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Life and Health Insurance

DISTRICT OF COLUMBIA | Law Supplement



LIFE AND HEALTH INSURANCE DISTRICT OF COLUMBIA LAW
SUPPLEMENT, EFFECTIVE AUGUST 1, 2008
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INTRODUCTION

This supplement focuses on statutes regarding District of Columbia insurance law. Key aspects of each statute are discussed to help the student pass the state law portion of the licensing examination. In order to understand the content of this supplement, the student should first study the national insurance License Exam Manual. Thorough preparation for the exam requires the complete study of both the national License Exam Manual and the supplement.

I. DISTRICT OF COLUMBIA LAW AND REGULATIONS PERTAINING TO LIFE, ACCIDENT, AND HEALTH INSURANCE

- A. CERTIFICATE OF AUTHORITY [SEC. 31-4304, 4403]** A certificate of authority is an insurance company's license to transact insurance business. It is granted by the Commissioner and specifies the type of insurance business the company can transact in the District of Columbia.
1. Insurance companies that hold a certificate of authority are known as authorized insurers (or admitted insurers).
 2. Every insurance company must be authorized to transact insurance in the District.
- B. DOMESTIC, FOREIGN, AND ALIEN COMPANIES [SEC. 31-4202]** A **domestic company** is an insurance company organized in the District of Columbia. A **foreign company** is organized under the laws of another state. An **alien company** is organized under the laws of any country other than the United States.
- C. PERSON [SEC. 31-4202]** A **person** is an individual, corporation, association, or partnership.
- D. NET PREMIUM RECEIPTS [SEC. 31-4202]** Net premium receipts are gross premiums received, minus the sum of:
- premiums returned on cancelled policies;
 - premiums paid for reinsurances where the same are paid to companies licensed to do business in the District; and
 - dividends paid in cash or used by policyholders for renewal premiums or purchase of paid-up additional insurance.
- E. SURPLUS [SEC. 31-4202]** **Surplus** is the amount of assets that exceed an insurance company's liabilities (and its capital, for companies with capital stock).
- F. LIABILITIES [SEC. 31-4202]** **Liabilities** are all of an insurance company's debts of which it has knowledge (including reserves required by law).

- G. INDUSTRIAL LIFE INSURANCE [SEC. 31-4202]** Industrial life insurance is insurance that meets the following requirements:
- premiums are payable weekly, monthly, or more often;
 - the face amount of insurance is less than \$1,000; and
 - the words *industrial policy* are printed on the policy.
- H. INSURANCE AGENT [SECS. 31-4202]** An agent is an individual, partnership, or corporation licensed by the Commissioner and authorized to sell insurance and collect premiums on behalf of an insurance company, association, or exchange. Agents represent the insurer, not the insured, in any controversy.
- I. SOLICITOR [SEC. 31-4202]** A solicitor is an individual authorized by a licensed agent to sell insurance and collect premiums on behalf of the agent.
- J. INSURANCE BROKER [SEC. 31-4202]** A broker is a consultant or any other individual, partnership, association, or corporation that, for commission or anything of value, negotiates insurance contracts (including surety bonds) on behalf of the insured. A broker represents the insured, not the insurer, in any controversy.

II. REGULATION OF THE INSURANCE INDUSTRY

A. COMMISSIONER OF INSURANCE AND SECURITIES [SECS. 31-202, 31-4301]

1. The Commissioner of Insurance and Securities is appointed by the mayor of the District of Columbia to:
 - supervise all insurance matters in the District;
 - execute and enforce all laws of the United States relating to insurance companies, benefit orders, and associations doing business in the District of Columbia; and
 - maintain copies of all insurance companies' charters.
2. The Council of the District of Columbia makes rules and regulations regarding the conduct of all insurance companies that do business in the District.

B. ANNUAL REPORT [SECS. 31-205, 206, 207]

1. Every January, all insurance companies must provide the Commissioner with an annual statement of their business in the District of Columbia, including the:
 - net amounts of their premium receipts;
 - amount of losses paid; and
 - amount of expenses incurred.

2. The Commissioner maintains records that show the ratio of losses and expenses to premium receipts for all insurance companies that do business in the District.
3. By March 1 each year, insurance companies (except mutual fire insurance companies) must pay premium taxes that are due for the previous calendar year. The Commissioner may suspend or revoke the license of a company that fails to pay premium tax on or before the due date.
4. By March 31 each year, the Commissioner reports the financial condition of all insurance companies doing business in the District to the mayor. The Commissioner's annual report is printed by the first day of Congress' regular session.

C. CAPITAL REQUIREMENTS OF INSURERS [SEC. 31-208] The Commissioner determines whether the capital required by domestic insurance companies' charters has been invested in property or paid up in cash and held by the company's board of directors.

D. EXAMINATIONS [SECS. 31-1402, 1404]

1. The Mayor (or an appointed examiner) may do the following to each insurance company that is authorized to transact business in the District of Columbia:
 - examine the company's officers, agents, and anyone who has information regarding the company's property or business;
 - issue subpoenas compelling witnesses to testify;
 - require the company's officers and agents to produce all books, records, and papers relating to its affairs and examine these with the company's property; and
 - make an examination report.
2. The Mayor provides a copy of the examination report and grants a hearing to all examined companies before making a public report.
3. The Mayor examines all insurance companies at least once every five years.
4. Examination expenses are paid by the examined companies.

E. DISTRICT OF COLUMBIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION [SEC. 31-5401, 5405, 5501]

1. The purpose of the District of Columbia Life and Health Insurance Guaranty Association is to protect the financial interests of District residents who own or are beneficiaries of life or health insurance policies issued by insurers that have difficulty fulfilling their financial obligations.
2. **Members [Sec. 31-5401]** The association is funded by contributions from all life and health insurers authorized to transact business in the District. The following, however, are not members of the association:
 - nonprofit hospital or medical service organizations;
 - health maintenance organizations;
 - fraternal benefit societies;

- mandatory state pooling plans;
- mutual assessment companies;
- insurance exchanges; or
- risk retention groups.

3. Authorized actions [Sec. 54-5405] The association may take the following actions to carry out its duties:

- guarantee, assume, or reinsure, any policies of the impaired insurer;
- provide monies, pledges, notes, or guarantees to assure payment of the contractual obligations of the impaired insurer; or
- loan money to the impaired insurer.

III. LICENSING

A. GENERAL LICENSE REQUIREMENT [SEC. 31.1131.01-.09] Every insurance company, agent, and broker must hold the appropriate license to transact insurance business in the District of Columbia.

B. INSURANCE COMPANY LICENSING [SEC. 31-4304] All insurance companies must hold a certificate of authority (a license to transact insurance business, granted by the Commissioner) specifying the type of insurance business they can transact in the District.

1. Licensing procedure [Sec. 31-4304] Certificates of authority expire on April 30. Licensing applicants must submit an application form under oath for investigation by the Commissioner.

2. Suspension or revocation of certificate of authority [Sec. 31-4305]

- a.** The Commissioner can revoke or suspend the certificate of authority for any company that:
- fails to comply with any provision of the District's insurance laws;
 - is impaired in capital or surplus;
 - is insolvent;
 - is in a condition that would cause business to be hazardous to the public;
 - refuses to pay a final judgment within 30 days;
 - violates its charter;
 - refuses to submit its records for inspection by the Commissioner or appointed examiners;
 - has an officer who refuses to be examined;
 - fails to file a copy of any charter amendment with the Commissioner;

- has had its certificate of authority revoked in the state in which it was organized;
 - reinsures all its risks in another company without the Commissioner's prior approval;
 - makes a statement that misrepresents a policy's name, benefits, or advantages;
 - files a statement from an independent organization attesting to its qualifications to transact business in the District and received a certificate of authority, if the statement was based on false, misleading, or incomplete information; or
 - files a statement from a corporate officer attesting to its qualifications to transact business in the District and received a certificate of authority, and the statement was based on false, misleading, or incomplete information.
- b.** The Commissioner must give an insurance company 30 days' notice and the opportunity for a hearing before revoking or suspending its certificate of authority.
- The Commissioner can suspend an insurance company's certificate without notice if the company's business appears to be hazardous to the public.
- c. Fines [Sec. 31-4305]** If the Commissioner believes that continued operation of the company would benefit the public, he may fine the company up to \$10,000 instead of revoking or suspending its certificate of authority. The Commissioner may fine an intentional violator up to \$25,000 if it is determined that the public interest is best served by the continued operation of the company.

3. Licensing of foreign and alien companies

- a. Transacting insurance requirements [26 DCMR 1001]** A foreign or alien insurance company must have continuously transacted insurance business in its state of domicile for at least two years before applying to transact business in the District, except for companies that:
- are owned or controlled by a company that has been licensed in the District for at least three years;
 - have surplus (or capital surplus) of at least \$3 million; or
 - have established at least a \$300,000 escrow fund for the protection of District of Columbia policyholders and claimants (under conditions approved by the Commissioner).
- b. Filing requirements [Sec. 31-4501]** A foreign or alien applicant also must file the following information with the Commissioner:
- an application for a certificate of authority, stating the kind(s) of insurance to be transacted;
 - a copy of its charter or articles of incorporation;
 - a copy of its bylaws or regulations;
 - copies of the policies it has or plans to issue (and the applications);

- a statement authorizing the Commissioner to serve as its attorney in any lawsuit;
 - a statement of its financial condition and business (an alien company must only report on its condition and business in the United States);
 - evidence that its funds are invested according to the laws of its state or country of residence; and
 - if a stock company, evidence that its paid-up capital and surplus is at least equal to the capital and surplus required for domestic stock companies.
- c. Appointment of trustees [Sec. 31-4502]** The directors of an alien company may appoint American citizens or corporations as its trustees to hold funds and assets in trust for the benefit of American policyholders and creditors. When trustees are appointed, the Commissioner must:
- approve the appointments;
 - keep a certified copy of the appointments on record; and
 - examine the company's trustees, officers, agents, and records.
- d. Investigation of foreign and alien insurers [26 DCMR 1001]** The Commissioner can investigate the condition, records, and reputation of foreign and alien insurance companies to determine whether or not they are qualified to transact business in the District.
- e. Merger of foreign and domestic companies [Sec. 31-4446]**
Foreign and domestic insurance companies can merge if permitted by the laws of each company's state of residence.
- 4. Stock and mutual companies [Sec. 31-601]** A stock insurance company is owned and controlled by a group of stockholders. A mutual insurer is owned by its policyowners and has no capital stock.
- a. Membership [Secs. 31-4416, 4417]**
- 1.) Public and private corporations, boards, and associations may take applications and enter into agreements for, hold policies in, and become members of mutual companies.
 - 2.) Domestic mutual companies must have at least 200 subscribers, at least \$200,000 of insurance, and one annual premium paid in full upon the insurance subscribed.
- b. Formation [Sec. 31-4419]** Domestic stock companies can become mutual companies and carry out a plan for acquiring shares of their capital stock. The plan must be:
- adopted by a majority vote of the company's directors;
 - approved by a majority vote of stockholders at a stockholders' meeting;

- approved by a majority vote of the policyholders who are insured for at least \$1,000 each and whose insurance has been in force for at least one year before the stockholders' meeting; and
- submitted to the Commissioner and approved in writing.

c. Meeting notice [Sec. 31-4419] Notice of the policyholders' and stockholders' meetings must be mailed at least 30 days in advance.

