Department of Consumer and Business Services
Oregon Division of Financial Regulation - 5
P.O. Box 14480
Salem, Oregon 97309-0405
Phone (503) 947-7983

Standard Provisions for Long and Short Term Disability Group or Individual

This product standard checklist must be submitted with your filing, in compliance with OAR 836-010-0011(2).

The standards are summaries and review of the entire statute or rule will be necessary**.** Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form.

"Not applicable" can be used only if the item does not apply to the coverage being filed. Filings that do not include required information or policy provision will result in delays of the filing.

Insurer name: **Date:**

TOI (type of insurance): ☐ H11I Individual Health – Disability Income ☐ H11G Group Health – Disability Income

Sub TOI:

Filings unrelated to marketing with employer or association groups:

☐ H11I.001 or ☐ H11G.001 - Business Expense Overhead
☐ H11I.002 or ☐ H11G.002 - Short Term
☐ H11I.003 or ☐ H11G.003 - Long Term
☐ H11I.004 or ☐ H11G.004 – Other
☐ H11I.008 or ☐ H11G.0005 - Combined Short Term and Long Term

`

Filings related to marketing with employer or association groups:

☐ H11I.005 - Business Overhead Expense
☐ H11I.006 - Short Term
☐ H11I.007 - Long Term
☐ H11I.009 - Combined Short and Long Term

(If filing disability as a rider and part of a policy filing, skip to the "Policy Provisions" section.)

"" Indicates standard does not apply to Health Care Service Contractors.*

Review requirements	Reference	Description of review standards requirements	Check Answer
GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Submission package requirements	OAR 836-010-0011 As listed on SERFF or our website	Required forms are located on SERFF or on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx These must be submitted with your filing for it to be accepted as complete: 1. NAIC transmittal form. 2. Filing description on transmittal form (cover letter). 3. Third-party filer's letter of authorization. 4. Certificate of Compliance form signed and dated by authorized person. 5. Readability certification. 6. Product standards for forms (this document). 7. Actuarial memorandum for individual policies with an overview of the contents of the filing and the reasons and procedures used to derive the rates. 8. Forms filed for approval. (If filing revised forms, include a ***highlighted*** copy of the revised form to identify the modification, revision, or replacement language.) 9. For mailed filings, two self-addressed stamped envelopes one in which the Oregon Division of Financial Regulation can return approved forms.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
	Filing description on transmittal form	The filing description (cover letter) includes the following: 1. Changes made to previously-approved forms or variations from other approved forms. 2. Summary of the differences between previously-approved similar forms and the new form. 3. Application form number(s) you are using that have been approved and the approval date(s).	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐
Review requested	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy and/or certificate. 2. Amendment of an approved form. 3. Addition of supplemental options to previously approved forms.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐
Applicability	ORS 742.003(1), ORS 742.005	Amendments do not provide for unilateral changes that reduce or eliminate benefits or coverage or impair or invalidate any right granted to the policyholder under the policy. Riders or endorsements that change policy provisions are enhancements and do not reduce or delete any values or benefits in the policy.	Confirm ☐
	ORS 750.055 Health Care Service Contractors (HCSCs)	Statute references followed by an asterisk (*), may be marked "N/A" in the location column. These standards do not apply to HCSCs per ORS 750.055.	Yes N/A ☐ ☐
	OAR 836-010-0011	If filing includes options for accidental death or accidental death and dismemberment that includes exclusions, Form 440-3631 (Standards for Accidental Death and Dismemberment) is included.	Yes N/A ☐ ☐

