accepted. Those provisions do not adequately and clearly cover reinstatements and, therefore, waiting periods must be based upon the loss occurring (a specified number of) months after the effective date of the policy and read similar to: No indemnity will be paid for loss that occurs, or commences, prior to (a specified number of) months after the effective date of the policy.

l) Additional waiting periods for certain designated diseases or illnesses based upon inception beyond the usual customary 15 to 30 days provided for in the insuring provisions are not permissible. If additional waiting periods are deemed necessary by the company for certain diseases and illnesses, then the Department requires that waiting periods be based upon the loss occurring so many months after the effective date of the policy, rather than being based on the inception of the illness or disease.

m) "Strict compliance provisions" in accident and health insurance contracts will not be acceptable for use in this State.

n) Any specific requirement for medical attendance by a licensed physician, other than that attendance that is normally and customarily required for the disease or accident resulting in loss for which claim is made, will not be acceptable.

o) In accident and health insurance contracts that include "medical attendance benefits" and "surgical benefits" and limits liability to only one, provision must be made for the payment of the greater benefit.

p) Broad, indefinite, ambiguous and inconsistent language must be excluded from all accident and health insurance forms. Examples of such wording are:

1) The use of the words "indirectly" and "partly" in connection with Exclusions, Limitations and Reductions;

2) The use of the word "reasonable" when used in connection with medical attendance or any other condition or requirement included in the policy form, unless use of that word results in the provision being more favorable to the insured;

3) The use of such words as "appendages", "involving", "affecting", etc., in connection with specified physical conditions. Medical terms should be definite. For instance, various types of hernia should be spelled out, or the forms should provide a general statement that all types of hernia are meant.

q) Surgical Benefit Provisions in accident and health insurance contracts must include and provide either:

1) That all operations will be covered not to exceed a stipulated amount for any operation that may be performed; or

2) A schedule of operations that includes:

A) Comparable benefits for operations of comparable severity;

B) A provision that requires the company to pay a benefit for any operation not listed in the schedule, based on an amount equivalent to that specified for a listed operation of comparable severity; and

C) A provision that requires the company to pay for that operation that provides the largest benefit when the company's liability is limited to one operation when more than one is performed, under named or enumerated conditions.

r) Surgical benefit provisions that are contingent upon payment of a hospital confinement benefit will not be approved.

s) Benefits for hospital room that are based upon the actual expense incurred may be made contingent only upon a charge being made by the hospital. Benefits payable on a stated or flat rate basis, regardless of the amount of expense incurred, may make the benefit contingent upon hospital confinement of so many hours.

t) Premium, Cancellation and Renewal Provisions

1) Waiver of Premium Provisions must include a statement of coverage and of the insured's rights and obligations regarding the resumption of premium payments after the period of total disability has terminated, during which the premium has been waived. This statement must read similarly to: After the termination of the period of total disability, during which a premium has been waived, the insurance afforded in this contract shall continue in full force and effect until the next premium due date, at which time the insured shall have the right to resume the payment of premiums as provided in the contract.

2) If a premium is to be charged for the period from the expiration of the period of total disability during which a premium has been waived and the expiration date of the policy, then a statement of this fact must be added to the provision, together with a provision that the insurer will notify the insured of the premium due.

3) A policy that contains a cancellable provision may add at the end of the provision in (u)(2) "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof".

4) A policy in which the insurer reserves the right to refuse any renewal premiums shall add "unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by records of the insurer, written notice of its intention not to renew this policy beyond the period for which the premium has been waived".

u) Requirements for the so-called "franchise insurance" are different from those for individual contracts in the following respects: Termination either by cancellation or refusal to renew any individual contracts of the group is prohibited, unless all like contracts of the group are terminated at the expiration of the contracts and upon at least ten days' notice in advance. The only other termination conditions that may be included in these contracts are those that terminate coverage because of nonpayment of premium, discontinuance of employment of the insured by the named employer, or the discontinuance of membership in the designated organization or association, and, in addition, coverage may be automatically terminated at a designated attained age.