C. AGENT AND BROKER LICENSING

1. Licenses required [Sec. 31-1131.03, 26 DCMR 100] All agents and brokers must be licensed by the Commissioner to sell insurance in the District of Columbia.

a. An insurance producer may receive a license in one or more of the following lines of insurance:

- life;
- accident and health;
- property;
- casualty;
- variable life and variable annuity;
- personal lines;
- bail bonds;
- surplus lines; and
- limited lines of insurance, including car rental, credit, crop, surety, and travel.

b. Business entity [Sec. 31-1131.06(b)] A business entity acting as an insurance producer obtain an insurance producer license. Before approving the application, the Commissioner must find that the business entity has:

- paid the required fee; and
- designated a licensed individual producer to be responsible for the business entity's compliance with the insurance laws, rules, and regulations of the District.

2. Application requirements [Secs. 31-1131.06, .08]

a. Resident insurance producer [Sec. 31-1131.06] An applicant for a resident insurance producer license must submit an application and:

- complete a prelicensing education course;
- be at least 18 years of age;
- pay the required fees; and
- pass the examination for the lines of authority for which the applicant is applying.

b. Nonresident licenses [Sec. 31-1131.08] A person can receive a nonresident license if he or she is licensed as a resident insurance producer in another state and:

- is currently licensed and in good standing in his or her home state;
- has submitted the proper request for a nonresident insurance producer license and has paid the required fees; and
- has submitted a completed NAIC Uniform Application or the licensing application that the person submitted to his or her home state.

3. Prelicensing education [26 DCMR 101(101.1)] Each agent or broker applicant must furnish evidence of completing a prelicensing course consisting of at least 40 hours at the time of filing the application. Every applicant must take the appropriate examination within one year of completing a prelicensing course.

4. Appointments [Sec. 31-1131.14]

a. An insurance producer may not act as an agent of an insurer unless the insurance producer is an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not be required to be appointed.

b. To appoint an insurance producer as its agent, the appointing insurer must:

- file a notice of appointment within 30 days from the date that the agency contract is executed or the first insurance application is submitted; and
- pay a fee for each insurance producer appointed.

c. Upon receipt of the notice of appointment, the Commissioner must verify, within 10 days, that the insurance producer is eligible for appointment. If the insurance producer is ineligible for appointment, the Commissioner must notify the insurer within five days of the determination.

5. Termination of appointment [Sec. 1131.5]

a. An insurer that terminates the appointment or other business relationship with an insurance producer must notify the Commissioner within 30 days. Upon the Commissioner's written request, the insurer must provide additional information, documents, records, or other data pertaining to the termination or activity of the insurance producer.

b. Within 15 days of notifying the Commissioner, the insurer must mail a copy of the notification to the insurance producer at his or her last known address.

c. Within 30 days of receiving the notification, the producer may file written comments concerning the substance of the notification with the Commissioner and simultaneously send a copy of the comments to the reporting insurer.

6. Examination requirements [Sec. 31-1131.05] Every applicant for a resident insurance producer license in the District must take a written examination that will test the applicant's competence to perform the duties of a licensee. The applicant must take a separate examination for every line of insurance he wants to transact.

a. Exemptions from examination requirements [Sec. 31-1131.05, .09] The following applicants for resident insurance producer licenses are not required to take a written examination.

- 1.)** The applicant is applying for a limited lines or surplus lines insurance producer license;
- 2.)** The applicant is currently licensed for the same line of authority in another state; or
- 3.)** The applicant was previously licensed for the same lines of authority in another state, files an application within 90 days of cancelling his or her previous license, and the state verifies the applicant was in good standing in the state.

7. License renewal [26 DCMR 102]

a. Licenses expire on April 30 of each odd-numbered year.

- 1.)** At least 30 days before the expiration of a license, the Commissioner will mail a renewal application to the license holder.
- 2.)** Failure of the license holder to receive the notice does not relieve him of the responsibility to renew the license.

b. An insurance agent or broker who fails to renew a license before the expiration date may renew the license within 30 days after expiration if he pays the late fee.

c. If an insurance agent or broker fails to renew a license within 30 days of the expiration date, the license will lapse on the date of expiration, and the license holder will be required to apply for reinstatement.

8. Continuing education [26 DCMR 106]

a. In order to renew an insurance license, an agent or broker must certify to the Commissioner that he has successfully completed at least 16 credit hours of approved continuing education within the two-year period before the expiration of the license.

- 1.)** Courses can be taken either in a classroom or through a program of independent study.

- 2.)** If the course is independent study, a supervised final examination must be administered to the students.
- b.** An insurance agent or insurance broker renewing a license for more than one line of authority must complete at least 24 credit hours of continuing education, including at least six credit hours for each line of authority and two hours of ethics.
- c.** All continuing education requirements must be completed by December 31 of each even-numbered year.
 - 1.)** This requirement does not apply to an applicant seeking the first renewal of a license or an applicant who received his license during the second year of the two-year period before the expiration date.
- d.** A renewal applicant must show proof on a form that has been approved by the Commissioner of having completed the required education.
- e.** If an agent or broker successfully completes any of the courses necessary to obtain certain designations, 16 credit hours will be counted toward the continuing education requirement after the person successfully completes the national examination. The nationally recognized designations are:
 - Accredited Advisor in Insurance (AAI);
 - Associate in Claims (AIC);
 - Associate in Loss Control Management (ALCM);
 - Associate in Risk Management (ARM);
 - Associate in Underwriting (AU);
 - Certified Employee Benefits Specialist (CEBS);
 - Certified Insurance Counselor (CIC);
 - Chartered Financial Consultant® (ChFC®);
 - Chartered Life Underwriter® (CLU®);
 - Chartered Property Casualty Underwriter (CPCU®);
 - Fellow Life Management Institute (FLMI);
 - General Insurance (INS);
 - Life Underwriter Training Fellow, 26 weeks (LUTCF); and
 - other designations approved by the Commissioner.
- f.** The Commissioner may grant approval for courses approved by the insurance regulatory agency in another state, provided the course meets the requirement of the District or the state grants reciprocity to the District's agents.
- g.** Instructors will earn one hour of continuing education credit for each hour of instruction of an approved course.
 - 1.)** Licensees and instructors may not earn credit for repeating a course they already attended or instructed during the same biennium.

- 2.) Excess credit hours accumulated during any biennium may not be carried forward to the next biennium.

h. Exemptions from continuing education [26 DCMR 106] An applicant for the renewal of a license may request an exemption from the continuing education requirement if he:

- is 65 years of age or older;
- has been continuously licensed for at least 25 years; and
- holds one of the designations listed above; or
- is the majority shareholder of a corporation or the partner of a partnership that holds a license as an agent or broker, and neither solicits insurance nor actively participates in the operations of the business.

9. Temporary license [Sec. 31-1131.11] The Commissioner can issue a temporary insurance producer license for up to 180 days to the following people without requiring an examination:

- The surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow time to sell the insurance business or for the producer to recover or return to the business or to provide for the training and licensing of new personnel to operate the producer's business;
- A member or employee of a business entity licensed as an insurance producer upon the death or disability of an individual designated in the business entity application or the license;
- The designee of a licensed insurance producer entering active service in the U.S. armed forces; or
- Any other circumstance where the Commissioner determines that the public interest will best be served by issuing the license.

D. SUSPENSION OF LICENSE [SEC. 31-1131.12]

1. The Commissioner may refuse to issue an insurance producer license, suspend, revoke, or refuse to renew the license of a producer who:
- violates any insurance law or lawful ruling of the Commissioner or another state's insurance commissioner;
 - attempts to obtain a license by fraud or misrepresentation;
 - refuses to pay or deliver, upon request, money belonging to an insurer or beneficiary;
 - has been convicted of a felony or has committed any unfair trade practice or fraud; otherwise shown to be untrustworthy or incompetent to act as a life insurance agent, general agent, solicitor, or broker.
 - provides incorrect, misleading, incomplete, or materially untrue information in the license application;
 - intentionally misrepresents the terms of an insurance contract or application for insurance;

- uses fraudulent, coercive, or dishonest practices, or demonstrates incompetence, untrustworthiness, or financial irresponsibility in conducting business;
- has an insurance producer license denied, suspended, or revoked in any state or territory of the United States, province of Canada, or other foreign country;
- forges another's name to an insurance application or other document related to an insurance transaction;
- cheats on a licensing, prelicensing, or continuing education examination;
- knowingly accepts insurance business from an individual who is not licensed;
- fails to comply with an administrative or court order imposing a child support obligation;
- fails to pay District income tax or comply with an administrative or court order directing payment of District income tax; or
- misrepresents that they have satisfactorily completed an examination in a prelicensing or continuing education course.

2. Hearings and penalties [Sec. 31-1131.12] Before revoking, suspending, or refusing to renew a license, the Commissioner must give licensees an opportunity to have a hearing and introduce evidence on their behalf.

