

the petition is for amendment, the new matter shall be underscored and the matter proposed to be deleted shall appear in double parentheses. Where the petition is for repeal of an existing rule, such shall be stated and the rule proposed to be repealed shall either be set forth in full or shall be referred to by rule number. The third paragraph shall set forth concisely the reasons for the proposal of the petitioner and shall contain a statement as to the interest of the petitioner in the subject matter of the rule. Additional numbered paragraphs may be used to give full explanation of petitioner's reason for the action sought.

Petitions shall be dated and signed by the person or entity named in the first paragraph or by his or her attorney. The original and two legible copies of the petition shall be filed with the board. Petitions shall be on white paper, 8 1/2" x 11" in size.

(3) Consideration of petitions. All petitions shall be considered by the entire board, and the board may, in its discretion, order an informal hearing or meeting for the further consideration and discussion of the requested promulgation, amendment or repeal of any rule.

(4) Notification of disposition of petition. The board shall notify the petitioning person within a reasonable time of the disposition, if any, of the petition.

[Statutory Authority: RCW 51.52.020, 95-02-065, § 263-12-190, filed 1/3/95, effective 2/3/95. Statutory Authority: RCW 51.52.104, 51.52.020 and chapters 51.48 and 42.17 RCW. 86-03-021 (Order 20), § 263-12-190, filed 1/10/86; Order 4, § 263-12-190, filed 6/9/72; General Order 2, Rules 13.1-13.4, filed 3/23/60; Subsections (3)-(4), General Order 3, Rule 13.3, filed 10/29/65. Formerly WAC 296-12-190.]

Title 284 WAC

INSURANCE COMMISSIONER

Chapters

- 284-13** **Assets—Liabilities—Investments and reinsurance.**
- 284-14** **Regulations pertaining to fees and taxes.**
- 284-20** **Insurance policies.**
- 284-22** **USL&H Assigned risk plan.**
- 284-30** **Trade practices.**
- 284-32** **Plan of operation for Washington insurance guaranty association.**
- 284-44** **Health care services contractors—Agents—Contract formats—Standards.**
- 284-48** **Bulletins.**
- 284-54** **Long-term care insurance rules.**
- 284-87** **Joint underwriting association for midwifery and birthing centers malpractice insurance.**
- 284-97** **Viatical settlement regulation.**

Chapter 284-13 WAC

ASSETS—LIABILITIES—INVESTMENTS AND REINSURANCE

WAC

- 284-13-110 Repealed.
- 284-13-120 Repealed.
- 284-13-130 Repealed.
- 284-13-140 Repealed.
- 284-13-150 Repealed.
- 284-13-310 Repealed.
- 284-13-320 Repealed.
- 284-13-330 Repealed.
- 284-13-340 Repealed.
- 284-13-350 Repealed.
- 284-13-360 Repealed.
- 284-13-370 Repealed.
- 284-13-380 Repealed.
- 284-13-390 Repealed.
- 284-13-400 Repealed.
- 284-13-410 Repealed.
- 284-13-420 Repealed.
- 284-13-850 Scope.
- 284-13-855 Accounting requirements.
- 284-13-860 Written agreements.
- 284-13-863 Existing agreements.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-13-110 Purpose. [Statutory Authority: RCW 48.02.060, 87-09-056 (Order R 87-4), § 284-13-110, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
- 284-13-120 Scope. [Statutory Authority: RCW 48.02.060, 87-09-056 (Order R 87-4), § 284-13-120, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
- 284-13-130 Accounting requirements. [Statutory Authority: RCW 48.02.060, 87-09-056 (Order R 87-4), § 284-13-130, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
- 284-13-140 Written agreements. [Statutory Authority: RCW 48.02.060, 87-09-056 (Order R 87-4), § 284-13-140, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
- 284-13-150 Existing agreements. [Statutory Authority: RCW 48.02.060, 87-09-056 (Order R 87-4), § 284-13-150, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
- 284-13-310 Definitions. [Statutory Authority: RCW 48.02.060 and 48.05.340(4), 93-19-012 (Order R 93-16), § 284-13-310, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-320 RBC reports. [Statutory Authority: RCW 48.02.060 and 48.05.340(4), 93-19-012 (Order R 93-16), § 284-13-320, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-330 Company action level event. [Statutory Authority: RCW 48.02.060 and 48.05.340(4), 93-19-012 (Order R 93-16), § 284-13-330, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-340 Regulatory action level event. [Statutory Authority: RCW 48.02.060 and 48.05.340(4), 93-19-012 (Order R 93-16), § 284-13-340, filed 9/1/93, effective 10/2/93.]

- 284-13-350 Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060. Authorized control level event. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-350, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-360 Mandatory control level event. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-360, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-370 Hearings. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-370, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-380 Confidentiality and prohibition on announcements. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-380, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-390 Supplemental provisions. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-390, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-400 Foreign and alien insurers. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-400, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-410 Notices. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-410, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-420 Phase-in provision. [Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-420, filed 9/1/93, effective 10/2/93.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

WAC 284-13-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-120 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-130 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-140 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-150 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-310 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-320 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-330 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-340 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-350 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-360 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-370 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-380 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-390 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-400 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-410 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-420 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-13-850 Scope. (1) The insurance commissioner recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus. It is improper, however, for an authorized insurer, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival.

(2) This regulation (WAC 284-13-850 through 284-13-863) applies to all domestic life and disability insurers and to all other licensed life and disability insurers which are not subject to a similar regulation in their domiciliary state. This regulation also applies to the disability insurance policies issued by authorized property and casualty insurers. This regulation does not apply to assumption reinsurance, yearly renewable term reinsurance or nonproportional reinsurance (such as stop loss or catastrophe reinsurance).

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-850, filed 9/8/95, effective 10/9/95.]

WAC 284-13-855 Accounting requirements. (1) No insurer subject to this regulation shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the commissioner if, by the terms of the

reinsurance agreement, in substance or effect, one or more of the following conditions exist:

(a) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Such expenses include commissions, premium taxes and direct expenses including, but not limited to billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured.

(b) The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets.

(c) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty.

(d) The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded.

(e) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company.

(f) The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies, for a representative sampling of the products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk categories:

(i) Morbidity.

(ii) Mortality.

(iii) Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

(iv) Credit Quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

(v) Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or moneys received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

(vi) Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

+ - Significant 0 - Insignificant

RISK CATEGORY

	i	ii	iii	iv	v	vi
Disability - other than LTC/LTD*	+	0	+	0	0	0
Disability - LTC/LTD*	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-Par Permanent	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	0	+	+	+	+	+

*LTC = Long Term Care Insurance

LTD = Long Term Disability Insurance

(g)(i) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in subsection (1)(g)(ii) of this section) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner which legally segregates, by contract or contract provision, the underlying assets.

(ii) Notwithstanding (g)(i) of this subsection, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of such assets:

- Disability Insurance - LTC/LTD
- Traditional Non-Par Permanent
- Traditional Par Permanent
- Adjustable Premium Permanent
- Indeterminate Premium Permanent
- Universal Life Fixed Premium
- (no dump-in premiums allowed)

The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2(I + CG)}{X + Y - I - CG}$$

Where: I is net investment income (Exhibit 2, Line 16, Column 7)

CG is capital gains less capital losses (Exhibit 4, Line 10, Column 6)

X is the current year cash and invested assets (Page 2, Line 10A, Column 1) plus investment income due and accrued (Page 2, Line 16, Column 1) less borrowed money (Page 3, Line 22, Column 1)

Y is the same as X but for the prior year

(iii) Line references are for the commissioner's 1992 annual statement form.

(h) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety days of the settlement date.

(i) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

(j) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

(k) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(2) Notwithstanding subsection (1) of this section, an insurer subject to this regulation may, with the prior approval of the commissioner, take such reserve credit or establish such asset, including actuarial interpretations or standards adopted by the commissioner.

(3)(a) Every agreement entered into after the effective date of this regulation which involves the reinsurance of business issued prior to the effective date of the agreement, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within thirty days after its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this regulation and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the commissioner. The actuary shall maintain adequate documentation and be prepared to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this regulation.

(b) Any increase in surplus net of federal income tax resulting from arrangements described in (a) of this subsection shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for

gains and losses in surplus in the capital and surplus account, page 4 of the annual statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "reinsurance ceded" line, page 4 of the annual statement as earnings emerge from the business reinsured.

For example: On the last day of calendar year N, company XYZ pays a \$20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is \$13.2 million (\$20 million - \$6.8 million) which is reported on the "aggregate write-ins for gains and losses in surplus" line in the capital and surplus account. \$6.8 million (34% of \$20 million) is reported as income on the "commissions and expense allowances on reinsurance ceded" line of the summary of operations. At the end of year N+1 the business has earned \$4 million. ABC has paid \$.5 million in profit and risk charges in arrears for the year and has received a \$1 million experience refund. Company ABC's annual statement would report \$1.65 million (66% of (\$4 million - \$1 million - \$.5 million) up to a maximum of \$13.2 million) on the "commissions and expense allowances on reinsurance ceded" line of the summary of operations, and - \$1.65 million on the "aggregate write-ins for gains and losses in surplus" line of the capital and surplus account. The experience refund would be reported separately as a miscellaneous income item in the summary of operations.

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-855, filed 9/8/95, effective 10/9/95.]

WAC 284-13-860 Written agreements. (1) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the commissioner, unless the agreement, amendment, or a binding letter of intent has been executed by both parties no later than the "as of date" of the financial statement.

