Regulatory Bulletin 2009-05
Attachment A

STATE OF ARIZONA
LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM
INSURER CERTIFICATION FORM

The State of Arizona has implemented a Long-Term Care Insurance Partnership Program (the "Partnership Program") as authorized by the Deficit Reduction Act of 2005 ("DRA"), which provides that an Arizona resident who purchases a long-term care insurance policy that meets federal consumer protection and inflation protection requirements (a "Partnership Policy") is subject to special rules for determining financial eligibility for long-term care Medicaid assistance.

The Arizona Insurance Director will certify whether a long-term care insurance policy qualifies as a Partnership Policy, based on the information an insurer provides in this Insurer Certification Form. Insurers must use this form when requesting certification for any policy, whether it is: (i) a previously approved policy; (ii) a new policy submitted for first time approval; and, (iii) policies exempt from filing under the 2003 Director's Order. (See Docket No. 03A-143-INS). (http://www.id.state.az.us/publications/LDExempt2003Order.pdf)

I. INSURER INFORMATION

A. Insurer NAIC number _____

B. Name, address, and telephone number of Insurer:

_____

_____

_____

C. Name, address, telephone number, and email address (if available) of an employee of Insurer who will be the contact person for information relating to this form:

_____

_____

_____

II. POLICY INFORMATION

Note: Please complete one Insurer Certification Form for each policy you are certifying as a Partnership Policy.

A. If you are submitting this Certification Form for a **previously approved form or an exempt in force form** please complete the following table.

Was this a Paper Filing? Yes ○ No ○
SERFF Tracking Number (as Applicable): _____
State Tracking Number (as Applicable): _____

Policy/Rider/Endorsement Form Number	Policy/Rider/Endorsement Form Name	Date of Approval or "Exempt," as Applicable

B. If you are submitting this Certification Form as **part of a new filing for review and approval or with reference to a new exempt form**, please complete the following table.

Policy/Rider/Endorsement Form Number	**Policy/Rider/Endorsement Form Name**	**Date of Approval or "Exempt," as Applicable (for Insurance Department use only)**

III. POLICY REQUIREMENTS

Please answer each of the following questions with respect to each form identified in section II.A or II.B above. In order for a policy to qualify as a Partnership Policy, the answers to all the following requirements should be "yes" (or "N/A" where a requirement with respect to a provision is not applicable). **Please provide an explanation for all "N/A" responses.**

(1) Does each policy, rider and endorsement listed in section II.A or II.B comply with the 2000 NAIC Model Regulation requirements listed below?

Yes ○ No ○ N/A ○	A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.
Yes ○ No ○ N/A ○	B. Section 6B (relating to prohibitions on limitation and exclusions) other than paragraph (7) thereof.
Yes ○ No ○ N/A ○	C. Section 6C (relating to extension of benefits).
Yes ○ No ○ N/A ○	D. Section 6D (relating to continuation or conversion of coverage).
Yes ○ No ○ N/A ○	E. Section 6E (relating to discontinuance and replacement of policies).
Yes ○ No ○ N/A ○	F. Section 7 (relating to unintentional lapse).
Yes ○ No ○ N/A ○	G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
Yes ○ No ○ N/A ○	H. Section 9 (relating to required disclosure of rating practices to consumer).
Yes ○ No ○ N/A ○	I. Section 11 (relating to prohibitions against post-claims underwriting).
Yes ○ No ○ N/A ○	J. Section 12 (relating to minimum standards).
Yes ○ No ○ N/A ○	K. Section 14 (relating to application forms and replacement coverage).
Yes ○ No ○ N/A ○	L. Section 15 (relating to reporting requirements).
Yes ○ No ○ N/A ○	M. Section 22 (relating to filing requirements for marketing).
Yes ○ No ○ N/A ○	N. Section 23 (relation to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
Yes ○ No ○ N/A ○	O. Section 24 (relating to suitability).
Yes ○ No ○ N/A ○	P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
Yes ○ No ○ N/A ○	Q. The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(g)(4)).
Yes ○ No ○ N/A ○	R. Section 29 (relating to standard format outline of coverage).
Yes ○ No ○ N/A ○	S. Section 30 (relating to requirement to deliver shopper's guide).

(2) Does each policy, rider and endorsement listed in section II.A or II.B comply with the 2000 NAIC Model Act requirements listed below?

Yes ○ No ○ N/A ○	A. Section 6C (relating to preexisting conditions).
Yes ○ No ○ N/A ○	B. Section 6D (relating to prior hospitalization).
Yes ○ No ○ N/A ○	C. The provisions of section 8 relating to contingent nonforfeiture benefits.
Yes ○ No ○ N/A ○	D. Section 6F (relating to right to return).
Yes ○ No ○ N/A ○	E. Section 6G (relating to outline of coverage).
Yes ○ No ○ N/A ○	F. Section 6H (relating to requirements for certificates under group plans).
Yes ○ No ○ N/A ○	G. Section 6J (relating to policy summary).
Yes ○ No ○ N/A ○	H. Section 6K (relating to monthly reports on accelerated death benefits).
Yes ○ No ○ N/A ○	I. Section 7 (relating to incontestability period).

(3) Does the policy listed in section II.A or II.B comply with the inflation protection requirements of 42 U.S.C. § 1396p(b)(1)(C)(iii)(IV)? Yes ○ No ○

IV. CERTIFICATION

I hereby certify that the answers, accompanying documents, and other information set forth herein for certification of the listed forms are to the best of my knowledge and belief, true, correct, and complete and that the policies identified in this form meet all of the consumer protection and inflation protection requirements pertaining to qualified Long-Term Care Insurance Partnership Policies. I understand that false, inaccurate or incomplete information on this certification form or accompanying documents may result in disapproval of listed policies for use in Arizona and/or other administrative sanctions.

_____ _____

Date Signature

Required Contact Information:

Name and Title of Certifying Officer: _____

Phone Number: _____

Fax Number: _____

E-Mail Address: _____

Mailing Address: _____

Reset Form