- a. The Commissioner must give written notice to the applicant or licensee of the proposed action and the reason for the proposed action. The applicant or licensee has 30 days after the date of the Commissioner's notice to request a hearing to determine whether the proposed action should be taken. Any hearing must be held within 30 days.
 - 1.) If the Commissioner determines that further transaction of business by a producer would be hazardous to the public or the policyholders or creditors of the producer, the Commissioner may revoke or suspend the producer's license without giving notice or holding a hearing. The Commissioner must then hold a hearing within 30 days after the effective date of the order of the revocation or suspension.
 - 2.) The Commissioner may administer oaths, issue subpoenas for witnesses and documents, and petition the courts to enforce subpoenas.
- b. In addition to or instead of revoking or suspending a license, the Commissioner may:
 - fine violators up to \$5,000; or
 - order the offender to pay restitution to any person who suffered financial injury or damage from the violation.

E. PENALTY FOR VIOLATING FIDUCIARY RESPONSIBILITY [SEC. 31-4329]

All insurance agents, solicitors, and brokers who initiate or renew insurance contracts and receive premiums from the insured must hold the money in trust for the company that makes the contract. Anyone who fails to pay the premium to the company after written demand has been made is guilty of theft.

- F. COMMISSIONS AND PAYMENTS [SEC. 31-1131.13]** A person may not receive any type of payment for acting as an insurance agent or broker unless he was licensed as an agent or broker at the time the services were performed. This does not prevent a person from receiving deferred compensation for work performed when licensed.
- G. CHANGE OF ADDRESS [26 DCMR 102]** A licensee must notify the Commissioner within 30 days of a change of residential or business address.
- H. REPORTING OF ACTIONS [SEC. 31-1131.17]** An insurance producer must report to the Commissioner any administrative action taken against him or her in another jurisdiction or by another governmental agency in the District within 30 days of the final disposition of the matter. Insurance producers must also report to the Commissioner any criminal prosecution brought against the producer in any jurisdiction, within 30 days of the pretrial hearing. All reports must include a copy of the initial complaint filed, the order resulting from the hearing, the consent to order, or any other relevant legal documents.

IV. ETHICAL CONDUCT

The insurance business requires honesty and good faith. As a result, the insurance industry is regulated to ensure that its responsibilities to the public are upheld.

- A. UNFAIR TRADE PRACTICES** It is illegal to engage in any trade practice that is considered an unfair method of competition or a deceptive act. The Commissioner has the authority to investigate possible unfair trade practices and fine violators or suspend or revoke their licenses.
- B. MISREPRESENTATION AND FALSE ADVERTISING**
- 1. Definition of advertising [26 DCMR 299]** For the purposes of this regulation, advertisements consist of the following.
 - a.** Printed and published descriptive literature of an insurer used in newspapers, magazines, radio and TV scripts, billboards, and similar displays
 - b.** Descriptive literature and sales aids used by an insurer for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters
 - c.** Prepared sales talks, presentations, and material for use by agents and brokers, and representations made by agents and brokers
 - 2. False advertising [Sec. 31-2231.04]** It is illegal to make, issue, or circulate any statement about the insurance business or an insurer in the conduct of its business, which is untrue, deceptive, or misleading.

3. Twisting [Sec. 31-2231.21] It also is illegal to make misrepresentations for the purpose of inducing policyholders to lapse, forfeit, or surrender their policies (twisting).

4. Insurance application misrepresentations [Sec. 31-2231.19] It is illegal for a agent, broker, examining physician, or other person to knowingly makes a false or fraudulent statement on an application for insurance for the purpose of obtaining a fee, commission, or benefit from any insurer, agent, broker, or insurance company. It is also illegal to present a false or fraudulent claim, or proof to support a claim, or to prepare a false or fraudulent certificate or other document to be used to support a false or fraudulent claim.

C. DEFAMATION OF INSURER [SEC. 31-2231.05] It is illegal to make any defamatory or false statement (written or verbal) about any insurance company doing business in the District in order to injure the reputation or business of the company.

D. ILLEGAL INDUCEMENTS [SEC. 31-2231.09] It is illegal for any life insurance company doing business in the District to issue or permit, as an inducement to purchase insurance, the delivery of agency company stock, capital stock, benefit certificates, securities, special advisory board contracts, or any contracts promising returns and profits.

E. FALSE FINANCIAL STATEMENTS [SEC. 31-2231.08] It is illegal for a person to knowingly file with an insurance or other public official to publish or otherwise disseminate or place before the public, a false material statement of fact about an insurer's financial condition. It is also illegal for a person to knowingly:

1. make a false entry of a material fact in a book, report, or statement of an insurer;
2. fail to make a true entry of any material fact pertaining to an insurer's business in a book, report, or statement of the insurer, in order to deceive the commissioner or the agent who is examining the insurer; or
3. make a false material statement to an insurance department official.

F. DISCRIMINATION [SEC. 31-2231.11, .13]

1. It is illegal to discriminate unfairly between individuals of the same class and equal life expectancy in the amount of payment, premiums, rates, dividends, benefits, or any other terms or conditions of a life insurance policy or annuity contract.
2. Insurers also may not make or permit a difference in ratings, premium payments, or dividends based on the marital status, race, color, personal appearance, sexual orientation, identity or expression, matriculation, or political affiliation of an applicant or policyholder unless there is actuarial justification for the differential.

G. REBATES [SEC. 31-2231.12] It is illegal for anyone to make an insurance contract or agreement other than that plainly expressed in the policy.

1. It is illegal for a company to allow or pay, as an inducement to buy insurance, anything not specified in the policy, including:
 - stocks, bonds, or other securities;
 - rebates of premiums;
 - special favors or advantages in dividends; or
 - paid employment or contract for services.

2. The following activities are not considered rebating:
 - paying bonuses to policyholders or abating premiums out of surplus accumulated from nonparticipating insurance (if in the best interest of the company);
 - return the amount of premium saved on collection to industrial insurance policyholders who have continuously made premium payments directly to the insurance company for a specified period;
 - readjusting premium rates for group insurance policies based on the loss or expense experience at the end of a policy year (made retroactive for that policy year only);
 - reducing premium rates for policies of large amounts, but not exceeding savings in issuance and administration expenses attributable to the policies compared with policies issued in smaller amounts;
 - issuing life or health insurance policies or annuity contracts on a salary savings or payroll deduction plan, or other distribution plan, at reduced rates commensurate with the savings made by the use of the plan; and
 - issuing health insurance policies which provide for increases in benefits to policyholders who maintain their policies continuously in force without lapse for specified periods.

H. INSURANCE APPLICATION MISREPRESENTATIONS [SEC. 31-2231.19]

1. It is illegal for anyone to make false or fraudulent statements on an insurance application in order to obtain a fee, commission, or other benefit.

2. It is illegal for any person to present a false or fraudulent claim or proof in support of a claim under an insurance contract.

I. PENALTIES AND HEARINGS [SECS. 31-2231.22, .23] The Commissioner may examine and investigate the affairs of anyone engaged in the business of insurance in the District of Columbia to determine whether the person is engaged in an unfair trade practice, unfair method of competition, or other unfair or deceptive action.

1. The Commissioner may suspend or revoke a person's license or certificate of authority for violating any rule or regulation of the insurance code, or for failing to comply with an order of the Commissioner.

2. The Commissioner can also:
 - a. order a person to cease and desist from violating the District of Columbia's insurance laws; and
 - b. require the person to correct the violation, including making restitution of money or property to the injured party.
3. The Commissioner may impose a \$1,000 penalty for each violation of a cease and desist order or other violation that the person failed to correct.
4. The Commissioner may also ask the Corporation Counsel of the District of Columbia to take appropriate action in the Superior Court to enforce any orders issued.
5. Before any penalties can be imposed, the Commissioner must provide the person with an opportunity for a hearing.
 - a. Written notice must be given at least 30 days before the hearing.
 - b. The Commissioner may administer oaths, examine and cross-examine witnesses, receive evidence, and have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents.

V. LIFE INSURANCE AND ANNUITIES

A. REQUIRED INDIVIDUAL LIFE INSURANCE POLICY PROVISIONS [SEC. 31-4703]

All individual life insurance policies delivered in the District of Columbia (not including pure endowments, annuities, and industrial insurance) must contain a(n):

- 30-day grace period for payment of premium (which begins on the premium-paying date stated in the policy), during which the death benefit coverage continues in force (subject at the option of the company to an interest charge of up to 6% per year for the number of days of grace elapsing between the stated premium-paying date and the actual payment of the premium);
- provision stating that if the policy becomes due during the grace period (before overdue or deferred premiums of the current policy year are paid), then the amount of premiums, with interest on any overdue premiums, may be deducted from any settlement payable under the policy;
- entire contract provision stating that the policy and the application constitute the entire insurance contract and that all statements included (in absence of fraud) are deemed representations and not warranties;
- incontestable provision stating that the validity of the policy cannot be contested (except for nonpayment of premiums) after it has been in force for at least two years;

- misstatement of age provision stating that if the insured's age was misstated on the application, the insured will receive the amount of benefits that the premiums paid would have purchased for the correct age;
- provision for nonforfeiture of benefits and cash surrender values;
- provision specifying the options to which the policyholder is entitled in the event of default in a premium payment;
- table showing the loan values and options available under the policy each year upon default in premium payments, during the policy's first 20 years or the premium paying period, if less than 20 years;
- death claims provision stating that when a policy becomes payable because of the insured's death, settlement must be made upon receipt of proof of death; and
- table showing the amount of installments, if any, in which the policy proceeds may be payable.

B. REINSTATEMENT [SEC. 31-4703(A)(10)] All individual life insurance policies must include a reinstatement provision stating that if the policyholder defaults in premium payments, the value of the policy can be applied to purchase other insurance. If the insurance is in force and the original policy has not been cancelled or surrendered to the company, the policy can be reinstated within three years from the default if:

- satisfactory evidence of insurability is given;
- back payment of premiums (with interest not to exceed 6% per year) is made; and
- payment or reinstatement of any other indebtedness to the company is made.