(2) In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

(3) The reinsurance agreement shall contain provisions which provide that:

(a) The agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

(b) Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by the parties.

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-860, filed 9/8/95, effective 10/9/95.]

WAC 284-13-863 Existing agreements. Insurers subject to this regulation shall reduce to zero by December 31, 1996, any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this regulation which under the provisions of this regulation would not be entitled to recognition of the

reserve credits or assets; provided however that: The reinsurance agreements are in compliance with laws or regulations in existence immediately preceding the effective date of this regulation.

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-863, filed 9/8/95, effective 10/9/95.]

Chapter 284-14 WAC REGULATIONS PERTAINING TO FEES AND TAXES

WAC

284-14-010 through 284-14-020 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-14-010 Filing fee for rates and forms. [Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-010, filed 10/6/82.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

284-14-020 Filing transmittal information. [Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-020, filed 10/6/82.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

WAC 284-14-010 through 284-14-020 Repealed.
See Disposition Table at beginning of this chapter.

Chapter 284-20 WAC INSURANCE POLICIES

WAC

284-20-200 Retention of policy forms.

WAC 284-20-200 Retention of policy forms. Beginning July 1, 1996, every insurer shall adopt a record retention procedure and shall maintain records sufficient to reconstruct a copy of every general liability insurance policy issued for delivery in this state to a Washington resident on or after July 1, 1996.

(1) Records may be kept in any reasonable and customary format, including any photographic or electronic format.

(2) Records shall be kept for at least twenty years following the expiration date of the policy.

(3) The insurer shall maintain the capacity to retrieve records sufficient to reconstruct any policy by name of the named insured(s) as shown on the policy declarations page and by policy number.

(4)(a) The insurer shall keep either a copy of each form of general liability insurance policy issued to a resident of this state so that it can be matched to an insured's record upon request, or a copy of the insured's policy as issued. For manuscript policies, the insurer shall retain a copy of the insured's policy as issued.

(b) For each insured, the insurer shall maintain at least the following information as the insured's record:

(i) The name of all named insureds as shown on the policy declarations page;

(ii) The address of the named insured as shown on the policy declarations page;

(iii) The name of any additional named insured(s);

(iv) The policy number;

(v) The form number(s) or a copy of the insured's policy as issued;

(vi) The limits of liability;

(vii) The annual premium;

(viii) The form number(s) or a copy of any endorsement(s); and

(ix) The policy period.

(5) Records of general liability insurance policies issued to Washington residents and that are in the possession of the insurer on the effective date of this section shall not be destroyed for twenty years after the effective date of this section: *Provided however*, That such records need not be catalogued or indexed to meet the standards of this section.

(6) Records of general liability insurance policies issued by unauthorized insurers shall be kept in this state; however, such records may be maintained on behalf of an unauthorized insurer by the surplus line broker of record on the policy, or the broker's successor.

(7) For purposes of this section, "general liability insurance policy" means a contract of insurance that provides coverage for the legal obligations of an insured for bodily injury or property damage to others. It includes, for example, pollution liability insurance policies and comprehensive general liability insurance policies; it does not include insurance policies relating to motor vehicles, personal coverage such as homeowners, or specialty line liability coverage such as directors and officers insurance, errors and omissions insurance, or other similar policies.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-20-200, filed 4/10/95, effective 5/11/95.]

Chapter 284-22 WAC USL&H ASSIGNED RISK PLAN

WAC

284-22-030 Effective date.

WAC 284-22-030 Effective date. (1) The assigned risk plan shall become effective at 12:01 a.m. July 1, 1992.

(2) The assigned risk plan shall not terminate until all policies under the plan have expired and outstanding obligations incurred under such policies have been satisfied.

[Statutory Authority: RCW 48.02.060. 95-18-106, § 284-22-030, filed 9/6/95, effective 10/7/95; 93-20-019 (Order R 93-17), § 284-22-030, filed 9/24/93, effective 10/25/93. Statutory Authority: RCW 48.02.060 and 1992 c 209. 92-19-095 (Order R 92-12), § 284-22-030, filed 9/16/92, effective 10/17/92.]

Chapter 284-30 WAC TRADE PRACTICES

WAC

284-30-900 Purpose.
284-30-905 Scope.
284-30-910 Definitions.

284-30-920	Procedures for resolving lost policy disputes regarding environmental claims.
284-30-930	Specific unfair environmental claims settlement or trade practices defined.
284-30-940	Environmental claim mediation program.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-905, filed 4/10/95, effective 5/11/95.]

WAC 284-30-900 Purpose. (1) There are many insurance coverage disputes involving Washington insureds who face potential liability for their roles at polluted sites in this state. State and federal mandates exist for cleaning up the environment in order to address the adverse effects of hazardous substances on human health and safety and the environment in general. It is in the public interest to reduce the costs incurred in connection with environmental claims and to expedite the resolution of such claims. The state of Washington has a substantial public interest in the timely, efficient, and appropriate resolution of environmental claims involving the liability of insureds at polluted sites in this state. This interest is based on practices favoring good faith and fair dealing in insurance matters and on the state's broader health and safety interest in a clean environment.

(2) Insureds and insurers alike face claims complicated by factual issues concerning events that occurred in the distant past. Many sites with environmental damage involve long-term operations with multiple owners; therefore, issues related to lost policies which may provide insurance coverage in the environmental claims context provide uniquely challenging problems of both lost evidence and witnesses.

(3) Cooperation between insureds and insurers in fairly and expeditiously resolving legitimate disputes and in reducing or eliminating nonmeritorious claims is in the public interest. Facilitating cooperation in resolving legitimate lost policy disputes in environmental claims will reduce unnecessary litigation, thereby freeing more resources for environmental cleanup. Insureds and insurers are encouraged to participate in a mediation program in order to achieve a mutually acceptable, expeditious resolution of environmental claims without resort to costly and lengthy litigation.

(4) This regulation is adopted to provide minimum standards for the conduct of insureds and insurers for presenting and resolving environmental claims with the goal of facilitating the fair, principled, and efficient resolution of environmental claims without resort to unnecessary, time-consuming, and expensive litigation.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-900, filed 4/10/95, effective 5/11/95.]

WAC 284-30-905 Scope. (1) This regulation applies to actions taken by an insurer on or after July 1, 1995, with regard to environmental claims arising under a general liability insurance policy issued to a Washington resident and concerning sites located within this state. This regulation does not apply to environmental claims for which coverage is resolved by judgment, settlement, or payment before July 1, 1995.

(2) This regulation is not exclusive, and acts or omissions, whether or not specified in WAC 284-30-900 through 284-30-940, may also be violations of other sections of the insurance code or other regulations promulgated thereunder.

WAC 284-30-910 Definitions. As used in this regulation:

(1) "Environmental claim" means a claim for defense or indemnity submitted under a general liability insurance policy by an insured facing, or allegedly facing, potential liability for bodily injury or property damage to others arising from a discharge of pollutants into land, air, or water.

(2) "General liability insurance policy" means a contract of insurance that provides coverage for the legal obligations of an insured for bodily injury or property damage to others. It includes, for example, pollution insurance policies and comprehensive general liability insurance policies; it does not include insurance policies relating to motor vehicles, personal coverage such as homeowners, or specialty line liability coverage such as directors and officers insurance, errors and omissions insurance, or other similar policies.

(3) "Insured" means a Washington resident who is either the named insured or is acting on behalf of a Washington resident who is a named insured, and is presenting an environmental claim.

(4) "Lost policy" includes general liability insurance policies that are alleged by an insured to be lost.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-910, filed 4/10/95, effective 5/11/95.]

WAC 284-30-920 Procedures for resolving lost policy disputes regarding environmental claims. The commissioner has found and hereby defines it to be an unfair act or practice or an unfair method of competition for an insurer to fail to investigate thoroughly and promptly all claims of lost policies. It is also an unfair practice or an unfair method of competition for an insurer to fail to provide all facts known or discovered during an investigation concerning the issuance and terms of a policy, including copies of documents establishing such facts, to an insured claiming coverage under a lost policy. A single violation of this section may be deemed by the commissioner to be an unfair act or practice or an unfair method of competition. The following procedures are minimum standards for the facilitation of reconstructing a lost policy and determining its terms. These procedures do not create a presumption of coverage for the loss once the contract is reconstructed.

(1) Within fifteen working days after receipt by the insurer of notice of a lost policy, an insurer shall commence an investigation into its records, including its computer records, to determine whether it issued the lost policy. If the insurer determines that it issued the policy in question, it shall promptly commence an investigation into the terms and conditions relevant to the environmental claim.

(a) For purposes of this section, "notice of a lost policy" means written notice of the lost policy in sufficient detail to identify the person or entity seeking coverage, including information concerning the name of the alleged policyholder, if known, together with material facts known to the insured concerning the lost policy.

(b) Insureds and insurers shall fully cooperate with each other in the investigation of lost policy issues.

(i) Each shall provide to the other facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to the issuance or existence of a lost policy.

(ii) Each shall provide the other with copies of documents establishing facts related to the lost policy.

(iii) Neither an insured nor an insurer shall be required to produce material subject to the attorney-client privilege or the work product doctrine, or confidential claims documents provided to the insurer by another policyholder.