v) Policy forms that, in the opinion of the Department, will invite misrepresentations in the advertising and sale of the policy, due to the restrictive nature of the forms as a result of unusual and/or over-lapping exclusions, limitations, reductions or conditions, will not be accepted for use in this State.

w) Time limitations, when included in benefit provisions, must be explained in terms such as hours, days, weeks, months or years. Terms such as "immediately" or "reasonably" are not acceptable, unless use of those words makes the provision more favorable to the insured.

x) Policy contracts issued by assessment companies must include a provision setting forth the contingent liability of the insured and should be based upon the regular premium provided in the policy and, in addition, such premium payments as may be required by the company from time to time. This provision should be placed in the contract with equal prominence to the benefit provisions.

y) When a contingent liability provision is included in a contract issued by a mutual company as provided for in Section 55 of the Code, the contingent liability of the policyholder must be based upon not less than one nor more than ten times the amount of the premium expressed in the continuation paragraph of the policy. This provision should be placed in the contract with equal prominence to the benefit provisions.

z) Limited policy contracts will not be approved that, in the opinion of the Director, set forth in a more prominent manner the provisions for relatively large benefits for specified accidents of rare occurrence than provisions for relatively low benefits for accidents of more frequent occurrence. Accumulative indemnities benefits are permissible, but schedules showing those benefits will not be approved in accident and health contracts.

aa) Riders, Endorsements and Exclusions

1) Riders and endorsements that are not complete in themselves must be accompanied by the fill-in material to be used with the riders and endorsements to be acceptable.

2) Exclusion of coverage riders and endorsements, executed subsequent to the issuance of the policy, must provide for the signed acceptance of the insured in addition to a statement to the effect that the rider or endorsement is not valid unless signed by the insured. Policy forms that unilaterally reduce benefits must be formally approved by the Director prior to the date they are attached to a policy issued or delivered in this State.

3) Riders or endorsements submitted for the purpose of amending forms submitted in accordance with Section 355 of the Code will not be accepted for approval, unless the Director is given an adequate justification, in writing, for the use of the riders or endorsements.

bb) Application

1) Questions in an application pertaining to diseases or conditions must be broken down so that applicants may insert their answer at least after every four or five diseases or conditions listed, unless questions are grouped as to related diseases or conditions.

2) Application forms that are completed by individuals for themselves and others cannot include a certification as to the correctness of the answers in the application without some qualifications, preferably in the Attestation Provision, and should read similar to "to the best of your knowledge", or "to the best of your knowledge and belief". The courts have held that answers to the questions are given to the best of the applicant's belief, and the Department sees no reason why the aforementioned qualification should not be contained in the application.

3) The receipt and/or application or policy provisions may provide that the insurance shall be effective upon issuance and the payment of the first premium while the insured is in good health. Provisions that provide the insurance shall not become effective until delivery of the policy while the insured is in good health will not be acceptable.

cc) When the application provides for a written proxy, that proxy must be executed over the separate signature of the applicant. The signature required for the application in accordance with Section 359a of the Code may not be used to satisfy this requirement.

dd) Advertising appearing on an application form, or any other form that requires the approval of the Director, is reviewed and filed by the Director in conjunction with the approval of the form. This is in conformity with Section 143 of the Code.

ee) The Director requires that any form, previously approved and subsequently revised, must be submitted under a new form number, and be approved in accordance with Section 143 of the Code. This applies to advertising appearing on applications or other forms approved by the Director. The only exception to this is advertising that contains statistical information, such as the amount of claims paid or assets. For changes of this kind, the insurer need not submit a new form number, but only advise the Department in writing as to the change in the statistical information and the date of change. Advertising is not subject to approval but is filed for informational purposes only. See 50 Ill. Adm. Code 916 for appropriate transmittal sheets and instructions.

(Source: Section 2001.120 renumbered from 2001.20 and amended at 38 Ill. Reg. 2037, effective January 2, 2014)