Review requirements	Reference	Description of review standards requirements	Check Answer
Applicability	ORS 744.700 to 744.740	If this policy utilizes a third-party administrator (TPA), an agreement is written for each TPA that transacts business under ORS 744.702 according to ORS 744.720.	Yes ☐ N/A ☐
Application	Form 440-2442H	If filing includes an application form, Form 440-2442H (Standards for Health Applications) is included.	Yes ☐ N/A ☐
Association/ Trusts/ Discretionary groups	ORS 731.486*, Form 440-2441A	If filing includes issues to an association, trust, or discretionary group, Form 440-2441A (Transmittal and Standards for Group Health Coverage to be issued to an Association, Union Trust, Trust Group, or Credit Union) is included.	Yes ☐ N/A ☐
Clarity/ Readability	ORS 742.005(2)	Forms are clear and understandable in their presentation of premiums, labels, description of contents, title, headings, backing, and other indications (including restrictions) in the provisions. The information is clear and understandable to the consumer and is not unintelligible, uncertain, ambiguous, abstruse, or likely to mislead.	Yes ☐ N/A ☐
		The style, arrangement, and overall appearance of the policy or certificate gives no undue prominence to any portion of the text or to any endorsements or riders.	Confirm ☐
	ORS 743.106	If filing includes forms in a language other than English, readability requirements do not apply if the forms are direct translations of policies that meet product standards. A certification of direct translation is included.	Yes ☐ N/A ☐
	ORS 743.103, ORS 743.106(1)(d)	Policy and certificate contain a table of contents or index of the principal sections if longer than 3 pages or 3,000 words.	Yes ☐ N/A ☐
Discrimination	ORS 746.015	No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.	Yes ☐
	ORS 106.305, Bulletin 2008-2 Domestic partners	ORS 106.305 recognizes and authorizes domestic partnerships in Oregon. A domestic partnership is defined in ORS 106.305 as “a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.” Any time that coverage is extended to a spouse it must also extend to a domestic partner.	Yes ☐ N/A ☐
Fairness	ORS 742.005(2)	The policy does not contain inconsistent, ambiguous, or misleading clauses, or contain exceptions and conditions that unreasonably affect the risk purported to be assumed in the general coverage of the policy.	Confirm ☐
Form numbers	OAR 836-010-0011	The policy and certificate are filed under one form number and the form provides core coverage with all basic requirements. Basic policy requirements are not bracketed unless an alternative selection is included. Optional benefits to the policyholder are filed under separate form numbers. See guidelines on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx	Yes ☐ N/A ☐

Review requirements	Reference	Description of review standards requirements	Check Answer
Insurable interest	ORS 743.038, ORS 743.040	1. This policy provides benefit payments to the insured, insured's personal beneficiary, or the insured's estate. 2. If a consent form is required, an explanation is included as to how the policy will meet the insurable interest and consent requirements in ORS 743.038 and 743.040. 3. The consent form is limited to providing information regarding the coverage and requesting consent. A copy of the consent form is included with this filing, if applicable.	Yes ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐
Variability in forms	ORS 742.003, ORS 742.005(2)	Variable material in forms will only be permitted if it is clearly identified by brackets along with an explanation of when each would be used. ☐ Variable text includes all optional text, changes in language, and choices in terms or provisions. ☐ Variable numbers are limited to numerical values showing all ranges (minimum to maximum benefit amounts). ☐ Explanation must be clear and complete. ☐ The filing includes a certification that any change outside the approved ranges will be submitted for prior approval ☐ Variability in forms may be described either through embedded Drafter's Notes or a separate Statement of Variability form. In general, Drafter's Notes are preferred. **Note:** detailed variability instructions can be found at: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx	Yes ☐ N/A ☐
		Group policies may include variable language as alternatives based on group issue. If included, variable items that apply to each alternative option are grouped in the statement of variability to clearly show the bracketed items that apply to each option.	Yes ☐ N/A ☐
(*Skip to Requirements for Rates if filing only a rate change.*)			

GENERAL FORM REQUIREMENTS			
Review requirements	Reference	Description of review standards requirements	Check Answer
Cover page	ORS 742.005, ORS 743.106, OAR 836-010-0011 (all), ORS 742.023* (individual)	1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or company logo, if used on the policy, does not mislead as to the identity of the insuring company. Policy title and subtitles are generic and clearly describe the guaranteed elements; policy contains no marketing or agency/broker names. 3. The insuring company's address, consisting of at least a city and state, appears on the first page of the policy. 4. The signatures of at least two company officers appear on the first page of the policy. 5. The individual policy or certificate includes a right-to-examine provision that appears on the cover page of the policy or certificate. 6. A form-identification number appears in the lower left-hand corner of the forms. The form number is adequate to distinguish the form from all others used by the company. 7. The cover contains a brief caption that appears prominently on the cover page and describes the type of coverage. 8. The cover contains a statement as to whether the coverage is renewable or non-renewable, non-cancellable or non-cancellable, and guaranteed renewable or conditionally renewable. 9. The cover contains a conspicuous statement as follows: Preexisting condition limitations or exclusions and other limitations or exclusions may apply. Please read your policy carefully. 10. The cover contains benefit limits or reductions due to the attainment of certain ages.	Yes ☐ N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Specifications page	ORS 742.005, ORS 743.106, OAR 836-010-0011 (all), ORS 742.023* (individual)	1. The specifications page includes the disability benefits, amounts, durations, premium information, and any other benefit data applicable to the owner or insured. 2. The specifications page is completed with hypothetical data that is realistic and consistent with the other contents of the policy and any required actuarial memorandum. 3. Any information appearing on the specification page that is variable is bracketed or otherwise marked to denote variability. 4. When rates increase due to the attainment of certain ages or duration of the policy, an applicable schedule of rates is prominently placed on the specifications page.	Yes ☐ N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐

POLICY PROVISIONS			Enter page & paragraph
Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Individual health insurance policy	ORS 743.405(1)* through (8)	An individual health insurance policy **must** meet the following requirements: 1. Include a statement of money and considerations due; 2. Define the start and stop date; 3. Define who is covered under the plan; 4. May not be used to separate an individual from a group product under which they are eligible for coverage; 5. The policy may not give undue prominence to any provision, the style must be consistent and uniform throughout, and must be in 12 point font; 6. Exclusions and limitations must be clearly stated; 7. Each policy forms must be identified by a unique form number in the lower left portion of each page; 8. No portion of the insurers' internal corporate regulations may be made part of the policy.	Page: Paragraph or Section
Group health insurance policy	ORS 743.406(1) through (3)	1. A provision that, in the absence of fraud, all statements made by applicants, the policyholder or an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person. 2. Policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member, to whom the insurance benefits are payable. 3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.	Page: Paragraph or Page: Paragraph or Section Page: Paragraph or Section
Accident	ORS 742.005	The definition of injury or accidental death means benefits paid to an insured due to loss caused solely by an accident independent of sickness, illness, or disease; and does not characterize the definition by requiring a visible or external wound or an autopsy if there is no visible wound or the concept of violent or similar words as part of the description.	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Accident	ORS 742.005(3),(4) (all); ORS 742.023(1)(d),(f)* (individual)	If the company may cancel or refuse to renew an accidental policy, the policy is not required to be in force at the time loss commences if the accident occurred while the policy is in force.	
		Benefits for specific injuries due to accident do not provide that benefits are in lieu of or limit disability benefits unless the benefit for specific injuries due to accident exceeds the disability benefit.	
Accidental death and dismemberment	ORS 743.053*	Accidental death and dismemberment benefits cover losses for at least 180 days after the accident.	
Applications	ORS 743.039* (life policies only)	Coverage is issued for the amount of insurance, classification of risk, plan of insurance, or benefits, unless the application contains a statement that no such changes are effective until approved in writing by the applicant.	
	ORS 746.650	Any adverse decision made in accepting or not accepting an applicant, including preliminary questions prior to filling out an application, are subject to the notification requirement under ORS 746.650.	
Arbitration	ORS 36.600 to 36.740	If the policy provides for arbitration if claim settlement cannot be reached, the parties may elect arbitration by mutual agreement at the time of the dispute after the claimant has exhausted all internal appeals and mutually-agreed arbitration can be binding. One party may initiate arbitration proceedings; however, if there is no mutual agreement the resulting arbitration is binding only on the party who demanded arbitration. Arbitration proceedings take place under the laws of Oregon and are held in the insured's county or another county in this state if agreed upon.	
Assignment	ORS 743.043*	The policy describes the availability of an assignment and its related procedures. Unless otherwise specified by the policy owner, an assignment will take effect on the date the assignment is signed subject to any payments made or actions taken by the company prior to receiving notice of the assignment. The policy may state that the company will not be liable for the validity of the assignment.	
Beneficiaries	ORS 743.444*	Policy states that unless the insured makes an irrevocable designation of beneficiary, the right to change beneficiary is reserved to the insured and the consent of the beneficiary shall not be requisite to surrender or assignment of this policy.	
Benefit reimbursement	ORS 743.423(2)*	If the policy provides for loss-of-time benefit for disability of at least two years, a provision that states the insured shall, at least once in every six months after having given notice of claim, give the company notice of continuance of such disability, except in the event of legal incapacity.	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Benefit reimbursement	ORS 742.023(1)(c),(f)* (individual)	Survivorship benefits or transition benefits. The life benefit may not be more than three times the monthly periodic income benefit amount for total disability. (*Disability income policy benefits cannot be used as a method of evasion of life insurance standards.*)	
Claim forms	ORS 743.426*	The "claim forms" statement in ORS 743.426, or a similar statement, is included in the policy, providing that, if claim forms are required and are not furnished within 15 days after the claimant gives notice of claim, the claimant shall be deemed to have complied with the requirement of the policy.	
Claim notice	ORS 743.423*	The "notice of claim" statement in ORS 743.423(1), or a similar statement, is included in the policy, explaining that written notice of claim is given to the company within 20 days after occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible.	
Claim payment	ORS 743.432* Time of payment of claims	A "time payment of claims" statement similar to that in ORS 743.432 is included in the policy, stating that indemnities payable will be paid immediately upon receipt of due written proof of loss or stating the intervals of periodic payment of benefits.	
	ORS 743.435* Payment of claims	Policy states that benefits paid for loss of life are payable in accordance with the beneficiary's designation. If no such designation or provision is in effect, such payments shall be payable to the estate of the insured.	
	ORS 743.459* (individual) Insurance with other insurers	A company may require that the claimant apply for all benefits for which the claimant may be eligible from other sources and submit documentation of such. If the claimant refuses to apply for other income for which he or she is eligible, the company may estimate that amount and deduct it from benefits payable under the policy.	
	ORS 743.465* Relation of earnings to insurance	If the total monthly amount of valid loss of time coverage on an insured exceeds the monthly earnings of the insured when disability commenced or the insured's average monthly earnings for the period of two years immediately preceding a disability, whichever is greater, the benefit will be the proportional amount of benefits under the policy containing a provision covering this matter.	