C. POLICY LOANS [SECS. 31-4703(A)(6)]

1. All life insurance policies must contain a policy loan provision stating that after premiums have been paid for three years, the company can loan the insured (at a specified interest rate) an amount equal to or less than the policy's nonforfeiture value. Policy loans are not required for:
 - term insurance;
 - temporary insurance; or
 - pure endowment insurance issued in exchange for lapsed or surrendered policies.
2. Applicable policies issued after March 14, 1985 must include:
 - a fixed policy loan interest rate of no more than 8% per year; or
 - an adjustable maximum interest rate established by the company. Adjustable interest rate policies must determine the maximum interest rates at least once every 12 months (at regular intervals), but not more often than once every three months.
3. The company must provide the following information to policyholders who borrow under a policy:
 - notice of initial interest rate when a cash or premium loan is made;
 - notice of any rate increase within a reasonable period of time; and
 - a statement of how frequently the company reevaluates the rates.

D. CONTRACTUAL RIGHTS OF MINORS [SEC. 31-4330]

1. Minors who are at least 15 years old can contract for life, health, and accident insurance on their own lives for the benefit of themselves, their parents, spouses, siblings, or anyone in charge of their care or custody.
2. Minors can exercise the same contractual rights as people of full legal age and may surrender their interest in the insurance at any time.

E. BENEFITS PROTECTED FROM CREDITORS [SECS. 31-4176(A), 4717]

Life insurance companies may enter into agreements with policyholders to hold the proceeds of any policy in a trust and exempt from the claims of creditors. Furthermore, the proceeds of a group life insurance policy are exempt from the claims of the employee's creditors.

F. AIDS LAW [SEC. 31-1601, 1603]

1. Health and disability insurance policies cannot contain exclusions, reductions, or other limitations related to the care and treatment of:
 - acquired immune deficiency syndrome (AIDS);
 - AIDS-related complex (ARC);
 - human immunodeficiency virus (HIV) infection; or
 - any illness or disease arising from those medical conditions, unless the provisions apply to all benefits under the policy.
2. Life insurance policies cannot contain exclusions, reductions, or other limitations relating to AIDS, ARC, HIV infection, or any disease arising from those medical conditions as a cause of death.
3. **Consent [Sec. 31-1606]** Insurers cannot require an AIDS test without first obtaining the signature of the proposed insured.
 - a. Insurers must provide information about the availability of AIDS counseling at public and private health facilities to all proposed insureds who the insurer requests to take the tests.
 - b. Insurers can only disclose AIDS test results or the fact that a proposed insured was tested to:
 - the proposed insured or the legal guardian of the proposed insured;
 - a court, if ordered by the court; and
 - anyone authorized by the proposed insured or legal guardian.
4. **Contestability [Sec. 31-1607]** Insurers can contest the validity of a policy contract for three years from the date of issuance, amendment, or renewal if:
 - the insured knowingly failed to disclose to the insurer that he had AIDS at that time; and
 - the insurance company was prohibited from conducting a test to determine the insured's exposure to AIDS when the insured entered into the contract.

5. Inquiries [Sec. 31-1610]

- a. Insurers cannot inquire about the sexual orientation, identity, or expression of an applicant in an application for life, health, or disability income insurance coverage or in an investigation by an insurer in connection with an application.
- b. Sexual orientation, identity or expression cannot be used as a factor when underwriting or determining insurability.
- c. Insurance companies cannot use sexual orientation, identity or expression, lifestyle, living arrangements, occupation, gender, or beneficiary designations to determine whether to test an individual who applies for life, health, or disability insurance.

G. FLESCH GUIDELINES FOR POLICY READABILITY

1. Readability standards [Sec. 31-4725] All policy forms delivered in the District of Columbia must adhere to the following readability standards.

- a. The text of the policy form must score at least 40 on the Flesch reading ease test.
- b. The forms must be printed in at least 10-point type.
- c. The style, arrangement, and overall appearance of the policy form must not unduly highlight any endorsement, rider, or portion of the text.
- d. If the policy has more than 3,000 words on three pages (or has more than three pages), the form must contain a table of contents or index.

2. Flesch test [Sec. 31-4725] The Flesch test measures the readability of policies. If the policy form contains up to 10,000 words, the entire form must be analyzed. If the policy contains more than 10,000 words, two 200-word samples (separated by at least 20 printed lines) must be analyzed.

- a. Readability is measured by using the following method.
 - 1.) The number of words is divided by the number of sentences
 - 2.) The quotient is multiplied by 1.015
 - 3.) The number of syllables is divided by the number of words
 - 4.) The quotient is multiplied by 84.6
 - 5.) The answer is subtracted from 206.835 to equal the Flesch reading ease score

3. The following words and sections are not counted in the Flesch reading ease computations:
 - insurance company name and address;
 - policy name, number, and title;
 - table of contents and index;
 - captions and subchapters;
 - specification pages, schedules, and tables;
 - policy language included to conform to law or to a collectively bargained agreement; and
 - medical terminology or language that is defined in the policy.
4. Insurance companies can decide whether to score riders, endorsements, applications, and other forms separately or as part of the policy.
5. Other reading tests may be used if approved by the Commissioner.

H. GROUP LIFE INSURANCE POLICIES [SEC. 31-4711]

1. **Mandatory provisions [Sec. 31-4711]** All group life insurance policies delivered in the District must include the following provisions:
 - a 31-day grace period;
 - an incontestability provision stating that the validity of the policy cannot be contested after it has been in force for two years (except for nonpayment of premiums);
 - a provision stating that the application is part of the insurance contract and is a representation, not a warranty;
 - a provision establishing the conditions, if any, under which the insurer may require evidence of individual insurability as a condition of coverage;
 - a misstatement of age provision;
 - a provision that any sum due because of the insured's death must be payable to the designated beneficiary; and
 - a provision that the insurer will issue to the policyholder (for delivery to each person insured) a certificate stating the insurance protection to which the insured is entitled and to whom the benefits are payable.
2. **Termination rights [Sec. 31-4711(8)]** A group life insurance must also contain a provision stating that if the insurance ceases because of termination of employment or membership in the group, the insured is entitled to have an individual life insurance policy issued by the insurer, without evidence of insurability, provided application is made and the first premium is paid to the insurer within 31 days of the termination.
3. **Termination of group policy [Sec. 31-4711(9)]** If a group policy terminates the insurance of any class of insureds, everyone who has been insured for at least five years before the termination date is entitled to have an individual policy issued by the insurer. The individual policy may not exceed the lesser of:

- the amount of the person's life insurance protection that ceases because of the termination, less the amount of any life insurance that he or she becomes eligible for under any group policy within 31 days after termination; or
- \$2,000.

4. Conversion rights [Sec. 31-4711.01] All individuals insured under group life insurance policies delivered in the District of Columbia are entitled, under the terms of the policy, to have an individual life insurance policy issued without evidence of insurability if they submit an application and pay the first premium within the time period specified in the policy.

If an individual is not notified about his or her rights at least 15 days before the expiration of the time period specified in the policy, the individual will receive an additional period in which to exercise the right to receive an individual policy.

I. STANDARD NONFORFEITURE LAW [SEC. 31-4705.01, .02]

1. Life insurance policies delivered in the District must include nonforfeiture provisions that specify what can happen to the policy's cash value if the policyholder defaults in his or her premiums payments.
2. When requested within 60 days after the due date of the premium, the insurer must grant a paid-up nonforfeiture benefit on a plan stipulated in the policy, or the insurer may substitute an actuarially equivalent alternative paid-up non-forfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.
3. If premiums have been paid for at least three years (for ordinary insurance), upon surrender of the policy within 60 days after the due date of any premium in default, the insurer will pay the policy's cash value instead of any paid-up nonforfeiture benefit.

J. NONFORFEITURE OF ANNUITIES [SEC. 31-4705.03]

1. All annuity contracts issued in the District of Columbia (except reinsurance and group annuities purchased under a retirement plan or deferred compensation plan) must include the following provisions.
 - a. When all payments stop, the company must grant a paid-up annuity benefit on a plan stipulated in the contract.
 - b. If a contract provides for a lump-sum settlement at maturity (or any other time) and the contract is surrendered at or before any annuity payments begin, the company must pay a specified cash surrender benefit—which can be deferred for six months—instead of a paid-up annuity benefit.
 - c. Contracts must include a statement of the mortality table, if any, and interest rates used to calculate any paid-up annuity, cash surrender, or death benefits guaranteed under the contract.

- d. Annuity contracts must contain a brief statement of the method used to calculate any paid-up annuity, cash surrender, or death benefits available under the contract.

2. Minimum nonforfeiture amount [Sec. 31-4705]

- a. When contracts provide for flexible payments, the minimum nonforfeiture amount before any annuity payments must equal:
 - the accumulation up to that time based on an interest rate of 1.5% per year;
 - decreased by any withdrawals from the contract at an interest rate of 1.5% per year; and
 - decreased by the amount of indebtedness to the company on the contract (including interest due) plus any existing additional amounts credited by the company to the contract.
- b. Contracts that provide a single consideration define minimum nonforfeiture amounts in the same way as do contracts with flexible considerations, except that the percentage of net consideration used to determine the minimum nonforfeiture amount must equal 90% and the net consideration must be equal to the gross consideration minus a contract charge of \$75.

K. VARIABLE LIFE INSURANCE AND ANNUITIES [26 DCMR 1004, 2700-2799]

1. All companies that deliver variable contracts in the District must be licensed to sell life insurance and must prove to the Commissioner that their condition and methods of operation do not endanger the public. Similarly, all agents who transact variable life insurance cannot do so without an appropriate license.
2. **Insurer qualifications [26 DCMR 2702]** The Commissioner considers the following information when determining whether a company is qualified to deliver variable contracts in the District:
 - the company's history and financial condition;
 - the character, responsibility, and general fitness of the company's officers and directors; and
 - for foreign and alien companies, whether the regulations of the company's state or country of residence provide the public with the same protection as do the laws of the District.
3. **Withdrawal of authority [26 DCMR 1004]** A company's authority can be withdrawn if the Commissioner finds the:
 - company's management is incapable of conducting business in the public interest;
 - company's business is not being conducted to safeguard its solvency or the interests of its contractholders, policyholders, and creditors; or
 - company has not complied with the District's insurance laws.