(2) If the insurer discovers information tending to show the issuance of a policy applicable to the claim, the following procedures shall apply:

(a) If the insurer is able to determine the terms of the policy, upon request the insurer shall provide to an insured an accurate copy or reconstruction of the policy or the portions of the policy located.

(b) If after diligent investigation the insurer is not able to locate all or part of the policy or to determine the terms, conditions, or exclusions of the policy, the insurer shall provide copies of all insurance policy forms potentially applicable to the environmental claim issued by the insurer during the applicable policy period. The insurer shall state which of the potentially applicable forms, if any, is most likely to have been issued and why, or alternatively, shall state why it is unable to identify the forms after a good faith search. Providing copies of forms and meeting the standards of this section, is neither an admission by an insurer that a policy was issued or effective, nor, if a policy were issued, that it was necessarily in the form produced, unless the insurer so states.

(c) If it is concluded that a general liability insurance policy more likely than not was issued to the insured by the insurer, and neither the insured nor the insurer can produce any evidence which may tend to show the policy limits applicable to the policy, it shall be assumed, in the absence of other evidence, that the minimum limits of coverage offered by the insurer during the period in question were purchased by the insured.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-920, filed 4/10/95, effective 5/11/95.]

WAC 284-30-930 Specific unfair environmental claims settlement or trade practices defined. The commissioner has found and hereby defines the following acts or practices related to the settlement of environmental claims to be unfair methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance. A single violation of this section may be deemed by the commissioner to be an unfair claims settlement practice, an unfair trade practice, or an unfair method of competition.

(1) Failure to pay interest at the statutory rate as set by the state treasurer from time to time, pursuant to RCW 19.52.025:

(a) On payments that an insured has made and which the insurer is legally obligated to pay as damages: *Provided however*, That interest shall begin to accrue only when a claim is presented or payment is made by the insured, whichever is the later; or

(b) On overdue payments that an insurer agreed to make pursuant to an agreed settlement with an insured: *Provided however*, That interest shall begin to accrue on the thirty-first day after the date of the settlement or the agreed time, if later.

(2) Failure of an insurer to commence investigation of an environmental claim within fifteen working days after receipt of a notice of an environmental claim.

(a) Insureds and insurers shall fully cooperate with each other in the investigation of environmental claims.

(i) Each shall provide to the other facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to an environmental claim.

(ii) Each shall provide the other with copies of documents establishing facts related to an environmental claim.

(iii) Neither an insured nor an insurer shall be required to produce material subject to the attorney-client privilege or the work product doctrine, or confidential claims documents provided to the insurer by another policyholder.

(b) An excess insurer may rely on the investigation of a primary insurer.

(3) Failure to make payments, under its duty to defend, for costs reasonably incurred in an investigation to determine the source of contamination, the type of contamination, and the extent of the contamination.

(4) Denying a claim on the basis that the insured expected or intended the damage unless, to the best of the insurer's knowledge, information, and belief, formed after reasonable inquiry, the insurer's position is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

(5) Denying that there is damage to a site that is listed on the National Priorities List under the Comprehensive Environmental Response Compensation and Liabilities Act of 1980, 42 U.S.C. Sections 6901-6992k, or the hazardous sites list under the Model Toxics Control Act of Washington, chapter 70.105D RCW, if the federal Environmental Protection Agency or the state department of ecology has determined that there is actual damage on the site unless an insurer has evidence that no actual damage occurred. It should not be presumed that only sites on the National Priorities List or the hazardous sites list have environmental damage requiring action.

(6) Requiring the insured to provide answers to repetitive questions and requests for information concerning matters or issues unrelated to the insured's environmental claim. This does not prevent an insurer from clearly reserving its rights as to information that is not available at the time of the correspondence.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-930, filed 4/10/95, effective 5/11/95.]

WAC 284-30-940 Environmental claim mediation program. The commissioner has found and hereby defines it to be an unfair act or practice or an unfair method of competition for an insurer to fail to participate in good faith

in nonbinding mediation requested by an insured concerning the existence, terms, or conditions of a lost policy, or regarding coverage for an environmental claim.

(1) The insured may request in writing that the insurer participate in nonbinding mediation.

(2) Upon request from an insured for nonbinding mediation, an insurer shall provide an insured with information concerning an environmental claim mediation program. The information shall include, but need not be limited to, a description of how an insured can efficiently commence a mediation program.

(3) The purposes of mediation shall include, but need not be limited to, the following:

(a) To assist the parties in resolving disputes concerning whether or not a general liability insurance policy applicable to the environmental claim was issued to the insured by the insurer or concerning the relevant terms, conditions, and exclusions of the policy;

(b) To determine whether the entire claim, or a portion thereof, can be settled by agreement of the parties;

(c) If the claim cannot be settled, to determine whether one or more issues can be resolved to the satisfaction of the parties; or

(d) To discuss any other methods of streamlining or reducing the cost of litigation.

(4) Mediation shall be conducted pursuant to mediation rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

(5) Unless otherwise agreed, information provided and statements made by either party in a mediation shall be kept confidential by the parties and used only for purposes of the mediation in accordance with RCW 5.60.070.

(6) Insureds and insurers shall have representatives present, or available by telephone, with authority to settle the matter at all mediation sessions.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-940, filed 4/10/95, effective 5/11/95.]

Chapter 284-32 WAC

PLAN OF OPERATION FOR WASHINGTON INSURANCE GUARANTY ASSOCIATION

WAC

284-32-010 through 284-32-200 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-32-010	Purpose. [Emergency and Permanent Order R-71-3, § 284-32-010, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-020	Board of directors. [Emergency and Permanent Order R-71-3, § 284-32-020, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-030	Officers of board. [Emergency and Permanent Order R-71-3, § 284-32-030, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

284-32-040	Quorum, votes required, proxies. [Emergency and Permanent Order R-71-3, § 284-32-040, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-050	Annual meetings. [Emergency and Permanent Order R-71-3, § 284-32-050, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-060	Board's annual meeting. [Emergency and Permanent Order R-71-3, § 284-32-060, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-070	Meeting after notice of insolvency. [Emergency and Permanent Order R-71-3, § 284-32-070, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-080	Other meetings. [Emergency and Permanent Order R-71-3, § 284-32-080, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-090	Expenses of board members. [Emergency and Permanent Order R-71-3, § 284-32-090, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-100	Official address of association. [Emergency and Permanent Order R-71-3, § 284-32-100, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-110	Bank accounts, borrowing power. [Emergency and Permanent Order R-71-3, § 284-32-110, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-120	Board may levy fee. [Emergency and Permanent Order R-71-3, § 284-32-120, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-130	Contract with servicing facility. [Emergency and Permanent Order R-71-3, § 284-32-130, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-140	Claim settlements of one hundred fifty thousand dollars or more. [Statutory Authority: RCW 48.02.060 and 48.32.070. 93-19-001 (Order R 93-5), § 284-32-140, filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.32.070. 88-05-001 (Order R 88-2), § 284-32-140, filed 2/4/88; Emergency and Permanent Order R-71-3, § 284-32-140, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-150	Prevention of insolvencies. [Emergency and Permanent Order R-71-3, § 284-32-150, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-160	Records, reports, audit. [Emergency and Permanent Order R-71-3, § 284-32-160, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-170	Appeal. [Emergency and Permanent Order R-71-3, § 284-32-170, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-180	Indemnification. [Emergency and Permanent Order R-71-3, § 284-32-180, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-190	Conformity to statute. [Emergency and Permanent Order R-71-3, § 284-32-190, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-32-200	Effective date. [Emergency and Permanent Order R-71-3, § 284-32-200, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

WAC 284-32-010 through 284-32-200 Repealed.
See Disposition Table at beginning of this chapter.

Chapter 284-44 WAC

HEALTH CARE SERVICES CONTRACTORS— AGENTS—CONTRACT FORMATS—STANDARDS

WAC

284-44-170 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-44-170 Minimum required anticipated loss ratio. [Statutory Authority: RCW 48.44.050, 81-15-070 (Order R 81-3), § 284-44-170, filed 7/21/81, effective 10/1/81.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

WAC 284-32-170 Repealed. See Disposition Table at beginning of this chapter.

Chapter 284-48 WAC

BULLETINS

WAC

284-48-020 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-48-020 Authority of agents v. brokers: (1) Brokers of record, (2) marketing substandard auto, (3) rejected life and disability. [Filed May 18, 1966.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

WAC 284-48-020 Repealed. See Disposition Table at beginning of this chapter.

Chapter 284-54 WAC

LONG-TERM CARE INSURANCE RULES

WAC

284-54-020 Definitions of terms used in this chapter and chapter 48.84 RCW.
284-54-030 Standards for definitions applicable to long-term care contracts.
284-54-040 Minimum standards for benefit triggers—Physician certification, activities of daily living, and cognitive impairments.
284-54-180 Reduction of coverage.
284-54-190 Nonduplication with state or national health care benefits.
284-54-253 Unintentional lapse.
284-54-270 Requirement to offer inflation protection.
284-54-300 Information to be furnished, style.
284-54-350 Form to be used—Long-term care insurance disclosure form.

WAC 284-54-020 Definitions of terms used in this chapter and chapter 48.84 RCW. For purposes of the administration of chapter 48.84 RCW and this chapter:

(1) "Community based care" means services including, but not limited to: (a) Home delivered nursing services or therapy; (b) custodial or personal care; (c) day care; (d) home and chore aid services; (e) nutritional services, both in-home and in a communal dining setting; (f) respite care; (g) adult day health care services; or (h) other similar services furnished in a home-like or residential setting that does not provide overnight care. Such services shall be provided at all levels of care, from skilled care to custodial or personal care.