Claim payment	ORS 743.450* Change of occupation	When an insured makes a claim after changing to a more hazardous classification than that stated in the policy, the policy will pay only such portion of indemnities provided as the premium paid would have purchased at the rates and within the limits fixed by the company for the more hazardous occupation. When an insured changes to a less hazardous classification, the company will reduce the premium accordingly and return the excess pro-rata unearned premium from the date of change of occupation.	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Credibility	ORS 742.005(2),(3)	If plan includes a discretionary clause, it does not give the insurer the right to interpret the contract that is legally superior to that of the insured. Discretionary clauses are determined to be prejudicial, unjust, unfair, and inequitable under ORS 742.005(3) and (4). Because such clauses may also reduce an insurer's incentive to draft contracts unambiguously, contracts containing discretionary clauses may also be impermissible under ORS 742.005(2).	
Definitions	ORS 742.005 (all), ORS 742.023(1)(c)(d)(f)* (individual)	The terms used to qualify for total disability relating to the insured's occupation at the time of the injury, illness, or other conditions are defined and clearly stated (e.g.; "own occupation," "general occupation," "regular occupation," "any occupation," "gainful occupation," or similar terms). The definition is clearly stated whether or not benefits are paid based on the insured's current job with his or her employer and the terms are used consistently throughout the policy.	
		The definition of deductible income describes how it is used to offset or reduce the benefits under the policy. Deductible income must be received, not merely anticipated. If the policy contains the following terms or describes the concept, the definitions of the terms or descriptions **of the concepts are consistent with these and other standards**. (*Indicate by checking "Yes" if term is used in the policy)* Yes N/A 1. "Accident benefits." See "Accident" category. ☐ ☐ 2. "Benefit period" means the length of time, not less than six consecutive months, for which a disabled insured can be paid periodic income benefit amounts. ☐ ☐ 3. "Catastrophic disability" means a defined event that always pays a monthly periodic income benefit amount, in addition to any other disability benefit amount, or a single benefit of no less than $1,000. ☐ ☐ 4. "Concurrent disability" means one continuous period of disability that is caused or is continued by more than one injury or sickness and paid as if the cause were one injury or one sickness. ☐ ☐ 5. "Cost of living index" means an index used to measure the rate of change over time of the cost of living, such as the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. ☐ ☐	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Definitions, continued	ORS 742.005 (all), ORS 742.023(1)(c)(d)(f)* (individual)	6. "Disability" or "disabled" means that due to injury or sickness, the insured meets the definition of partial disability, residual disability, total disability, or other types of disability accepted by the director. 7. "Earnings" means the amount of income received by an insured from salary, wages, commissions, bonuses, profit sharing, and contributions to a pension or profit sharing plan on behalf of the insured. Earnings do not include formal sick pay plans, individual and group disability income insurance plans, or retirement plans. 8. "Elimination period" means the length of time an insured must wait after commencement of the disability. A separate elimination period may apply for injury and sickness. Benefit periods of one year or less cannot provide an elimination period alone or in conjunction with a qualification period that postpones payment in excess of 90 days from the commencement of a disability. 9. "Guaranteed renewable" means a renewal provision term that is used in a policy when the insured has the right to continue the policy in force by the timely payment of premiums until at least age 65 or until receipt of Social Security benefits. 10. "Hospital" means an institution that is licensed as a hospital by the proper authority of the state in which it is located. 11. "Injury" means accidental bodily injury that may be sustained independent of sickness and that occurs on or after the policy effective date and while the policy is in force. (See "Accident" category.) 12. "Mental or nervous disorder" may be no more restrictive than those classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), most current version. (See "Mental conditions" category.) 13. "Noncancellable" or "noncancellable and guaranteed renewable" means renewal terms that are only used in a policy when the insured has the right to continue the policy in force by the timely payment of premiums until at least age 65 or until receipt of Social Security benefits. The company has no right to unilaterally make changes. 14. "Nonparticipating" means that the insurance company does not allocate surplus to the policy. 15. "Non-renewable" means that the policy cannot be renewed after the policy term (time period the policy is in force) stated in the policy.	Yes ☐ N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Definitions, continued	ORS 742.005 (all), ORS 742.023(1)(c)(d)(f)* (individual)	16. "Occupation" means a job, position, or professional calling for which a person received or can receive remuneration. "Own occupation" is the occupation in which the insured works immediately prior to the disability. "Any occupation" is any occupation for which the insured is qualified by reason of education, training, or experience.	Yes ☐ N/A ☐
		17. "Other income sources" means (See "Other insurance" category.)	☐ ☐
		18. "Partial disability" means that due to injury or sickness, the insured has the inability to perform some of the substantial and material duties of an occupation for which he or she is qualified by reason of education, training, or experience or the inability to perform all of the substantial and material duties for as long as usually required. A time worked measurement is the ability to work or earn at least 20 percent but no more than 80 percent expressed as hours per week or earnings prior to disability.	☐ ☐
		19. "Participating" means the insurance company may allocate divisible surplus to the policy to share in the divisible surplus of the company.	☐ ☐
		20. "Physician" means a person legally licensed to practice medicine or psychology or a health care practitioner acting within the scope of his or her license. The definition may exclude the insured, policy owner, or any person related to the insured by blood or marriage.	☐ ☐
		21. "Preexisting condition" means a condition misrepresented or not revealed in the application for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care, or treatment. (See "Preexisting conditions" category.)	☐ ☐
		22. "Presumptive disability" is when benefits are triggered by a total and permanent loss of one or more bodily functions, such as speech, hearing, sight, or use of limbs. Total and permanent loss of any one of the six body functions is sufficient to trigger benefits based upon presumptive disability.	☐ ☐
		23. "Prior earnings" or "pre-disability earnings" means the measurement of earnings of an insured just before disability began, not to exceed five years based on the highest level of earnings during the period in excess of one year.	☐ ☐
		24. "Recurrent disability" means a disability that occurs within a specified period of time immediately following a period of disability, which is due to the same or related cause applicable to the prior period of disability. For subsequent periods to be considered continuous when the insured has not returned to work, the period cannot exceed 180 days for a policy with a 5-year benefit period and 365 days for greater than 5 years.	☐ ☐