- 4. Notices [26 DCMR 1004, 2730]** All variable annuity and variable life contracts and applications must contain a prominent notice stating that payments by the company (when based on investment experience) are variable and do not have a guaranteed fixed dollar amount.
- 5. Required reports [26 DCMR 2707]** Variable life insurers must submit an annual report to the Commissioner that accounts for their variable life insurance business over the preceding year. They also must submit for approval any information to be distributed to insurance applicants and any forms of reports to policyowners.
- 6. Minimum policy benefits and requirements [26 DCMR 2711]** All variable life insurance policies issued or delivered in the District must contain the following minimum requirements.
 - a.** The insurer bears mortality and expense risks, for which maximum charges will be stated in the policy.
 - b.** In scheduled premium policies, the minimum death benefit will be at least equal to the initial face amount of the policy provided the premiums are paid.
 - c.** The policy will reflect the investment experience of one or more of the insurer's separate accounts.
 - d.** Every policy will be credited with the full amount of the net investment return applied to the benefit base.
 - e.** Any changes in a policy's variable death benefit will be determined at least annually.
 - f.** The cash value of every policy will be determined at least monthly.
- 7. Mandatory policy provisions [26 DCMR 2712]** Every variable life insurance policy issued or delivered in the District must contain the following:
 - prominent statement that the amount or duration of the death benefit may be variable or fixed under specified conditions;
 - prominent statement that cash values may fluctuate in accordance with the experience of the separate account, subject to any specific minimum guarantees;
 - statement describing any minimum death benefit;
 - the manner for determining the amount of the death benefit, or a reference to the policy provision that describes the method;
 - a 10-day grace period from the date the insured received the policy, or 45 days from the date of the application, whichever is later, during which the policyowner may return the policy and receive a refund of all premium payments;
 - for scheduled premium policies, a provision that allows a 31-day grace period after the premium due date, less any deduction for an overdue premium, as if the premium were paid on or before the due date;

- for flexible premium policies, a provision that allows a grace period that begins when charges to keep the policy in force until the next processing date exceed the amounts available under the policy to pay these charges, provided this grace period ends no less than 61 days after the mailing date of the Report to Policyholders;
- for scheduled premium policies, a provision that allows for reinstatement of the policy within two years of a default in premium payments, provided the insured submits a written application and gives evidence of insurability;
- complete description of the benefit base and method of calculating the variable benefits under the policy;
- provision specifying the separate account to be used and the account assets, with a statement that these assets will be valued at least as often as any policy benefits vary, but no less than monthly;
- provision specifying what documents constitute the entire insurance contract;
- list of the insurer's officers authorized to contract for or represent the insurer;
- stipulation that the insured's statements, or those made on the insured's behalf, are representations and not warranties;
- identification of the owner of the policy;
- the conditions or requirements for assigning the policy;
- description of adjustments in policy values if the insured's age or sex is misstated;
- provision that makes the policy incontestable by the insurer after it has been in force for two years;
- stipulation that the insurer will not change the investment policy of the separate account without the approval of the insurance commissioner of the insurer's home state;
- provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, partial withdrawals, or partial surrenders may be deferred for up to six months or for any period during which the New York Stock Exchange is closed for trading or when the Securities and Exchange Commission deems such payments impractical;
- if settlement options are offered, at least one option must be provided on a fixed basis only;
- description of the basis for calculating the cash surrender value;
- separate statement of premiums or charges for incidental insurance benefits, if any; and
- provision for nonforfeiture of insurance benefits.

L. CREDIT LIFE AND HEALTH INSURANCE

1. Definitions [Sec. 31-5101, 5102]

- a. **Credit life insurance** is insurance on the life of a debtor in connection with a specific loan or other credit transaction.

- b. **Credit health insurance** is insurance on a debtor to cover payments on a specific loan or other credit transaction while the debtor is disabled (as defined in the policy).
- c. These rules do not include insurance issued in connection with a loan or other credit transaction of five years' duration or more.

- 2. Types of policies [Sec. 31-5103]** Credit life and credit health insurance can be issued only in the following types of policies:
- individual life insurance policies issued to debtors on a term plan;
 - individual health insurance policies issued to debtors on a term plan or disability benefit provisions in individual credit life insurance policies;
 - group life insurance policies issued to creditors, providing insurance upon the lives of debtors on a term plan; and
 - group health insurance policies issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies to provide such coverage.

- 3. Amounts of insurance [Sec. 31-5104]** The amount of credit life insurance cannot exceed the initial indebtedness, no matter how the indebtedness is to be repaid.

- a. If the indebtedness is repayable in substantially equal installments, the amount of insurance cannot exceed the scheduled amount of unpaid indebtedness in the case of any group policy.
- b. The total amount payable by credit accident and health insurance in the event of disability (as defined in the policy) cannot be greater than the indebtedness plus any additional fees for periodic payment.

4. Term of coverage [Sec. 31-5101]

- a. The term of any credit life or health insurance policy begins when the debtor becomes obligated to the creditor (or, if a group policy, on the effective date of the policy).
- b. The term of insurance cannot extend more than 15 days beyond the scheduled maturity date of the indebtedness (except when extended without additional cost to the debtor).
- c. The insurance must be terminated and a refund paid if the indebtedness is discharged (due to renewal or refinancing) before the scheduled maturity date.

- 5. Filing of policy forms [Sec. 31-5107]** All policy forms, certificates of insurance, applications, binders, endorsements, and riders delivered in the District (and premium rates) must be filed with the Commissioner, who has 30 days to disapprove any form if:
- the premium rates charged appear to be excessive in relation to the benefits paid; or
 - the form contains provisions that are unjust, unfair, or deceptive.

6. Penalties for violations [Secs. 31-2502.03, 2502.42, 4305, 5111]

- a.** Any company, agent, solicitor, or broker who violates the laws regulating credit life and health insurance is subject to the following penalties:
- revocation or suspension of a certificate of authority (if an insurer);
 - revocation or suspension of a license (if an agent, solicitor, or broker); and
 - a fine of up to \$1,000 for each violation or up to 12 months imprisonment, in the case of persons not required to be licensed who violate the credit life and health insurance laws.
- b.** The Commissioner may revoke or suspend a certificate or license alone or in addition to assessing a penalty against the offender.
- c.** A licensee may appeal the Commissioner's order and request a hearing on the matter.

VI. ACCIDENT AND HEALTH INSURANCE

A. POLICY FORMS [SEC. 31-4712]

- 1.** All individual accident and health insurance policy forms, classifications of risks, and premium rates must be filed with the Commissioner at least 30 days before delivery in the District of Columbia.
- 2.** Policies must state:
 - all costs involved in the policy;
 - the dates on which the insurance takes effect and terminates;
 - that only one person will be insured (or, upon application, additional eligible family members and dependents);
 - the policy's exceptions and reductions;
 - the form number;
 - that the policy contains no provisions that attempt to make any portion of the insurer's charter, rules, constitution, or bylaws a part of the policy (unless set forth in full in the policy); and
 - that the policy contains no provision restricting access to psychologists or optometrists.

B. REQUIRED PROVISIONS [SEC. 31-4712] The following provisions must be included in all individual accident and health insurance policies issued in the District of Columbia:

- an entire contract provision stating that the policy, including all endorsements and attached papers, constitutes the entire insurance contract and that no agent has the authority to change the policy or waive any of its provisions;
- a provision that extends coverage to an insured's grandchild, niece, or nephew who is under the insured's primary care, when the minor's legal guardian (if not the insured) is not covered by an accident or sickness policy;
- a time limit on defenses provision stating that three years after the date of issue, no misstatements on the application may be used to void the policy or deny a claim;
- a grace period provision granting at least seven days for weekly premium policies, 10 days for monthly premium policies, and 31 days for all other policies for payment of each premium after the first;
- a reinstatement provision stating that any lapsed policy can be reinstated if satisfactory evidence of insurability is provided and any past-due premiums are paid;
- a notice of claim provision requiring that a written notice of claim be given to the insurer no later than 20 days after the occurrence of any loss covered by the policy;
- a claim forms provision stating that the insurer must provide the claimant with the forms required for filing proof of loss no later than 15 days after receiving notice of the claim;
- a proof of loss provision stating that the insured must furnish a completed claim form to the insurer within 90 days of the date of loss;
- a time of payment of claims provision stating that indemnities payable under the policy for any loss (unless provided by periodic payment) will be paid immediately upon receipt of the written proof of the loss;
- a payment of claims provision stating that indemnity for loss of life is payable according to the beneficiary designation;
- a physical examination autopsy provision stating that the insurer, at its own expense, has the right to a physical examination or autopsy of the insured while a claim is pending (where it is not forbidden by law);
- a legal actions provision stating that legal actions to recover on the policy must occur between 60 days and three years after written proof of loss has been furnished; and
- a change of beneficiary provision stating that the insured has the right to change the beneficiary, unless an irrevocable beneficiary designation has been made.

C. OPTIONAL PROVISIONS [SEC. 31-4712] The wording of the descriptions must be approved by the Commissioner whenever insurers offer the following provisions:

- change of occupation;
- misstatement of age;
- other insurance with the same insurer;
- other insurance with other insurers;
- loss-of-time benefit adjustment;
- unpaid premiums;

- conformity with state statutes; and
- illegal occupation.

D. CANCELLATION [SEC. 31-4712(2)(H)]

1. If a policy contains an optional cancellation provision, the insurer can cancel the policy at any time after giving the insured at least five days' advance written notice.
2. The insured may cancel the policy any time after it has been continued beyond its original term by giving written notice to the insurer. The insurer must return any unearned premiums.

E. COVERAGE OF NEWBORN CHILDREN [SECS. 31-3801-3805]

1. Individual and group health insurance policies and contracts that provide coverage for a family member of the insured also must provide health insurance benefits for newborn children from the moment of birth.
2. **Notification of insurer [Sec. 31-3803]** If payment of a specific premium is required to provide coverage for a child, the policy can require that the insured notify the insurer within 31 days of the child's birth in order for coverage to continue beyond that 31-day period.
3. **Applicability [Sec. 31-3805]** These requirements do not apply to:
 - Medicare supplements;
 - accident-only policies;
 - dread disease policies;
 - student accident policies;
 - nursing home policies; and
 - home health care policies.