(2) "Contract" means a long-term care insurance policy or contract, regardless of the kind of insurer issuing it, unless the context clearly indicates otherwise.

(3) "Direct response insurer" means an insurer who, as to a particular contract, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

(4) A "gatekeeper provision" is any provision in a contract establishing a threshold requirement which must be satisfied before a covered person is eligible to receive benefits promised by the contract. Examples of such provisions include, but are not limited to the following: A three-day prior hospitalization requirement, recommendations of the attending physician, and recommendations of a case manager.

(5) "Institutional care" means care provided in a hospital, skilled or intermediate nursing home, or other facility certified or licensed by the state primarily affording diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services. Such a facility provides twenty-four-hour nursing services on its premises or in facilities available to the institution on a formal prearranged basis.

(6) "Insured" shall mean any beneficiary or owner of a long-term care contract regardless of the type of insurer.

(7) "Insurer" includes insurance companies, fraternal benefit societies, health care service contractors and health maintenance organizations unless the context clearly indicates otherwise.

(8) "Premium" shall mean all sums charged, received or deposited as consideration for a contract and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges as paid.

(9) "Terminally ill care" means care for an illness, disease, or injury which has reached a point where recovery can no longer be expected and the attending physician has certified that the patient is facing imminent death; or has a life expectancy of six months or less.

(10) "Adult day health care" means a program of community based social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the individual's home.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-020, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060, 48.84.030 and 48.01.030. 94-14-100 (Order R 94-10), § 284-54-020, filed 7/6/94, effective 8/6/94. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-020, filed 7/9/87.]

WAC 284-54-030 Standards for definitions applicable to long-term care contracts. The following definitions are applicable to long-term care contracts and the implementation of chapter 48.84 RCW and this chapter, and no contract may be advertised, solicited, or issued for delivery in this state as a long-term care contract which uses definitions more restrictive or less favorable to an insured than the following:

(1) "Acute care" means care provided for patients who are not medically stable. These patients require frequent monitoring by health care professionals in order to maintain their health status.

(2) "Benefit period" means the period of time for which the insured is eligible to receive benefits or services under a contract. A benefit period begins on the first day that the insured is eligible for and begins to receive the benefits of the contract. The benefit period ends when the insured is no longer eligible to receive benefits or has received the lifetime maximum benefits available. Such benefit period must be stated in terms of days rather than in terms of months of benefit.

(3) "Case manager" or "case coordinator" means an individual qualified by training and/or experience to coordinate the overall medical, personal and social service needs of the long-term care patient. Such coordination activities shall include but are not limited to: Assessing the individual's condition to determine what services and resources are necessary and by whom they might most appropriately be delivered; coordination of elements of a treatment or care plan and referral to the appropriate medical or social services personnel or agency; control coordination of patient services and continued monitoring of the patient to assess progress and assure that services are delivered. Such activities shall be conducted in consultation with the attending physician.

(4) "Chronic care" or "maintenance care" means care that is necessary to support an existing level of health and is intended to preserve that level from further failure or decline. The care provided is usually for a long, drawn out or lingering disease or infirmity showing little change or slowly progressing with little likelihood of complete recovery, whether such care is provided in an institution or is community-based and whether such care requires skilled, intermediate or custodial/personal care.

(5) "Convalescent care" or "rehabilitative care" is nonacute care which is prescribed by a physician and is received during the period of recovery from an illness or injury when improvement can be anticipated, whether such care requires skilled, intermediate or custodial/personal care, and whether such care is provided in an institutional care facility or is community-based.

(6) "Custodial care" or "personal care" means care which is mainly for the purpose of meeting daily living requirements. This level of care may be provided by persons without professional skills or training. Examples are: Help in walking, getting out of bed, bathing, dressing, eating, meal preparation, and taking medications. Such care is intended to maintain and support an existing level of health or to preserve the patient from further decline. Custodial or personal care services are those which may be recommended by the case manager in consultation with the

patient's attending physician and are not primarily for the convenience of the insured or the insured's family.

(7) "Guaranteed renewable" means that renewal of a contract may not be declined by an insurer for any reason except for nonpayment of premium, but the insurer may revise rates on a class basis.

(8) A "home health aide" is a person who is providing care under the supervision of a physician, licensed professional nurse, physical therapist, occupational therapist, or speech therapist. Care provided may include ambulation and exercise, assistance with self-administered medications, reporting changes in a covered person's conditions and needs, completing appropriate records, and personal care or household services needed to achieve medically desired results.

(9) "Home care services" or "personal care services" are services of a personal nature including, but not limited to, homemaker services, assistance with the activities of daily living, respite care services, or any other nonmedical services provided to ill, disabled, or infirm persons which services enable those persons to remain in their own residences consistent with their desires, abilities and safety. An insurer may require that services are provided by or under the direction of a home health care agency or home care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

(10) "Home health care" shall mean, but is not limited to, any of the following health or medical services: Nursing services, home health aide services, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional services, medical or social services, and medical supplies or equipment services. An insurer may require that services are provided by or under the direction of a regulated home health care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

(11) "Intermediate care" means technical nursing care which requires selected nursing procedures for which the degree of care and evaluation is less than that provided for skilled care, but greater than that provided for custodial/personal care. This level of care provides a planned continuous program of nursing care that is preventive or rehabilitative in nature.

(12) "Long-term care total disability" means the functional inability due to illness, disease or infirmity to engage in the regular and customary activities of daily living which are usual for a person of the same age and sex.

(13) "Managed long-term care delivery system" means a system or network of providers arranged or controlled by a managed long-term care plan. Such systems provide a range of long-term care services with provisions for effective utilization controls and quality assurance. In the case of provision of long-term care in the managed care environment, a case manager or other qualified individual may be used to develop and coordinate a care plan of appropriate long-term care services.

(14) "Managed long-term care plan" means a plan which on a prepaid basis assumes the responsibility and the risk for delivery of the covered long-term care services set forth in

the benefit agreement. Actual services are rendered by the plan through its own staff, through capitation, or other contractual arrangements with providers. Managed long-term care plans may include but are not limited to those offered by health maintenance organizations, and health care service contractors, if their services are provided through a managed long-term care delivery system.

(15) "Noncancellable" means that renewal of a contract may not be declined except for nonpayment of premium, nor may rates be revised by the insurer.

(16) "One period of confinement" means consecutive days of institutional care received as an inpatient in a health care institution, or successive confinements due to the same or related causes when discharge from and readmission to the institution occurs within a period of time not more than ninety days or three times the maximum number of days of institutional care provided by the policy to a maximum of one hundred eighty days, whichever provides the covered person with the greater benefit.

(17) "Preexisting condition," as defined by RCW 48.84.020(3), means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.

(18) "Respite care" is short-term care which is required in order to maintain the health or safety of the patient and to give temporary relief to the primary caretaker from his or her caretaking duties.

(19) "Skilled care" means care for an illness or injury which requires the training and skills of a licensed professional nurse, is prescribed by a physician, is medically necessary for the condition or illness of the patient, and is available on a twenty-four-hour basis.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-030, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-030, filed 7/9/87.]

WAC 284-54-040 Minimum standards for benefit triggers—Physician certification, activities of daily living, and cognitive impairments. (1)(a) Except as provided in (b) of this subsection, every long-term care insurance contract or certificate issued on or after January 1, 1996, which provides coverage to a resident of this state, shall require certification by the insured's attending physician that the services are appropriate due to illness or infirmity, or include provisions which condition the payment of benefits on an assessment of the insured's ability to perform specific activities of daily living or the insured's cognitive impairment.

(b) Certificates issued on or after January 1, 1996, under a group long-term care insurance contract that was in force on December 31, 1995, need not meet the standards of this section.

(2) Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the contract or certificate in a separate paragraph labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall be explained in that section. If a trigger differs for different benefits, an explanation of the trigger shall accompany each benefit description. If an attending physician or other specified

person must certify a certain level of functional dependency in order to be eligible for benefits, the policy shall so specify.

(3) Eligibility for the payment of benefits based on the inability of the insured to perform certain activities shall not be more restrictive than requiring a deficiency in the ability to perform not more than three of the following activities of daily living.

(a) "Activities of daily living" on which an insurer intends to rely as a measure of functional incapacity shall be defined in the policy, and shall include at least all of the following:

(i) Bathing: The ability of the insured to wash himself or herself either in the tub or shower or by sponge bath, including the task of getting into or out of a tub or shower.

(ii) Continence: The ability of the insured to control bowel and bladder functions; or, in the event of incontinence, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(iii) Dressing: The ability of the insured to put on and take off all items of clothing, and necessary braces, fasteners, or artificial limbs.

(iv) Eating: The ability of the insured to feed himself or herself by getting food and drink from a receptacle (such as a plate, cup, or table) into the body including intravenously or by feeding tube.

(v) Toileting: The ability of the insured to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene.

(vi) Transferring: The ability of the insured to move in and out of a chair, bed, or wheelchair.

(b) For purposes of this section, the determination of a deficiency shall not be more restrictive than:

(i) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(ii) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

(c) Upon prior approval of the commissioner in writing, an insurer may use standards or definitions for activities of daily living in addition to the standards set forth in (a) of this subsection; however, in no case may an insurer require a deficiency in more than three activities of daily living as a barrier to benefits. Any additional activities of daily living approved by the commissioner, shall be used in addition to those set forth in (a) of this subsection, and not in lieu thereof. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers. No contract or certificate may combine more than one activity of daily living to create a compound impairment requirement.