Review requirements	Reference	Description of review standards requirements	Check answer Yes	N/A
Definitions, continued	ORS 742.005 (all), ORS 742.023(1)(c)(d)(f)* (individual)	25. "Rehabilitation" means a program receiving services that is geared toward aiding an insured to better perform his/her occupation or any occupation for which he or she is fit.	☐	☐
		26. "Residual disability" means a reasonable reduction in the insured's earnings of 20 percent or more due to disability. If the reduction in earnings equals or exceeds 80 percent, the insured is eligible for payment of the total disability benefits. Residual disability may be predicated upon a qualification period during which the insured must be totally disabled. However, residual disability benefits cannot be denied for a period exceeding six months due to use of a qualification period alone or in conjunction with an elimination period.	☐	☐
		27. "Loss of earnings" means the difference between the insured's pre-disability earnings and the insured's earnings in a specified period of time for which a disability benefit is claimed.	☐	☐
		28. "Partial or residual disability" means that the insured is unable to perform some of the substantial and material duties of an occupation or is unable to perform them for as long as usually required.	☐	☐
		29. "Sickness" means illness, disease, or pregnancy (including complications of pregnancy) that first manifests on or after the effective date of the policy and while the policy is in force.	☐	☐
		30. "Total disability" means a general definition of total disability no more restrictive than indicating that during the first 12 months of a total disability, excluding the elimination period, an insured is unable to perform the substantial and material duties of the insured's own occupation and is not in fact engaged in any job or occupation for wage or profit.	☐	☐
		31. "Total disability" or "Totally disabled" solely due to injury or sickness means the complete inability of an insured to perform all of the substantial and material duties of an occupation and that the insured is not engaged in any employment or occupation for wage or profit. The definition may specify a period following the state of disability during which an "own occupation" standard would apply, followed by a period in which an "any occupation" standard would apply.	☐	☐
	ORS 742.005(6) (all), ORS 743.018* (individual)	If the company uses class for the purpose of rating, the policy includes a definition of class that is consistent with the actuarial basis.		