F. SUBSTANCE ABUSE AND MENTAL ILLNESS

1. **Covered treatment [Sec. 31-3101]** All group health insurance policies must cover the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness.
 - a. Covered treatment is limited to inpatient, residential, and outpatient services which a licensed medical practitioner certifies as necessary.
 - b. Before an insured party may qualify to receive benefits, a physician, psychologist, advanced practice registered nurse, or social worker must certify that the individual is suffering from drug abuse, alcohol abuse, or has a drug addiction, alcohol addiction, or a mental illness, and must prescribe appropriate treatment, which may include referral to other treatment providers.

2. Coverage periods [Secs. 31-3103, 31-3104]

- a. An insurer will cover treatment for withdrawal of dependency on alcohol or drugs for at least 12 days per year.
- b. If the insured requires inpatient or residential care, coverage will extend to at least 60 days per year.
- c. An insurer must pay benefits at a minimum rate of 75% for the first 40 outpatient visits each year, and at a minimum rate of 60% for any outpatient visits thereafter during that year.
- d. An insurer is required to cover treatment of mental illness for at least 60 days per year.
 - 1.) This care can be inpatient or residential care.
 - 2.) The maximum lifetime benefit under individual and small employer policies can be no less than \$80,000 or one third of the lifetime maximum benefit for physical illness, whichever is greater.

G. CANCER PREVENTION [SECS. 31-2901-2903; 2931; 2951-2954]

1. Every individual and group health insurance policy, including Medicaid, must cover the following preventative measures for women:
 - baseline mammogram;
 - annual screening mammogram;
 - annual cytologic screening (pap test); and
 - cytologic screening whenever medically necessary.
2. Benefits paid for such preventative measures are not subject to an annual or coinsurance deductible.
3. Every individual and group health insurance policy, including Medicaid, must cover colorectal cancer screening for policyholders residing in the District of Columbia. The screening must comply with the American Cancer Society colorectal cancer screening guidelines.
4. Each individual and group health benefits plan must cover prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

H. PORTABILITY

1. **Network limitations [Sec. 31-3302.02]** A health insurer that offers health insurance coverage in the individual market may limit the individuals who may be enrolled to those who live, reside, or work within the service area for the network plan.

- 2. Issuance of coverage [Sec. 31-3302.01]** Any health insurer offering individual health insurance in the District cannot refuse to offer coverage to, or deny enrollment of, an eligible individual or impose any pre-existing condition provision on an eligible individual.

 - a. Exception [Sec. 31-3302.02]** The insurer may deny coverage to individuals within the service area if it can demonstrate to the Commissioner that it:

 - does not have the financial reserves necessary to underwrite additional coverage; and
 - is applying this section uniformly to individuals without regard to any health-status-related factor of such individuals and without regard to whether they are eligible.
 - b. Limitation on business [Sec. 31-3302.03]** A health insurer who denies health insurance coverage in the District according to the provisions of the department may not offer coverage in that market for 180 days after the coverage is denied.
- 3. Nonrenewal or discontinuation of coverage [Sec. 31-3302.05]** A health insurer that provides individual health insurance coverage must renew or continue in force the coverage at the option of the individual.
- 4.** A health insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based on one of the following reasons.

 - a.** The individual has failed to pay premiums or contributions according to the terms of the health insurance coverage or the issuer has not received them in a timely manner.
 - b.** The individual has performed a fraudulent act or made an intentional misrepresentation of material fact under the terms of the coverage.
 - c.** The insurer no longer offers coverage in the individual market in accordance with regulations of the Department.
 - d.** In the case of an insurer that offers coverage through a network plan, the individual no longer resides, lives, or works in the service area, but only if the coverage is terminated uniformly without regard to the health status of the covered individuals.
 - e.** In the case of health insurance sold through associations, the membership of the individual in the association ceases.

I. REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE [SEC. 31-3302.05]

- 1.** When discontinuing a particular type of health insurance coverage in the individual market, the insurer must:
 - provide notice to each covered individual at least 90 days before the coverage is discontinued;
 - offer to each individual the option to purchase any other individual health insurance coverage currently being marketed by the health insurer; and
 - act uniformly without regard to any health-related factor of enrolled individuals or individuals who may become eligible for such coverage.

- 2.** When discontinuing all health insurance coverage in the individual market in the District of Columbia, the health insurer:
 - must provide notice to the Commissioner and to each individual of the discontinuation at least 180 days before the expiration date;
 - may not issue any health insurance coverage in the individual market in the District of Columbia for five years thereafter.

- 3. Policy modification [Sec. 31-3302.05]** At the time of renewal, a health insurer may modify the insurance coverage offered to individuals provided the modification is consistent with the laws of the District of Columbia and effective on a uniform basis among all individuals with the same policy.

VII. MEDICARE SUPPLEMENT POLICIES [SECS. 31-3701-31-3710]

- A. PURPOSE [26 DCMR 2200]** The purpose of the Medicare regulations is to:
- standardize coverage and simplify the terms and benefits of Medicare supplement policies;
 - help the public understand and compare policies;
 - eliminate misleading or confusing provisions; and
 - provide for full disclosures in the sale of accident and sickness insurance coverages to people eligible for Medicare by reason of age.
- B. DUPLICATE BENEFITS [SEC. 31-3701]** Medicare supplement policies include group or individual accident and health insurance policies that:
- are designed primarily to supplement reimbursements under Medicare for the hospital, medical, or surgical expenses of people who are eligible for Medicare by reason of age;
 - cannot contain benefits that duplicate benefits provided by Medicare.

C. GENERAL STANDARDS [26 DCMR 2205, 2207] A policy must meet the following minimum benefit standards to be advertised or issued for delivery in the District of Columbia as a Medicare supplement policy.

1. The policy cannot exclude or limit benefits for losses incurred more than six months from the effective date of coverage due to a pre-existing condition (which cannot be defined more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within six months before the effective date of coverage).
2. The policy cannot indemnify against a claim resulting from sickness on a different basis than losses resulting from accidents.
3. The policy must provide that benefits designed to cover cost-sharing amounts under Medicare be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors.
4. Medicare supplement policies must be guaranteed renewable (the insurer cannot cancel or not renew the policy except for nonpayment of premiums or material misrepresentation). Also, the insurer cannot cancel or not renew a policy solely on the grounds of the insured's health status.
5. An insurer cannot terminate a spouse's coverage solely because an event which was specified for termination of the insured's coverage occurred (other than for nonpayment of premium).

D. MINIMUM BENEFIT STANDARDS [26 DCMR 2207] Medicare supplement policies must offer at least the following coverage:

- Part A Medicare-eligible expenses for hospitalization not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;
- Part A Medicare-eligible expenses incurred as daily hospital charges during the use of Medicare's lifetime hospital inpatient reserve days;
- upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, 100% of Part A Medicare-eligible expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days;
- coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells), unless replaced in accordance with federal regulations; and
- coverage for the coinsurance amount, or in the case of hospital outpatient department services under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

E. LIMITATIONS AND EXCLUSIONS [26 DCMR 2205]

1. Generally, Medicare supplement policies cannot contain limitations and exclusions that are more restrictive than those that apply to the Medicare program.
 - a. Medicare supplement policies cannot use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or policy conditions.
 - b. Medicare supplement policies can exclude coverage for any expenses that have benefits available under Medicare.

F. RIGHT TO RETURN (FREE LOOK) [SEC. 31-3707; 26 DCMR 2205]

Policyholders must have 30 days to return policies after delivery and have their premiums refunded if they are not satisfied with the policy for any reason.

G. DISCLOSURE REQUIREMENTS [SEC. 31-3705; 26 DCMR 2218] All

Medicare supplement policies are subject to the following requirements.

1. They must contain a renewal, continuation, or nonrenewal provision that clearly states the duration of any limit on renewability and the term of coverage for which the policy is issued and may be renewed.
2. All riders and endorsements added to Medicare supplement policies after the date of issue that reduce or increase benefits or coverage require a signed acceptance by the insured (not including riders and endorsements in which the insured exercises a specifically reserved policy right or increase required by law).
3. Medicare supplement policies may not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import.
4. Any limitations regarding pre-existing conditions must appear in a separate paragraph of the policy.
5. Insurers must provide all applicants with a buyer’s guide at the time of application (or no later than policy delivery for direct-response insurers).
6. Insurers must provide an outline of coverage to all applicants at the time the application is made.

H. NOTICE OF CHANGE [26 DCMR 2219]

1. Medicare supplement insurers must notify their policyholders and certificateholders of any modifications they make to their policies or certificates within 30 days of the change.

2. The notice must:
 - include a description of the revisions and modifications made to the Medicare program;
 - inform each policyholder or certificateholder as to when any premium adjustment will be made due to changes in Medicare;
 - be in outline form and in clear and simple terms; and
 - not contain or be accompanied by any solicitation.

I. OUTLINE OF COVERAGE [SEC. 31-3705] The insurer will give to the applicant an outline of coverage that must contain:

1. a description of the principal benefits and coverage provided by the policy;
2. a statement of the renewal provisions, disclosing any reservation by the insurer to change premiums or automatic renewal premium increases based on the insured's age; and
3. a statement that the outline of coverage simply is a summary of the policy and that the policy should be consulted for the terms of coverage.

J. REPLACEMENT OF MEDICARE SUPPLEMENT POLICIES [26 DCMR 2222]

1. Applications for Medicare supplement policies must include a question asking applicants whether a Medicare supplement policy is intended to replace any accident or sickness policy or certificate that is currently in force.
2. If the sale involves replacement:
 - the insurer or agent must furnish the applicant with a notice regarding replacement before delivering the policy;
 - for direct-response solicitations, the notice must be given when the policy is issued; and
 - one copy of the notice must be left with the applicant and an additional copy must be signed by the applicant and returned to the insurer.
3. If a Medicare supplement policy replaces another Medicare supplement policy:
 - the replacing insurer must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy, to the extent such time was spent under the original policy; and
 - the replacing policy may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods, for benefits similar to those contained in the original policy, if the policy has been in effect for at least six months.

VIII. LONG-TERM CARE INSURANCE [SECS. 31-3601-3612]

A. LONG-TERM CARE DEFINED [SEC. 31-3601]

1. Long-term care insurance is any insurance policy or rider designed to provide coverage for at least one year for each covered person on an expense incurred, indemnity, prepaid, or other basis. Coverage must include one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.
2. Long-term care insurance also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity as well as qualified long-term care insurance contracts.