(d) Each long-term care insurance contract or certificate shall include a clear description of the process for appealing and resolving benefit determinations.

(4) If an insurer proposes standards other than those described in this section, the insurer shall describe to the satisfaction of the commissioner how the proposed assessment will reasonably be expected to produce reliable, valid, and clinically appropriate results and shall demonstrate that the alternate assessment method is not less beneficial to the insured than the standards described in this section.

(5) For purposes of this section the following definitions apply:

(a) "Cognitive impairment" means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

(b) "Hands-on assistance" means any amount of physical assistance (whether minimal, moderate, or maximal) without which the insured would not be able to perform the activity.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-040, filed 9/11/95, effective 10/12/95.]

WAC 284-54-180 Reduction of coverage. Effective January 1, 1996, every person purchasing a long-term care insurance contract in this state shall have the right to reduce the benefits of a long-term care contract without providing evidence of insurability. Such a reduction may include, for example, changes which result in a contract with a longer elimination period, a lower daily benefit, or a shorter benefit period: *Provided, however,* That an insurer shall not reduce benefits to a level below the minimum level which has been approved by the commissioner on the date the reduction of coverage is requested.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-180, filed 9/11/95, effective 10/12/95.]

WAC 284-54-190 Nonduplication with state or national health care benefits. In the event that a state or federal program is enacted which substantially duplicates all or part of the coverage of an in-force long-term care insurance contract or certificate, current benefits or features which are duplicated by a state or national program shall be revised or eliminated promptly and in an orderly manner, subject to prior approval by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-190, filed 9/11/95, effective 10/12/95.]

WAC 284-54-253 Unintentional lapse. The purpose of this section is to protect insureds from unintentional lapse by establishing standards for notification of a designee to receive notice of lapse for nonpayment of premiums at least thirty days prior to the termination of coverage and to provide for a limited right to reinstatement of coverage unintentionally lapsed by a person with a cognitive impairment or loss of functional capacity. These are minimum standards and do not prevent an insurer from including benefits more favorable to the insured. This section applies to every insurer providing long-term care coverage to a resident of this state, which coverage is issued for delivery or renewed on or after January 1, 1996.

(1) Every insurer shall permit an insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium, if the premium is not paid on or before its due date. The designation shall include the designee's full name and home address.

(a) The notice shall provide that the contract or certificate will not lapse until at least thirty days after the notice is mailed to the insured's designee.

(b) Where a policyholder or certificateholder pays premium through a payroll or pension deduction plan, the insurer shall permit the insured to designate a person to

receive notice of lapse or termination for nonpayment of premium within sixty days after the insured is no longer on such a premium payment plan. The application or enrollment form for contracts or certificates where premium will be paid through a payroll or pension deduction plan shall clearly indicate the payment plan selected by the applicant.

(c) The insurer shall offer each insured in writing an opportunity to change the designee, or update the information concerning the designee, no less frequently than once in every twenty-four months.

(2) Every insurer shall provide a limited right to reinstate coverage in the event of lapse or termination for nonpayment of premium, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity and reinstatement is requested within the five months after the policy lapsed or terminated due to nonpayment of premium.

(a) The standard of proof of cognitive impairment or loss of functional capacity shall be no more restrictive than the benefit eligibility criteria for cognitive impairment or loss of functional capacity contained in the contract or certificate.

(b) Current good health of the insured shall not be required for reinstatement if the request otherwise meets the requirements of this section.

(3) An insurer shall permit an insured to waive his or her right to designate an additional person to receive notice of lapse or termination for nonpayment of premium.

(a) The waiver shall be in writing, and shall be dated and signed by the applicant or insured.

(b) No less frequently than once in every twenty-four months, the insured shall be permitted to revoke this waiver and to name a designee.

(4) Designation by the insured to receive notice of lapse or termination for nonpayment of premium does not constitute acceptance of any liability on the part of the designee for services provided to the insured or applicant.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-253, filed 9/11/95, effective 10/12/95.]

WAC 284-54-270 Requirement to offer inflation protection. (1) No insurer may offer a long-term care insurance contract unless, in addition to any other inflation protection option, the insurer offers to the policyholder the option to purchase a contract that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the contract. Insurers must offer to each applicant, at the time of purchase, the option to purchase a contract with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the

period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the contract is issued to a group, the required offer in subsection (1) of this section shall be made to the group policyholder; except, if the policy is issued to an association group (defined in RCW 48.24.045) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(3) The offer in subsection (1) of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4)(a) Insurers shall include the following information in or with the disclosure form:

(i) A graphic comparison of the benefit levels of a contract that increases benefits over the contract period with a contract that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(c) It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations may, for example, include providing increases to attained age, or for a period such as at least twenty years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

(5) Inflation protection benefit increases under a contract which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the contract.

(6) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7)(a) Inflation protection as provided in subsection (1)(a) of this section shall be included in a long-term care insurance contract unless an insurer obtains a written rejection of inflation protection signed by the applicant.

(b) The rejection shall be considered a part of the application and shall state:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this contract with and without inflation protection. Specifically, I have reviewed Plans, and I reject inflation protection."

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-270, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060, 48.84.030 and 48.01.030. 94-14-100 (Order R 94-10), § 284-54-270, filed 7/6/94, effective 8/6/94.]

WAC 284-54-300 Information to be furnished, style. (1) Each broker, agent, or other representative of an insurer selling or offering benefits that are designed, or represented as being designed, to provide long-term care

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insurance benefits, shall deliver the disclosure form as set forth in WAC 284-54-350 not later than the time of application for the contract. If an agent has solicited the coverage, the disclosure form shall be signed by that agent and a copy left with the applicant. The insurer shall maintain a copy in its files.

(2) The disclosure form required by this section shall identify the insurer issuing the contract and may contain additional appropriate information in the heading. The informational portion of the form shall be substantially as set forth in WAC 284-54-350 and words emphasized therein shall be underlined or otherwise emphasized in each form issued. The form shall be printed in a style and with a type character that is easily read by an average person eligible for long-term care insurance.

(3) Where inappropriate terms are used in the disclosure form, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor, or health maintenance organization shall substitute appropriate terminology.

(4) In completing the form, each subsection shall contain information which succinctly and fairly informs the purchaser as to the contents or coverage in the contract. If the contract provides no coverage with respect to the item, that shall be so stated. Address the form to the reasonable person likely to purchase long-term care insurance.

(5) A policy which provides for the payment of benefits based on standards described as "usual," "customary," or "reasonable" (or any combination thereof), or words of similar import, shall include an explanation of such terms in its disclosure form and in the definitions section of the contract.

(6) If the contract contains any gatekeeper provision which limits benefits or precludes the insured from receiving benefits, such gatekeeper provision shall be fully described.

(7) All insurers shall use the same disclosure form. It is intended that the information provided in the disclosure form will appear in substantially the same format provided to enable a purchaser to compare competing contracts easily.

(8) The information provided shall include the statement: "This is NOT a Medicare supplement policy," and shall otherwise comply with WAC 284-66-120.

(9) The required disclosure form shall be filed by the insurer with the commissioner prior to use in this state.

(10) In any case where the prescribed disclosure form is inappropriate for the coverage provided by the contract, an alternate disclosure form shall be submitted to the commissioner for approval or acceptance prior to use in this state.

(11) Upon request of an applicant or insured, insurers shall make available a disclosure form in a format which meets the requirements of the Americans With Disabilities Act and which has been approved in advance by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-300, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-300, filed 7/9/87.]

WAC 284-54-350 Form to be used—Long-term care insurance disclosure form. No later than January 1, 1996, the disclosure form shall be substantially as follows:

(Company Name)
Disclosure Form
Long-term Care Insurance

The decision to buy a new long-term care policy is very important. It should be carefully considered.

The following data give you some general tips and furnish you with a summary of benefits available under our policy.

Your long-term care policy provides thirty days (sixty days for direct response insurers) within which you may decide without cost whether you wish to keep it. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available under your policy.

If you now have insurance which provides benefits for long-term care, read your policy carefully. Look for what is said about renewing it. See if it contains waiting periods before benefits are paid. Note how it covers preexisting conditions (health conditions you already have). Compare these features with similar ones in any new policy. Use this information to measure the value of any insurance or health care plans you now have.

DON'T BUY MORE INSURANCE THAN YOU REALLY NEED. One policy that meets your needs is usually less expensive than several limited policies.

If you are eligible for state medical assistance coupons (Medicaid), you should not purchase a long-term care insurance policy.

After you receive your policy, make sure you have received the coverage you thought you bought. If you are not satisfied with the policy, you may return it within thirty days (sixty days for direct response insurer) for a full refund of premium.

LTC DISCLOSURE FORM

1. INSTITUTIONAL CARE

What levels of care are covered by the policy?

YES

NO

Does the policy provide benefits for these levels of care?

Skilled Nursing Care?

Intermediate Nursing Care

Custodial/Personal Care?

(By state law, all long-term care policies in Washington State must cover all three of the above levels of care.)

Where can care be received and be covered under the policy?

Does the policy pay for care in any licensed facility?

If no, define the restrictions on where care can be obtained:

Is the alternative plan of care benefit available with institutional part of policy?

Does the alternative plan of care benefit include home care?

