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Addendum: for use with Virginia Life & Health online ExamFX courses and study guides version # 25742en (Life) and #25746en (Health), per exam content outline updates effective 3/1/2022.

*The following are **content additions** to supplement your existing text unless otherwise indicated:*

LIFE

Life Insurance Basics

A. Individual Underwriting by the Insurer

2. Unfair Discrimination

It is illegal to refuse to issue or renew a life insurance policy on the life of an individual based on the individual's

- Race, color, sexual orientation, gender identity, religion, national origin, or sex; or
- Being a member of the United States Armed Forces, the Reserves of the United States Armed Forces, or the National Guard.

Federal Tax Considerations for Life Insurance and Annuities

A. Taxation of Personal Life Insurance

Cost Recovery Rule

Cost recovery rule is the general rule for taxation of lump-sum surrender value payments on life insurance policies under which the amount included in the policyowner's income upon policy surrender is the excess of the gross proceeds received over the cost basis. If the policyowner withdraws any of the cash value or surrenders the policy for the cash value, the amount of cash value that exceeds the sum of the total premiums paid will be taxed to the policyowner as ordinary income.

Insurance Regulation – LIFE AND HEALTH

D. Marketing Practices

False Statements and Entries

False financial statements are those that are intended to deceive public officials or the general public about the financial condition of an insurer. This often occurs when an important fact about the financial status of an insurer is deliberately withheld in order to present the company in a more favorable light.

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Notice of Information Practices

Agents and insurers must provide clear and conspicuous notice of financial information they will collect and disclose in connection with insurance transactions. Notification must be given to

- Applicants before any financial information is disclosed about that applicant to any nonaffiliated third party;
- Policyholders at the later of delivery or issuance of the policy or any other evidence of coverage; and
- All policyholders (other than title insurance policyholders) at least once each calendar year.

Notices must be in writing or in electronic format (with applicant or policyholder agreement) and must state the following:

- The types of financial information that may be collected and disclosed;
- The categories of persons to whom financial information may be disclosed;
- The types of financial information that may be disclosed and the categories of nonaffiliated third parties to whom financial information may be disclosed by contractual agreement;
- An explanation of the right to direct that financial information not be disclosed to nonaffiliated third parties;
- A description of the policies and practices for protecting the confidentiality and security of financial information;
- Any disclosure required under the federal Fair Credit Reporting Act pertaining to the notices regarding the ability to opt out of disclosure of information among affiliates; and
- A description of the types of financial information about former policyholders that may be disclosed and a description of the types of affiliates and nonaffiliated third parties to whom financial information about former policyholders may be disclosed.

Individuals may submit to any insurance institution, agent, or insurance-support organization a written request for access to recorded personal information about the individual that is reasonably described by the individual and reasonably able to be located and retrieved.

After receiving a request, the entity or agent has **30 business days** to

- Inform the individual of the nature and substance of the recorded personal information in writing, by telephone, or by other oral communication;
- Permit the individual to see and copy, in person, the recorded personal information or to obtain a copy of the recorded personal information by mail;
- Disclose to the individual the identity, if recorded, of people to whom the personal information has been disclosed within 2 years prior to such request (if the identity is not recorded, the names of people to whom such information is normally disclosed); and
- Provide the individual with the process to request the correction, amendment, or deletion of recorded personal information.

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Any personal information provided must identify the source of the information if it is an institutional source.

After receiving a written request from an individual to correct, amend, or delete any recorded personal information about the individual, an insurance institution, agent, or insurance-support organization has **30 business days** to

- Correct, amend, or delete the portion of the recorded personal information in dispute; or
- Notify the individual of
    - Its refusal to make the correction, amendment, or deletion;
    - The reasons for the refusal; and
    - The individual's right to file a statement regarding the refusal.

An insurance institution, agent, or insurance-support organization may not disclose any medical-record information or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is with the **written authorization** of the individual, provided

- If submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the following requirements:
    - Is written in plain language;
    - Is dated;
    - Specifies the types of persons authorized to disclose information about the individual;
    - Specifies the nature of the information authorized to be disclosed;
    - Names the insurance institution or agent and identifies by generic reference representatives of the insurance institution to whom the individual is authorizing information to be disclosed;
    - Specifies the purposes for which the information is collected; and
    - Specifies the length of time such authorization shall remain valid; or
- If submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is
    - Dated,
    - Signed by the individual, and
    - Obtained 2 years or less prior to the date a disclosure is sought.

HEALTH

Insurance for Senior Citizens and Special Needs Individuals

B. Medicare Supplement Insurance

5. Virginia Regulations and Required Provisions

Continuation and Conversion Requirements

Medicare Supplement policies must provide for benefits and premiums to be suspended at the policy or certificateholder's request for the period he or she has applied for (up to 24 months) in which he or she is entitled to medical assistance under Medicaid. The policyholder must notify the insurer within 90 days after becoming entitled to assistance.

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If the policyholder loses such entitlement, the policy must be automatically reinstituted. The policyholder must notify the insurer of loss of entitlement within 90 days after the date of loss and pay the premium attributable to the period. Reinstituted coverage may not provide any waiting period for pre-existing conditions, must be substantially equivalent to the coverage in effect before the suspension, and must classify premiums on terms at least as favorable to the policyholder as those that would have applied had the coverage not been suspended.

Supplement Policies for those Eligible by Reason of Disability

Any type of insurer that issues Medicare supplement policies to persons eligible for Medicare based on age must offer at least one policy to Virginia residents who are

- Under 65 years of age;
- Eligible to Medicare by reason of disability; and
- Enrolled in Medicare Part A and B, or will be by the effective date of coverage.

Such policies must be offered upon the request of the individual:

- In the first 6 months after the individual is eligible for Medicare by reason of a disability; or
- During the 63-day period following voluntary or involuntary termination of coverage under a group health plan.

A Medicare supplement policy issued to an individual eligible by reason of disability may not exclude benefits based on a pre-existing condition if the individual has a continuous period of creditable coverage of at least 6 months as of the effective date of coverage.

Insurance Regulation

F. Federal Regulation

3. ACA-Related Federal Market Reforms

Excepted Benefits

The renewability, eligibility, and benefit requirements for the individual health insurance market do not apply to the following limited lines coverages and are considered excepted benefits under all circumstances:

- Accident-only coverage;
- Disability income insurance; and
- Credit-only insurance.

In addition, the following are also excepted benefits if provided under a separate policy, certificate, or contract of insurance and if they meet certain requirements:

- Limited dental or vision benefits;
- Specified disease or illness (for example, cancer policies); and
- Hospital indemnity or other fixed indemnity insurance.

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