B. GENERAL REQUIREMENTS [SEC. 31-3605] Long-term care insurance policies cannot:

1. be cancelled, not renewed, or otherwise terminated on the grounds of the insured's age or deterioration of his or her mental or physical health;
2. contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form of coverage within the same company, unless the insured individual or group policyholder voluntarily selects to increase benefits; or
3. provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

C. PREEXISTING CONDITIONS [SEC. 31-3605]

1. Long-term care insurance policies cannot use a definition of preexisting condition that is more restrictive than the following: "A condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of an insured's coverage."
2. No long-term care insurance policy, other than a group policy, can exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of the insured's coverage.

D. LIMITATIONS AND EXCLUSIONS [SEC. 31-3605] A long-term care insurance policy cannot be delivered or issued for delivery in the District if it:

1. conditions eligibility for any benefits on a prior hospitalization requirement;
2. conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

3. conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

E. RIGHT TO RETURN (FREE LOOK) [SEC. 31-3605] Applicants for long-term care insurance can return the policy within 30 days of its delivery and have the premium refunded if, after examining the policy, they are not satisfied for any reason.

F. OUTLINE OF COVERAGE [SEC. 31-3606] All applicants for long-term care insurance must receive an outline of coverage at the time the policy is initially solicited. The outline of coverage must include a:

- description of the policy's principal benefits and coverage;
- statement of the policy's principal exclusions, reductions, and limitations;
- statement of the terms under which the policy can be continued in force or discontinued (including any reservation in the policy of a right to change premiums);
- statement that the outline of coverage is a summary only, not an insurance contract, and that the policy should be consulted to determine the governing contractual provisions;
- brief description of the relationship between the cost of care and benefits;
- statement that discloses to the policyholder that the policy is intended to be a long-term care insurance contract;
- brief description of the relationship of cost of care and benefits; and
- statement that discloses to the policyholder whether the policy is intended to be a qualified long-term care insurance contract.

IX. ADVERTISEMENT OF ACCIDENT AND HEALTH INSURANCE [26 DCMR 211.3]

All individual, group, blanket, and franchise accident and health insurance advertisements intended for use in the District of Columbia must be truthful and not misleading. Insurers are responsible for establishing and maintaining control over the content, form, and method of dissemination of their policy advertisements.

A. ADVERTISING DEFINED [26 DCMR 299] Advertisements may assume any of the following forms:

- an insurer's printed and published material;
- descriptive literature and sales aids issued by an insurer for presentation to members of the insurance-buying public, such as circulars, leaflets, depictions, illustrations, and form letters; and
- prepared sales talks and presentations made by agents and brokers.

B. PROHIBITED ADVERTISING PRACTICES [26 DCMR 211]

1. The following practices are prohibited regarding advertisements:
 - including words or phrases that require a familiarity with insurance terminology in order to be understood;
 - using words such as *all*, *full*, *comprehensive*, or *unlimited* in a manner that exaggerates any benefits beyond the terms of the policy;
 - phrases such as *this policy pays \$5,000 for hospital room and board expenses* must indicate the maximum daily benefit and time limit for hospital room and board expenses;
 - implying coverage beyond the terms of the policy, when the policy actually covers only specified diseases;
 - stating or implying that an insurer or policy has been approved or an insurer's financial condition has been found to be satisfactory by a governmental agency;
 - stating or implying that an insurer or policy has been approved or endorsed by an individual or group unless it is a fact;
 - including untrue statements about the time within which claims are paid or implying that claim settlements will be liberal or generous beyond the terms of the policy;
 - including false or misleading statements regarding the insurer's assets or financial standing;
 - making unfair or incomplete comparisons of policies or benefits or otherwise falsely disparaging competitors or their policies, services, or business methods;
 - implying licensing beyond the limits of the jurisdiction for which the insurer is licensed;
 - stating or implying that prospective policyholders will become group members and enjoy special rates, unless that is the fact; or
 - stating or implying that enrollment in a plan or under a policy is limited to a specific period without disclosing the time period to enroll.
2. The benefits of a policy that pays different amounts for the same loss occurring under different conditions must disclose the limited conditions under which the benefits are provided by the policy.
 - a. When a choice of benefit amounts is mentioned, an advertisement must disclose that:
 - the amount of benefits provided depends upon the plan selected; and
 - the premium will vary according to the amount of benefits selected.
 - b. The fact that the insurer offers a premium refund for anyone dissatisfied with a policy does not remedy misleading or deceptive statements contained in that advertisement.

C. DISCLOSURE OF EXCEPTIONS AND LIMITATIONS [26 DCMR 211.11, .12]

1. When an advertisement refers to the specific cost of a policy or the time period for which its benefits are payable, it also must disclose the exceptions, reductions, and limitations that affect those provisions.
2. Advertisements must disclose any waiting, elimination, or probationary time period between the date a loss occurs and the date benefits begin to accrue for that loss.

D. PRE-EXISTING CONDITIONS [26 DCMR 211.13]

1. Advertisements must disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing before the effective date of the policy.
2. Advertisements for policies that do not cover losses traceable to a condition existing before the effective date of the policy must not state or imply that the applicant's physical condition or medical history will not affect the issuance of a policy or payment of a claim. This limits the use of phrases such as *no medical examination required*.

E. RENEWABILITY AND CANCELLABILITY [26 DCMR 211.14] An advertisement that refers to renewability, cancellability, or termination of a policy, or which refers to a policy benefit or states the time or age in connection with applicant eligibility or continuation of a policy, must disclose the provisions relating to renewability, cancellability, termination, and any modification of benefits, losses covered, or premiums because of age or other reasons.

F. TESTIMONIALS [26 DCMR 211.16] Testimonials used in advertisements must be genuine, represent the author's current opinion, apply to the policy advertised, and be accurately reproduced.

G. USE OF STATISTICS [26 DCMR 211.17] Advertisements relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy must use relevant facts. Advertisements must not imply that the statistics are derived from the policy advertised unless that is a fact.

H. IDENTITY OF INSURER [26 DCMR 211.21] The identity of the insurer must be made clear in all of its advertisements. Advertisements must not use any trade name, service mark, slogan, or symbol that might misrepresent the true identity of the insurer.

- I. SPECIAL OFFERS [26 DCMR 211.23]** Insurers can offer an enrollment period during which a particular insurance product may be purchased on an individual basis only if there has been a lapse of at least 90 days between the close of the preceding enrollment period for the same product and the opening of the new enrollment period.

- J. ADVERTISING RECORDS [26 DCMR 211.25]** Insurers must maintain files of all advertisements for individual policies and typical published advertisements for blanket, franchise, and group policies, including a note about the extent of distribution of the advertisements. These files must be kept for at least three years.

DISTRICT OF COLUMBIA LAW SUPPLEMENT PRACTICE FINAL

Student instructions: Following your thorough study of this supplement, take this 50-question sample examination. Grade your performance utilizing the answer key provided. Carefully review the topics pertaining to those questions answered incorrectly.

I. General Insurance

1. Which type of insurance company is organized in a country other than the United States?
 - A. Foreign
 - B. Domestic
 - C. Alien
 - D. International
2. Which of the following does an insurance agent represent in an insurance transaction?
 - A. Policyowner
 - B. Insurer
 - C. District of Columbia
 - D. Broker
3. The District of Columbia Life and Health Insurance Guaranty Association may do all of the following EXCEPT
 - A. provide additional funds to the Medicare program
 - B. lend money to an impaired insurer
 - C. reinsure the policies of District of Columbia residents
 - D. assume the business of insolvent insurers
4. Which of the following executes and enforces all laws of the United States relating to insurance companies doing business in the District of Columbia?
 - A. Commissioner of Insurance and Securities
 - B. Insurance brokers
 - C. Federal insurance association
 - D. District of Columbia legislature
5. Which of the following is NOT a duty of the Commissioner of Insurance and Securities?
 - A. Examining the affairs of all insurers authorized to transact insurance business in the District of Columbia
 - B. Issuing certificates of authority to transact insurance business in the District of Columbia
 - C. Writing the District of Columbia's insurance laws
 - D. Submitting a report to the mayor regarding the financial condition of all insurance companies doing business in the District
6. The insurance industry in the United States is primarily regulated by
 - A. Congress
 - B. the president
 - C. the states
 - D. the Supreme Court
7. Who selects the Commissioner of Insurance and Securities?
 - A. Department of Insurance and Securities
 - B. Citizens of the District of Columbia
 - C. Mayor of the District of Columbia
 - D. District of Columbia legislature
8. What is the minimum score on the Flesch reading ease test that is required of all policy forms delivered in the District of Columbia?
 - A. 10
 - B. 20
 - C. 30
 - D. 40

9. Which of the following is NOT a reason for the Commissioner to revoke or suspend the certificate of authority of an insurance company?
- A. The company is insolvent.
 - B. The company refuses to pay a final judgment within 30 days.
 - C. The company refuses to submit its records to inspection by the Commissioner.
 - D. The company did not meet its sales goals for the year.
10. Which of the following insurance companies must have continuously transacted insurance business in its state of domicile for at least 2 years before applying to transact business in the District of Columbia?
- A. Foreign insurance company that transacts life insurance only
 - B. Foreign insurance company owned by a company that has been licensed in the District for at least 3 years
 - C. Alien insurance company that has a surplus of at least \$3 million
 - D. Domestic companies that wish to transact insurance business in the District
11. An insurer's license to do business in the District of Columbia is called a
- A. notice of risk assignment
 - B. certificate of authority
 - C. mutual benefit card
 - D. license to solicit registration
12. A business entity acting as an insurance producer must meet all of the following requirements EXCEPT
- A. obtain an insurance producer license
 - B. pay the required fee
 - C. designate a licensed individual producer to be responsible for the entity's legal and regulatory compliance
 - D. comply with all federal insurance laws
13. How old must an individual be to apply for an agent license?
- A. 15
 - B. 18
 - C. 21
 - D. 30
14. Domestic insurance companies must be examined at least once every
- A. 3 years
 - B. 5 years
 - C. 6 years
 - D. 10 years
15. The Commissioner of Insurance and Securities can suspend an agent's license for all of the following reasons EXCEPT
- A. refusal to deliver money that belongs to an insurer
 - B. misrepresentation of policies to induce people to surrender their insurance in force
 - C. failure to meet the annual sales requirements
 - D. attempting to obtain a license by fraud
16. What is twisting?
- A. Knowingly misstating an applicant's age on a policy application form
 - B. Acting as an agent without holding an agent's license
 - C. Making misrepresentations to induce policyholders to lapse, forfeit, or surrender their policies
 - D. Making false statements about a competitor's financial condition
17. Circulation of a maliciously critical statement about any insurer's financial condition to injure the insurer is called
- A. conservation
 - B. unfair discrimination
 - C. defamation
 - D. coercion
18. Which of the following is NOT an example of an unfair and deceptive trade practice?
- A. Rebating premiums
 - B. Providing a false financial statement from an examining physician
 - C. Issuing advisory board contracts, with the promise of returns, as an inducement to purchase insurance
 - D. Offering lower premiums for younger life insurance policyholders