Does the alternative plan of care benefit include structural home improvements?

2. HOME / COMMUNITY BASED CARE

What types of care are covered by the policy?

Does the policy provide home care benefit for:

Check all that apply

Adult day care

Adult day health care

Chore services

Home health aides

Homemaker services

Hospice

Hygiene/personal care

Laboratory services

Meals/nutrition services

Medical equipment/supplies

Prescription drugs

Physician/nursing services

Respite care

Social workers

Therapies (List)

Transportation

Other: _____

Are these separate or post-confinement benefits?

Separate _____ Post- Confinement _____

Where can home/community-based care be received?

Check all that apply

Adult day care centers

Alternative care facilities

Assisted living facilities

Boarding homes

Community centers

Congregate care facilities

Multiple family residences

Single family residences

Other: _____

Does the alternative plan of care benefit include home care?

Does the alternative plan of care benefit include structural improvements?

Must the alternative plan of care be pre-certified?

If yes, by whom? _____

3. BOTH INSTITUTIONAL AND COMMUNITY-BASED CARE

What is the maximum daily benefit amount for:	YES/NO/COMMENTS
Institutional/nursing home care?	_____
Home/Community Based Care?	_____
Are there limits on the number of days (or visits) per year for which benefits will be paid for:	
Institutional/nursing home care?	_____
Home/Community based care?	_____
What are the dollar limits the policy will pay during the policyholder's lifetime for:	
Institutional/Nursing home care?	_____
Home/Community based care?	_____
Total lifetime limit?	_____
What basic features and benefits does the policy offer?	
Is the policy guaranteed renewable?	_____
Can you purchase additional increments of coverage? If yes:	_____
When can additional coverage be purchased?	_____
How much can be purchased?	_____
When is additional coverage no longer available for purchase?	_____
Does the policy have inflation protection?	_____
If yes, what is the % amount of the increase?	_____
Is the rate of increase simple or compound?	_____
When do increases stop?	_____
If policy includes inflation coverage, what is the daily benefit for:	
Institutional/nursing home care..	
5 years from policy effective date?	_____
10 years from policy effective date?	_____
Home/Community based care..	
5 years from policy effective date?	_____
10 years from policy effective date?	_____
After the limits have been reached for inflation adjustments, what is the maximum daily benefit for:	
Institutional/nursing home care	_____
Home/community based care	_____
After the limits have been reached for inflation adjustments, what is the maximum lifetime benefit for:	
Institutional/nursing home care	_____
Home/community based care	_____
Is there a waiver of premium provision for:	
Institutional/nursing home care?	_____
Home/community based care?	_____
How many days of confinement in an institution are required before the waiver of premium benefit is available?	_____
Home many days of confinement at home are required before the waiver of premium benefit is available?	_____
How many days of benefits must be paid before waiver is effective?	_____
Does the policy have a nonforfeiture benefit?	_____
If yes, how many years must policy be in effect before the insured benefits from nonforfeiture values?	_____
What would the benefit value be in terms of dollars after 20 years?	_____
What does the nonforfeiture benefit promise?(give an appropriate example showing dollars and time limits)	_____

	YES/NO/COMMENTS
Does the policy have a death benefit?	_____
If yes, specify value (in dollars of %)	_____
What conditions or limitations apply, if any?	_____
Does the policy have a restoration of benefits provision?	_____
If yes, give amount of benefit and minimum required # of days between benefits.	_____
If disability recurs, is there a new elimination or waiting period before benefits begin again?	_____
If yes, after how long?	_____
How long is the waiting period for pre-existing conditions?	_____
How is the pre-existing condition defined?	_____
When do benefits begin?	
How long is the elimination or waiting period before benefits begin for:	
Institutional/nursing home care?	_____
Home/community based care?	_____
What gatekeepers are required before benefits start?	
Doctor certification	_____
Case management	_____
If yes, by whom?	_____
Medical necessity	_____
Plan of treatment	_____
If yes, by whom?	_____
Inability to perform activities of daily living (ADLs)	_____
If yes, how many ADLs must fail before benefits begin?	_____
If the policy uses an ADL gatekeeper(s), define "inability to perform ADL."	_____
Is there a separate benefit qualification requirement if there is a cognitive impairment?	_____
Who determines a qualifying event?	_____
Define any separate benefit qualification requirement if there is a cognitive impairment:	_____
What does the policy cost?	
How often can the premium increase?	_____
By how much annually can the premium increase?	_____
Is there a discount if both spouses buy policies?	_____
If so, how much?	_____
Do you lose the discount if one spouse dies?	_____

4. **ADDITIONAL POLICY INFORMATION**

Use this space to outline additional benefits, further explanations or clarifications

5.

POLICY DEFINITIONS

(Include definitions of policy provisions)

WHAT DOES THE POLICY COST?

	POLICY OPTION 1	POLICY OPTION 2	POLICY OPTION 3	POLICY OPTION 4
COMPANY NAME.	_____	_____	_____	_____
ELIMINATION(DEDUCTIBLE)PERIOD	_____	_____	_____	_____
BENEFIT PERIOD	_____	_____	_____	_____
\$ BENEFIT FOR DAY	_____	_____	_____	_____
\$ MAXIMUM BENEFIT	_____	_____	_____	_____
Institutional/Nursing Home	_____	_____	_____	_____
Home Health/Community Based	_____	_____	_____	_____
PREMIUM SUBTOTAL \$	_____	_____	_____	_____
OPTIONAL BENEFITS	_____	_____	_____	_____
Inflation	_____	_____	_____	_____
Non Forfeiture	_____	_____	_____	_____
Spousal Discount	_____	_____	_____	_____
Death Benefit	_____	_____	_____	_____
Other _____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____
PREMIUM TOTAL \$	_____	_____	_____	_____
BENEFIT "TRIGGERS" (QUALIFICATION REQUIREMENTS)				
List _____	_____	_____	_____	_____
List _____	_____	_____	_____	_____
List _____	_____	_____	_____	_____

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-350, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-350, filed 7/9/87.]

Chapter 284-87 WAC

JOINT UNDERWRITING ASSOCIATION FOR MIDWIFERY AND BIRTHING CENTERS MALPRACTICE INSURANCE

WAC

284-87-030 The association.

WAC 284-87-030 The association. (1) A nonprofit joint underwriting association for midwifery and birthing centers malpractice insurance is hereby established. Membership in the association shall be mandatory for all insurers that on or after July 25, 1993, possess a certificate of authority to write medical malpractice, general casualty insurance, or both, within this state. Every such insurer shall be and remain a member of the association and fulfill all its membership obligations as a condition of its authority to continue to transact property and casualty insurance business in this state. An insurer ceases to be a member insurer upon surrender of its certificate of authority to transact insurance in this state.

(2) The association shall remain inactive, except for the actions of the board enumerated in WAC 284-87-050 through 284-87-080, until it is activated by the commissioner as provided in WAC 284-87-040.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 95-05-034, § 284-87-030, filed 2/8/95, effective 3/11/95; 94-02-053 (Order R 93-18), § 284-87-030, filed 12/30/93, effective 1/30/94.]

Chapter 284-97 WAC

VIATICAL SETTLEMENT REGULATION

WAC

284-97-010 Purpose, scope, and effective date.
284-97-015 Definitions.
284-97-020 Licensing requirements for viatical settlement providers.
284-97-030 Licensing requirements for viatical settlement brokers.
284-97-040 Contract and rate filing requirements for viatical settlement providers and viatical settlement brokers.
284-97-050 Standards for evaluating reasonability of compensation.

WAC 284-97-010 Purpose, scope, and effective date.

(1) The purpose of this chapter is to effectuate chapter 48.102 RCW, by establishing minimum standards and disclosure requirements to be met by viatical settlement providers and viatical settlement brokers with respect to viatical settlement contracts advertised, solicited, or issued for delivery in this state, and licensing requirements for viatical settlement providers and viatical settlement brokers.

(2) Except as otherwise specifically provided, this chapter applies to every viatical settlement provider or viatical settlement broker as defined in RCW 48.102.005, that transacts viatical settlement business in this state on or after July 23, 1995. This chapter also applies to every viatical settlement contract executed between a viator and a

viatical settlement provider in this state on or after July 23, 1995.

(3) This regulation is not exclusive, and acts or omissions, whether or not specific in this chapter, may also be violations of other sections of the insurance code or other regulations promulgated thereunder.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-010, filed 10/20/95, effective 11/20/95.]

WAC 284-97-015 Definitions. For purposes of this chapter:

(1) "Solicitation" means, for example; proposing, negotiating, signing, or doing any act in furtherance of making or proposing to make a viatical settlement contract. Solicitation specifically includes advertising by mail, use of the print or electronic media, telephone, or any other method of presenting, distributing, issuing, circulating, or permitting to be issued or circulated any information or material in connection with a viatical settlement contract.

(2) "Viatical settlement contract" has the meaning set forth at RCW 48.102.005(3). The commissioner finds that the purchase of a life insurance policy or certificate is outside the scope of this chapter if the viatical settlement contract is entered into between the viator and a close friend or relative.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-015, filed 10/20/95, effective 11/20/95.]

WAC 284-97-020 Licensing requirements for viatical settlement providers. (1) Beginning July 23, 1995, no individual, partnership, corporation, or other entity may act as a viatical settlement provider, or enter into or solicit a viatical settlement contract in this state unless it has first obtained a license from the commissioner.