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph or check answer
Disability income	ORS 742.005 (all), ORS 742.023(1)(b)* (individual)	The policy provides at least a total disability benefit.	
Eligibility	ORS 742.023(1)(d)* (individual)	The policy includes a provision addressing any conditions of eligibility that may apply on or after the effective date of the policy.	
Entire contract provision	ORS 742.016* (all), ORS 743.411*	The "entire contract" statement in ORS 743.411 or similar statement is included in the policy, explaining that the contract, including the endorsements and attached papers, if any, constitutes the entire contract of insurance.	
Examination of contract	ORS 743.492	There is a provision printed on the face of the policy or attached thereto entitling the prospective insured to a 10-day period in which to examine and return the policy for a refund of any premium paid, including any policy fees or other charges. If returned, the policy is considered void from the beginning and the parties are in the same position as if no policy had been issued.	
Grace period	ORS 743.417* ORS 743B.320 (group)	Provision states that a minimum 10-day grace period is granted for the payment of each premium falling due after the first premium, during which the policy shall continue in force.	
Incontestability	ORS 743.414(3),(4)*	The "incontestable" statement in ORS 743.414(3) and (4), or a similar statement, is included that after the initial coverage or subsequent increases in coverage has been in force for a period of two years during the lifetime of the insured. Only fraudulent misstatements or misrepresentations made in the application that are material to the acceptance for coverage may be used to void the policy or to deny a claim after two years of coverage.	
Insurability	ORS 742.023* (individual)	If the policy requires evidence of insurability on or after the effective date of the policy, the policy explains those conditions, which may include but are not limited to, medical, financial, and occupational requirements, as applicable. Evidence of insurability is not required for eligibility for benefits under in-force coverage.	
Legal action	ORS 743.441*	Provision states that no action at law or in equity will be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of 3 years after the time written proof of loss is required.	
Limits	ORS 742.023* (individual) Mental conditions	Mental and nervous conditions, substance abuse, and other limited conditions must be defined. The definitions should be adopted from or based on the diagnoses outlined in the latest *Diagnostic and Statistical Manual of Mental Disorders* by the American Psychiatric Association or in the latest International Classifications of Diseases.	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Limits, continued	ORS 743.459* (individual) Workers' compensation	Disability benefits may be limited or excluded to the extent that benefits are provided by workers' compensation benefits but only if those benefits are actually paid.	
	ORS 743.459* (individual) Social insurance benefits integration	Companies must properly underwrite for social insurance benefits so that an insured is not over insured in relation to earnings when benefits may be paid to an insured under both a disability income policy and programs providing social insurance benefits. Disability policies may integrate their benefits with the social insurance programs of federal Social Security, workers' compensation, and occupational disease laws when: (1) Periodic income benefit amount is reduced by a fixed percentage of no more than 50 percent when the insured is receiving social insurance benefits. (2) The balance of the periodic income benefit amount that is unaffected by the insured's receipt of the social insurance benefit paid whether or not the insured receives social insurance benefits. (3) The title of the policy accurately reflects the limited nature of the coverage when an insured receives social insurance benefits.	
	ORS 743.039* (life policies only) Waivers	Conditions identified through the underwriting process may be excluded or limited by waiver for specifically named or described diseases, physical conditions, or extra-hazardous activities as an alternative to refuse coverage. When waivers are required as a condition of coverage, signed acceptance by the insured is required and full text of the waiver is part of the policy and identified on the specifications page. (*Benefits are not limited or excluded through the use of a probationary or similar period for specified conditions or accidents without medical underwriting having occurred for those specified conditions or accidents.*)	
Misrespresentations, misstatements	ORS 743.453* Misstatement of age	If the insured's age or sex has been misstated, all amounts payable under the policy shall be amounts as the premium paid would purchase at the correct age or sex.	
	ORS 744.078	Any provision allowing for modification based on misrepresentations do not directly or indirectly imply that the company is not bound by statements given to the producer. Knowledge of or information given to the producer is knowledge or information of the company.	
Noncancelable or guaranteed renewable	ORS 743.495, ORS 743.498	A noncancelable or guaranteed-renewable policy includes the statement required by ORS 743.498 or similar language explaining the guaranteed or cancelable periods.	
Other insurance	ORS 743.459* (individual)	When other valid coverage exists, the benefit will pay proportional benefits. Benefits are not limited through coordination of benefits.	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Ownership	ORS 742.023*, ORS 743.038 (individual)	The policy contains an ownership provision that describes the terms and conditions for designating or changing the owner or for designating default owner as may be necessary and indicates when such designation is effective. The provision indicates the insured is the owner unless an owner designation different from the insured, with a proper insurable interest, is in effect.	
Physical examination/ autopsy	ORS 743.438*	The "physical examinations and autopsy" statement in ORS 743.438 or a similar statement is included in the policy, explaining that the company at its own expense shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim is pending.	
Preexisting conditions	ORS 742.005 (all), ORS 742.023(1)(d),(f)* (individual)	Preexisting condition is a defined period prior to the effective date of coverage. The provision states that no claim for loss incurred or disability commencing after two years from the policy issue date is reduced or denied on the grounds that the loss is caused by a preexisting condition.	
		The provision clearly defines the circumstances of the limitation or exclusion and discloses such limitation or exclusions at time of application. When a disease or physical condition has not been excluded from coverage by name or specific description effective on the date of loss, losses incurred or disabilities commencing on or after the coverage effective date due to that disease or physical condition must be covered immediately when: (1) The disease or physical condition is an injury or sickness and is not a preexisting condition as described in these standards. (2) The disease of physical condition is misrepresented or is not revealed in the application, but that disease or physical condition is not a preexisting condition as described in these standards. (3) The disease or physical condition is disclosed in the application, but the insurer has taken no express underwriting action for the disease or physical condition.	
Premium payment	ORS 743.468*	A provision covering premiums due and unpaid at claim time states that, upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted from the claim payment.	
	ORS 742.023(1)(e),(2)* (individual)	The policy clearly explains premium-payment requirements, including when and where payments are due.	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Proof of loss	ORS 743.429*	The "Proof of Loss" statement in ORS 743.429 or a similar statement that proof of loss is due to the company within 90 days of the loss or, in the case of continuing loss for which the company is obligated to make periodic payments, 90 days after the end of the period of company liability. (*If it is not reasonably possible for the policyholder to meet this requirement, the claim shall not be invalidated or reduced if proof of loss is provided as soon as is reasonably possible and not later than one year after the date proof is otherwise required, except in the absence of legal capacity.*)	
Reinstatement	ORS 743.420*	Provision states that if the renewal premium has not been paid within the time granted, but a company or authorized producer subsequently accepts a premium, the policy shall be reinstated. The only exception is an application for reinstatement required to be submitted by the enrollee and accepted by the company.	
Renewability	ORS 743.018 (health policies only), ORS 742.023* (individual)	Premium change or renewability provision provides for premium changes only when such changes apply to all policies of this form, are issued to persons in the same class in this state, and have been approved by the Oregon Division of Financial Regulation.	
Suspension	ORS 742.023(1)(d),(f)* (individual)	Suspension of coverage while in military service. A provision entitles persons in military service to have their coverage suspended during a period of military service that may be limited to five years but not to exceed the period of active duty. To be entitled to coverage suspension, the following applies: (1) Be in the military service of any nation or international authority or in a reserve component of the armed forces of the United States, including the National Guard; and serving active duty or active military training lasting at least three months. (2) The owner makes a written request for coverage suspension and provides verification of eligibility and the requested suspension date, not to precede the owner's date of request. Any unearned premiums for the period of suspension is refunded. (3) Upon termination of active duty, the owner has the right to resume coverage without evidence of insurability and the resumption of coverage shall be on the same basis as before the coverage suspension took effect. No exclusion, limitation, or modification of coverage is imposed unless: (a) The exclusion, limitation, or modification is stated in the policy prior to the suspension or a waiting period had not been completed prior to the suspension. (b) A condition arose during the course of active duty.	