19. How long must insurers keep files of all advertisements, if not until the filing of the next examination report?
- A. 90 days
 - B. 1 year
 - C. 3 years
 - D. 5 years

II. Life Insurance

20. How many days is the grace period provision that all individual life insurance policies delivered in the District of Columbia must include for payment of premium?
- A. 10
 - B. 30
 - C. 45
 - D. 60
21. All individual life insurance policies delivered in the District of Columbia must contain an incontestable provision, stating that the validity of the policy cannot be contested (except for nonpayment of premiums) after it has been in force for
- A. 10 days
 - B. 90 days
 - C. 2 years
 - D. 5 years
22. A minor must be at least what age to contract for life insurance?
- A. 5
 - B. 10
 - C. 15
 - D. 18
23. An insured under a group life insurance plan can have an individual policy issued when his employment ends, provided that
- A. he provides evidence of insurability
 - B. he applies for a policy and pays the first premium within 31 days of termination
 - C. he pays the first premium within 6 months of termination
 - D. he provides evidence of insurability and pays the premium within 60 days of termination
24. The amount of credit life insurance that may be issued is
- A. limited to no more than \$1,000 in excess of the amount of the loan or credit
 - B. limited to \$15,000, regardless of the loan or credit amount
 - C. dependent upon the amount of the loan or credit
 - D. not related to the amount of the loan or credit
25. In a variable life insurance policy, which of the following parties bears the mortality and expense risks?
- A. The insured
 - B. The beneficiary
 - C. The insurer
 - D. The insured and the insurer share the risk equally
26. What is credit life insurance?
- A. Life insurance purchased on credit, with the money due at a later date
 - B. Life insurance credited to the policyholder's account
 - C. Insurance that covers a debtor's life and will help provide funds to pay off a loan if the debtor dies before the loan is repaid
 - D. Insurance to cover the loss of credit cards
27. An insurer has the obligation to do which of the following when testing an applicant for the AIDS virus?
- A. Get written and signed consent from the applicant before the test
 - B. Inform the applicant's employer that the individual is undergoing an AIDS test
 - C. Get written permission to inform the applicant's family about the results of the test
 - D. Inform the Department of Insurance about the results of the applicant's test

28. When is it permissible to inquire about the sexual orientation of an applicant for life insurance?
- A. When the information is needed to determine the premium rates
 - B. It never is permissible
 - C. Only if the applicant is requesting an accelerated benefits rider to the policy
 - D. Only if the insurer must decide whether to test the applicant for AIDS
29. According to the loan provision of a life insurance policy, how much can an insured borrow on the policy?
- A. An amount equal to the premiums paid for the policy
 - B. Whatever amount the insured wishes to borrow
 - C. A maximum of twice the face value of the policy
 - D. An amount equal to or less than the policy's nonforfeiture value
30. What kind of policy must prominently display a notice stating that payments by the company (when based on an investment return) are not guaranteed or do not have a guaranteed fixed dollar amount?
- A. Variable annuity contract
 - B. Term life insurance
 - C. Credit life insurance
 - D. Temporary insurance
31. Group life insurance policies must contain all of the following provisions EXCEPT
- A. a 31-day grace period
 - B. misstatement of age provision
 - C. certificate provision
 - D. incontestability provision
32. An individual life insurance policy must include all of the following EXCEPT
- A. an incontestability provision
 - B. a misstatement of age provision
 - C. a 10-day grace period
 - D. an entire contract provision
33. All of the following statements regarding the reinstatement of a life insurance policy are correct EXCEPT
- A. a policy may be reinstated within 3 years of default
 - B. all back premiums must be paid before a policy may be reinstated
 - C. once a policy has been surrendered for its cash value, it may not be reinstated
 - D. a policy may be reinstated without proof of insurability
34. All of the following are conditions that must be met in order for an insured to borrow money on a life insurance policy EXCEPT
- A. premiums have been paid for 3 years
 - B. the policy has a cash surrender value
 - C. the pre-existing condition restriction has not yet been satisfied
 - D. a fixed or variable interest rate is assessed on the amount borrowed
35. A variable life insurance policy must contain all of the following EXCEPT
- A. a statement that the insurer bears the investment risk
 - B. a statement that cash values may fluctuate depending on the experience of the separate account
 - C. a description of the benefit base and method of calculating the variable benefits under the policy
 - D. the conditions for assigning the policy
36. What happens if, when paying benefits, the insurer discovers that a person's age had been misstated on the individual life insurance application?
- A. No benefits are paid.
 - B. Benefits are paid for the amount of coverage the premium would have purchased at the correct age.
 - C. Benefits are paid as if the incorrect age stated were actually the correct age.
 - D. The policyholder's estate must pay a fine before benefits are paid.

III. Accident and Health Insurance

37. When does coverage begin for children of family health insurance policyholders?
- A. At birth
 - B. 24 hours after birth
 - C. When the family notifies the insurer of the birth
 - D. 1 year after birth
38. Medicare supplement policies can limit or exclude coverage for all of the following EXCEPT
- A. chiropractic care
 - B. family history of heart condition
 - C. foot care in connection with corns
 - D. intentionally self-inflicted injury
39. All accident and health insurance policies must contain a proof of loss provision stating that the insured must send the insurer a completed claim form no later than how long after the date of the loss?
- A. 10 days
 - B. 2 weeks
 - C. 90 days
 - D. 2 years
40. How soon must all individual accident and health insurance policy forms be filed with the Commissioner before they are delivered to a policyholder?
- A. 10 days
 - B. 20 days
 - C. 30 days
 - D. 90 days
41. Which of the following statements about the cancellation of health policies is CORRECT?
- A. The insurer can cancel the policy at any time.
 - B. If a policy has an optional cancellation provision, the insurer can cancel it any time after giving the insured at least 5 days' written notice.
 - C. The insurer may keep any unearned premiums after the notice of cancellation is sent.
 - D. All premiums are to be returned to the policyholder after the insured cancels the policy.
42. An insurer must cover the treatment of alcohol or drug withdrawal and detoxification for at least
- A. 10 days per month
 - B. 12 days per year
 - C. 30 days per year
 - D. 45 days per 24-month period
43. Which of the following statements about coverage for health services for women is CORRECT?
- A. Baseline mammograms are covered under group policies only.
 - B. Pap tests are covered under individual policies only.
 - C. Medicare does not pay for mammograms or pap tests.
 - D. Benefits for mammograms or pap tests are not subject to annual or coinsurance deductibles.
44. A Medicare supplement that excludes the treatment of cancer is
- A. illegal and cannot be issued in the District of Columbia
 - B. less expensive than one that covers cosmetic surgery
 - C. the basis for the core Medicare supplement plan
 - D. more expensive than one that excludes the treatment of foot ailments

45. When must an applicant for a Medicare supplement policy receive the buyer's guide and outline of coverage?
- A. After the individual pays the first premium
 - B. Before the applicant meets with the agent
 - C. At the time the application is made
 - D. After the applicant has been approved for insurance
46. All of the following are mandatory provisions in a health insurance policy EXCEPT
- A. grace period
 - B. proof of loss
 - C. physical examination and autopsy
 - D. unpaid premiums
47. Which of the following statements about Medicare supplement insurance policies is CORRECT?
- A. It can only be sold by agents with a senior citizen specialist license.
 - B. It generally duplicates coverage provided by Medicare.
 - C. It is designed to supplement reimbursements under Medicare for hospital, medical, or surgical expenses.
 - D. It is mainly for people who are receiving welfare assistance from the government.
48. Which of the following statements about health insurance advertising is NOT correct?
- A. Testimonials cannot be used in advertisements.
 - B. The insurer's identity must be disclosed in all advertisements.
 - C. Advertising records must be kept for 3 years.
 - D. Any waiting elimination period between the effective date of the policy and the effective date of coverage must be disclosed.
49. All of the following statements about Medicare supplement policies are correct EXCEPT
- A. policies must have a 30-day free-look period
 - B. they can contain exclusions that are more restrictive than Medicare's exclusions
 - C. the issuers cannot cancel a policy because of the individual's health status
 - D. they cannot limit benefits for losses incurred more than 6 months from the effective date of coverage because the loss involved a pre-existing condition
50. All of the following are optional provisions in an individual health insurance policy EXCEPT
- A. misstatement of age
 - B. change of occupation
 - C. illegal occupation
 - D. change of beneficiary

ANSWERS TO DISTRICT OF COLUMBIA LAW PRACTICE FINAL

- | | | | | |
|--------------|--------------|--------------|--------------|--------------|
| 1. C | 11. B | 21. C | 31. C | 41. B |
| 2. B | 12. D | 22. C | 32. C | 42. B |
| 3. A | 13. B | 23. B | 33. D | 43. D |
| 4. A | 14. B | 24. C | 34. C | 44. A |
| 5. C | 15. C | 25. C | 35. A | 45. C |
| 6. C | 16. C | 26. C | 36. B | 46. D |
| 7. C | 17. C | 27. A | 37. A | 47. C |
| 8. D | 18. D | 28. B | 38. B | 48. A |
| 9. D | 19. C | 29. D | 39. C | 49. B |
| 10. A | 20. B | 30. A | 40. C | 50. D |