(2) An initial application for licensing as a viatical settlement provider, or a subsequent application for reinstatement of a viatical settlement provider's license if the license has lapsed for more than three months, shall be accompanied by a licensing fee in the amount of two hundred fifty dollars. The annual renewal fee shall be twenty-five dollars, due and payable on or before July 1 of each year.

(3) The application for a license as a viatical settlement provider shall furnish all of the applicable following information, on a form prescribed by the commissioner:

(a) The name of the applicant, its address, and organizational structure.

(b) Copies of its organizational documents, including but not limited to its: Articles of incorporation and any amendments thereto, certificate of incorporation and any amendments thereto, bylaws and any amendments thereto, partnership agreement and any amendments thereto, and articles of association and any amendments thereto.

(c) The identity of all: Stockholders holding ten percent or more of the voting securities; investors holding a ten percent or greater interest; partners; corporate officers; trustees; if an association, all of the members; and parent and affiliate entities, together with a chart showing the relationship of the applicant to any parent, affiliated or subsidiary entities.

(d) A list of all stockholders holding ten percent or more of the voting securities, investors holding a ten percent or greater interest, partners, and officers of any parent or affiliate entities.

(e) Biographical affidavits of all its officers, directors, investors holding a ten percent or greater interest, partners, and members (if an association).

(f) For domestic viatical settlement providers, fingerprint cards of all its officers, directors, trustees, investors holding a ten percent or greater interest, partners, and members (if an association).

(g) A list of states in which the viatical settlement provider is licensed on the date of application, a copy of each effective license, and a list of the states in which it is or was doing business.

(h) A list of all business licenses from any level of government, for which the applicant, its officers, partners, trustees, and members (if an association), have applied, together with a certificate of incorporation from the Washington secretary of state, and a statement showing the current status of any such licenses, such as whether it has been revoked or suspended.

(i) A report stating whether any formal or informal regulatory action, by any level of state or federal government, is pending or has been taken against the applicant or its officers, directors, trustees, investors holding a ten percent or greater interest, partners, or members (if an association).

(j) A report stating whether any criminal action or civil action has been taken, or is pending, against the applicant or its officers, directors, trustees, investors holding a ten percent or greater interest, partners, or members (if an association).

(k) A copy of its most recent financial and operating reports, audited and unaudited.

(l) Copies of documents filed with the federal Securities and Exchange Commission and any applicable state securities regulator.

(m) A detailed plan of operations for the applicant's business, including but not limited to information regarding or identification of the following items:

(i) Escrow accounts and banks;

(ii) Advertising, brokerage, or distribution system to be used;

(iii) Marketing techniques to be used;

(iv) Marketing training program; and

(v) Contract offering and servicing facilities.

(n) Appointment of the commissioner to receive service of process and a designation of the person to whom the commissioner shall forward legal process.

(o) Such other information as the commissioner may reasonably require.

(4) To qualify for authority to transact business as a viatical settlement provider, the applicant must possess unimpaired capital, and thereafter maintain unimpaired capital, in the amount of not less than one hundred fifty thousand dollars.

(5) Each viatical settlement provider holding a license in this state shall annually, on or before March 1 of each year, file with the commissioner an annual statement for the preceding calendar year. The annual statement shall be on a form prescribed by the commissioner.

(6) The commissioner may issue a temporary viatical settlement provider's license, that will expire no later than December 31, 1995, upon receipt and review of the application required in subsection (3) of this section. After reviewing the application, the commissioner may issue the viatical settlement provider's license, refuse to issue such license, or revoke the temporary viatical settlement provider's license.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-020, filed 10/20/95, effective 11/20/95.]

WAC 284-97-030 Licensing requirements for viatical settlement brokers. On and after July 23, 1995, no person may act as a viatical settlement broker, or solicit, negotiate, or enter into viatical settlement contracts in this state, unless licensed as a viatical settlement broker by the commissioner. A viatical settlement broker shall be qualified as a life insurance agent and appointed as a viatical settlement broker by each viatical settlement provider represented.

(1) Each applicant for a viatical settlement broker's license shall:

(a) Complete an application form furnished by the commissioner. The form shall be accompanied by a license fee in the amount of one hundred dollars. Applicants shall answer inquiries concerning their identity, provide fingerprint cards, and supply information about personal and business history and experience.

(b) A viatical settlement broker shall be appointed by each viatical settlement provider he or she represents. An appointment request form and the appointment fee in the amount of twenty dollars shall be submitted with the application for licensing.

(c) Applicants for a firm or corporate license shall provide copies of articles of incorporation, partnership agreements, or other indicia of current legal status, as appropriate.

(d) Every individual who acts as a viatical settlement broker on behalf of a firm or corporation shall be licensed and affiliated with the entity represented prior to solicitation or negotiation of a viatical settlement contract. Each request by a firm or corporation for an affiliation certificate shall be accompanied by a twenty-dollar filing fee.

(e) Applicants for a viatical settlement broker's license shall provide satisfactory evidence that no disciplinary action has resulted in the suspension or revocation of any federal or state license.

(f) Prior to application for a resident viatical settlement broker's license, an applicant shall pass the life insurance agent's examination in this state, but need not be licensed as a life insurance agent.

(g) Nonresident applicants may be licensed as viatical settlement brokers. Each nonresident applicant shall provide satisfactory proof that he or she has successfully passed a life insurance agent's examination in a state within the two-year period immediately preceding the date of the application, or that he or she holds a valid license as a life insurance agent or viatical settlement broker in his or her state of residence. In addition, the nonresident applicant shall certify that no disciplinary action has resulted in suspension or revocation of any federal or state license. Applicants for a

nonresident viatical settlement broker's license shall designate and authorize the commissioner as his or her agent for service of process and shall specify the person to whom the commissioner shall forward legal process.

(2) A person applying for a viatical settlement broker's license who is transacting viatical settlement business on the effective date of this chapter, may apply to the commissioner for a temporary resident or nonresident viatical settlement broker's license. A temporary license may be issued by the commissioner if the person is otherwise eligible for such license but has not taken and passed a life insurance agent's examination in a state. The temporary license issued by the commissioner shall expire no later than December 31, 1995. After review of the application, the commissioner may issue the viatical settlement broker's license, refuse to issue such license, or revoke the temporary viatical settlement broker's license.

(3) A viatical settlement broker's license is renewable every two years, upon payment of a renewal fee in the amount of one hundred dollars. A viatical settlement broker's license expires on the licensee's month and day of birth plus one year from the date the license is first issued, if an individual, or two years from the issue date in the case of a firm or corporation. Failure to pay the renewal fee by the renewal date will automatically terminate the authority conferred by the license.

(4) Appointments of a viatical settlement broker expire on July 1 following their issue dates and every two years thereafter, unless previously cancelled or revoked.

(5) Affiliations expire on the renewal date for the licensed firm or corporation to which they apply, and expire every two years thereafter, unless previously cancelled or revoked.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-030, filed 10/20/95, effective 11/20/95.]

WAC 284-97-040 Contract and rate filing requirements for viatical settlement providers and viatical settlement brokers. Beginning September 1, 1995, all viatical settlement contracts shall be approved by the commissioner prior to use in this state.

(1)(a) Every viatical settlement contract shall be in writing, in a type size of no less than ten points, shall be identified by a form number in the lower left-hand corner of the first page, and include the terms under which the viatical settlement provider will pay compensation (called by whatever name) to the viator in exchange for the assignment, transfer, sole devise, or bequest of the death benefit or assignment of ownership of the life insurance policy or certificate to the viatical settlement provider or viatical settlement broker.

(b) Every viatical settlement contract shall provide for payment to the viator in a lump sum and shall be voidable at the option of the viator if the agreed value is not paid in full within thirty days of the date the viatical settlement contract is executed by both the viator and the viatical settlement provider.

(c) Every viatical settlement contract shall provide for transfer of the entire life insurance policy: *Provided, however,* That if agreed to in writing by both the insurer and

the viator, a stated dollar value which is less than the full face amount of the life insurance policy (less any outstanding loans) may be transferred if:

(i) The viatical settlement provider obtains a bond in favor of all beneficiaries of the policy other than the viatical settlement provider in an amount sufficient to guarantee the payment of all premium for the balance of the premium-paying period as calculated on the effective date of the life insurance policy; or

(ii) Another arrangement acceptable to the commissioner is made which guarantees that the insurance policy will remain in full force and effect for the protection of beneficiaries designated by the viator (other than the viatical settlement provider) until the death of the insured.

(2) The viatical settlement contract shall provide for rescission no less favorable to the viator than as set forth in RCW 48.102.040 (3) and (4). The rescission provision shall appear on the first page of the contract. It shall provide that if the insured dies during the period of time allowed for rescission, the contract will be terminated effective the date of application and the parties are returned to their original positions. The contract shall provide a method for giving notice of rescission. If notice of rescission is given by mail, it shall be deemed given when deposited in the United States mail, first class postage prepaid.

(3)(a) Each form of viatical settlement contract filed with the commissioner shall include all of the following:

(i) A viatical settlement contract, completed in John Doe fashion;

(ii) A copy of a viator's application, completed in John Doe fashion;

(iii) A copy of an "Insurance Commissioner's Worksheet" as described in WAC 284-97-050(3), completed in John Doe fashion;

(iv) A copy of any written disclosure material that will be provided to a viator as required by RCW 48.102.035; this written disclosure shall set forth the name, address, and telephone number of the viatical settlement provider; and

(v) A copy of the pricing memorandum.