Review requirements	Reference	Description of review standards requirements	Enter page & paragraph
Suspension, continued	ORS 742.023(1)(d),(f)* (individual)	Continued (c) The condition that arose during suspension is a condition identified as an exclusion or limitation to coverage generally and included in the policy prior to suspension. (d) The period for application to resume coverage and payment of premium after the suspension period is not less than 90 days. Required premiums are the same as they would have been if coverage had remained in force.	
	ORS 742.023(1)(c),(f)* (individual)	Coverage for disabilities based upon an inability of an insured to perform the substantial and material duties of the insured's "own occupation" which requires a professional license or certificate, may allow a disabled insured to receive benefits based upon an "any occupation" definition for any time period the insured has his/her professional license or certificate revoked or suspended or is without authority of any professional license or certificate.	
Terrorism exclusions prohibited	Bulletin 2015-1	Oregon will not allow terrorism exclusion or limitation language in Annuities, Life Insurance, Health Insurance, Personal Insurance, or Workers' Compensation Insurance products.	
Time limit on certain defenses	ORS 743.414(1)*	A provision states that after two years from the date of issue of the initial coverage or two years from subsequent increases in coverage, no misstatements except fraudulent misstatements made by the applicant is used to void the policy or to deny a claim.	
	ORS 743.414(2)*	The policy provision does not affect any legal requirement for avoidance of a policy or denial of a claim during the first two-year period or limit the application of ORS 743.450 to 743.462 in the event of misstatement with respect to age or occupation or other insurance.	
Waiting period	ORS 742.023(1)(d)* (individual)	Clearly disclose any elimination period in relation to the benefit periods.	