(b) That portion of the disclosure notice warning of possible tax consequences and possible effects on eligibility for public funds shall be prominently displayed.

(c) The disclosure notice shall state that before entering into a viatical settlement contract, the viator should consult with his or her life insurance agent or life insurer to determine whether accelerated benefits are available.

(d) The disclosure notice shall contain the definition of accelerated benefits set forth in WAC 284-23-620(1) in its entirety.

(4) The viatical settlement contract shall specify any effect entering into the contract will have upon the continued availability of supplemental benefits or riders that are or may be attached to the life insurance policy that is the subject of the viatical settlement contract, including assigning the responsibility for the continued payment of premiums. The benefits and riders considered shall include, but need not be limited to, the following:

(a) Guaranteed insurability options;

(b) Accidental death benefits, or accidental death and dismemberment benefits;

(c) Disability income or loss of income protection;

(d) Waiver of premium or monthly deduction waiver; and

(e) Family, spousal, or children's riders or benefits.

(5) No viatical settlement contract may contain any limitation or restriction on the use of the proceeds by the viator.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-040, filed 10/20/95, effective 11/20/95.]

WAC 284-97-050 Standards for evaluating reasonability of compensation. In order to assure that benefits offered to a viator are reasonable in relation to the rate, fee, or other compensation that is charged, any payout shall be no less than the greater of the amounts defined in subsections (1) and (2) of this section.

(1) Payouts shall be no less than the following percentage of the expected death benefit under the insurance policy, net of loans. The following are minimum standards and shall not be presumed to be proof of fairness as to any specific transaction.

(a) If the insured's life expectancy is less than twelve months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator shall be no less than seventy-five percent.

(b) If the insured's life expectancy is at least twelve months, but less than twenty-four months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator shall be no less than sixty-five percent.

(c) If the insured's life expectancy is at least twenty-four months, but less than thirty-six months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator shall be no less than fifty percent.

(d) If the insured's life expectancy is at least thirty-six months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator, shall be no less than thirty percent.

(2) Payouts shall be no less than the expected death benefit under the insurance policy, net of loans, reduced by the sum of the amounts described in (a), (b), and (c) of this subsection.

(a) The viatical settlement provider may retain the amounts it would be required to pay to the insurer to keep the policy in force during the period of time ending concurrently with the insured's life expectancy.

(b) The viatical settlement provider may retain an allowance of fifteen percent of the expected death benefit, net of loans, to provide for a risk charge and for its expenses and profit.

(c) The viatical settlement provider may retain an allowance for the time value of money. The interest rate to be used is fifteen percent per annum, compounded monthly. The calculation shall be performed on the basis that the viatical settlement provider pays the present value of the expected death benefit under the insurance policy, net of loans, reduced by the amounts defined in (a) and (b) of this subsection. The payment to the viator shall reflect an interest adjustment for the period of time beginning when the

viator is paid and ending concurrently with the insured's life expectancy.

(3) The viatical settlement provider shall maintain for each viator, a document bearing the title, "Insurance Commissioner's Worksheet" for ten years after the death of the insured, or rescission of the contract. The viatical settlement contract shall provide that the viator may at any time obtain upon request, without charge, a copy of the "Insurance Commissioner's Worksheet," the purpose of which is to assure that benefits comply with this section. This provision shall appear on the same page or page following the first occurrence of the statement of the amount to be paid to the viator. In addition to identifying the insured, the "Insurance Commissioner's Worksheet" shall be dated and shall include the text shown in items (a) through (j) of this subsection.

(a) Line one shall state, "(1) Life expectancy (measured from the date the viator is paid) is n= _____ months."

(b) Line two shall state, "(2) Death benefit proceeds expected from insurer is \$ _____."

(c) Line three shall state, "(3) Amount expected to be paid by company to insurer is \$ _____." The viatical settlement provider may substitute its name for the word "company."

(d) Line four shall state, "(4) Allowance for risk, expenses and profit, 15% of (2), is \$ _____."

(e) Line five shall state, "(5) Interest rate is 15%."

(f) Line six shall state, "(6) Line (2), net of allowance for interest, is $(2)/1.0125^n = \$$ _____."

(g) Line seven shall state, "(7) Line (6), less (3) and less (4), is \$ _____."

(h) Line eight shall state, "(8) Minimum percentage, 75%, 65%, 50%, or 30%, of (2) is \$ _____."

(i) Line nine shall state, "(9) Minimum amount required by the commissioner, the greater of (7) or (8), is \$ _____."

(j) Line ten shall state, "(10) Amount to be paid by company, no less than (9), is \$ _____." The viatical settlement provider may substitute its name for the word "company."

(4) The viatical settlement provider shall enclose with the submission of a viatical settlement contract form, and with the submission of a rate revision, for approval prior to use in this state, a pricing memorandum providing a description of the method and assumptions used in determining the value to be paid viators. At the time of submission of a pricing memorandum or at the time of submission of any subsequent supporting documentation, the viatical settlement provider may request the commissioner to withhold that material from public inspection in order to preserve trade secrets or prevent unfair competition, in accordance with RCW 48.02.120(3). Each page covered by such request shall be clearly marked "confidentiality requested." The memorandum shall include a description, which may use reasonable ranges, of the following:

(a) The procedure used to determine the insured's life expectancy including medical evaluation and use of health care professionals in such evaluation;

(b) The portion of the discount (difference between the death benefit of the life insurance policy or certificate and viatical settlement provider payment) due to market value

interest rate (current worth of money) and how this interest rate is determined;

(c) The portion of the discount due to agent or broker compensation paid by the viatical settlement provider;

(d) The portion of the discount that is the viatical settlement provider's operation costs in connection with viatical settlements, including acquisition and maintenance cost and risk charge;

(e) The portion of the discount due to other overhead costs and profit margin;

(f) The effect, if any, that policy loans, surrender charges, and the net cash surrender value in the insurance plan have on the pricing determination;

(g) How provision is made in the settlement determination for future insurance plan premiums, dividends or excess amounts, if any; and

(h) What provision, if any, is made in the settlement determination for supplemental insurance benefits or riders.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-050, filed 10/20/95, effective 11/20/95.]

Title 287 WAC INVESTMENT BOARD

Chapters

- 287-01** Board organization and administration.
287-04 Conflict of interest.

Chapter 287-01 WAC

BOARD ORGANIZATION AND ADMINISTRATION

WAC

287-01-030 Regular board meetings.

WAC 287-01-030 Regular board meetings. The regular meetings of the state investment board are held on the third Thursday of each month, beginning at 9:30 a.m. at the board's offices at 2424 Heritage Court S.W., Olympia, Washington 98504-0916.

[Statutory Authority: RCW 43.33A.110 and 43.33A.040(2). 95-15-080, § 287-01-030, filed 7/18/95, effective 8/18/95.]

Chapter 287-04 WAC CONFLICT OF INTEREST

WAC

287-04-031 Rules of conduct.

WAC 287-04-031 Rules of conduct. This section is promulgated pursuant to RCW 43.33A.110 to ensure compliance with chapter [42.52] RCW and the code of conduct, as adopted by the board. All employees of the

board and board members must comply with the code of conduct.

(1) "Gifts" and "thing of economic value"

(a) No employee of the board or member of the board shall receive, accept, seek or solicit, directly or indirectly, any gift as defined in RCW 42.52.010(18) if such employee or member of the board has reason to believe that it could be reasonably expected that the gift, gratuity, or favor would influence the vote, action, or judgment of the officer or employee, or be considered as part of a reward for action or inaction.

(b) No employee of the board or member of the board shall accept gifts, except those specified in RCW 42.52.150 (2) and (5), with an aggregate value in excess of fifty dollars from a single source in a calendar year or a single gift from multiple sources.

(c) Notwithstanding the above exception found in RCW 42.52.150 (2) and (5), a board member or an employee of the board who participates in the acquisition of goods and services cannot accept things of economic value from a person who seeks to provide goods or services to the board, except for those items specifically listed in RCW 42.52.150(4).

(2) No employee of the board or board member may accept honorarium under the circumstances set forth in RCW 42.52.130. An employee or board member may accept honorarium if all of the following are met:

(a) The employee or board member will not be carrying out their agency duties nor engaging in activity which focuses specifically on the board's responsibilities, policies or programs;

(b) The honorarium is not being offered because of the employee's or board member's official position in the board;

(c) The topic is such that it does not appear that the employee or board member could have used information acquired in the course of employment or membership on the board;

(d) The honorarium is not being offered by a person or entity which does business with or can reasonably be expected to seek business with the board; and

(e) No use of government time or resources was used by the employee or board member to produce the materials or prepare for the article, appearance, or item for which the honorarium is being given.

(3) Personal investments.

(a) "Permissible investment" means any mutual fund or deposit account, certificate of deposit or money market fund maintained with a bank, broker, or other financial institution, any security publicly traded in an organized market if the interest in the security at acquisition is ten thousand dollars or less or an interest in real estate unless such interest involves a related party transaction.

(b) "Other investment" means any investment not defined as a permissible investment in (a) of this subsection.

(c) "Immediate family" includes the spouse, dependent children, other dependent relatives if living in the household and any other household member, whether or not related.

(d) Board members and employees may purchase "permissible investments" without prior approval.

(e) No employee of the board shall or shall permit any member of his or her immediate family to, purchase any "other investment," without the written prior approval of the