REQUIREMENTS FOR RATES FOR INDIVIDUAL POLICIES (*Information requested under this section is determined to be necessary to evaluate the filing for compliance. ORS 731.296)*			
Filing request	ORS 731.296	The following review is requested: 1. New rate filing 2. Rate change 3. Informational	Requested ☐ ☐ ☐

Review requirements	Reference	Description of review standards requirements	Check answer
Ratemaking, generally	ORS 731.296, OAR 836-010-0011	Appendix A (Form 440-2462) is included and all columns completed showing support of the rate requested. Includes actual and projected experience and overall loss ratio from policy inception for Oregon and the company's national experience.	Yes ☐
		A complete actuarial memorandum, signed by an accredited actuary, is included containing a description of all policy benefits and the actuarial assumptions used to develop each of the benefits.	Yes ☐
		The expected experience of the new rate or existing rate for the projected calculating period over which the actuary expects the premium rates to remain adequate is based on estimated future experience without expected rate increases.	Yes ☐
		The source of the data, information about new or experimental benefits, explanations of the reliability of projections, abrupt changes in the experience, and substantial differences between actual and expected experience are included.	Yes ☐
	ORS 731.296, OAR 836-010-0011	A statement that the grouping of policy forms has not changed or an explanation of the changes is included. Experience of forms must be grouped according to similar types of benefits, claims experience, reserves, margins for contingencies, expenses and profit, renewability, underwriting, and equity between policyholders.	Yes ☐
Ratemaking, continued	ORS 731.296, OAR 836-010-0011	The premium structure, as defined by the classification of insureds in the policy, is not changed at the time of rate increase (e.g., change from issue-age to attained-age basis)	Confirm ☐
	ORS 733.030	Filing identifies how reserving assumptions (including specific company experience) take into account any expected adverse mortality and lapses that are reflected in the pricing.	Yes ☐
Requirement not part of a listed category	ORS 742.023*, ORS 743.018	Premium changes are subject to prior approval and should not be filed more than once in a 12-month period.	Yes ☐
	ORS 742.041*	**Combined classes.** This filing includes classes of combined life and health insurance. *(No other classes are combined in this filing in which the liability of the company for unearned premiums or the reserve for unpaid, deferred, or undetermined-loss claims is estimated in a different manner.*)	Yes ☐ N/A ☐
Underwriting	ORS 731.296	Mark the type of health underwriting filed for the forms included in this rate request: 1. Full underwriting 2. Simplified underwriting 3. No underwriting	Mark one ☐ ☐ ☐