Subchapter C. Consumer Notices for Life Insurance Policy and Annuity Contract Replacements
28 TAC §§4.201 - 4.206

Subchapter F. Individual Life Insurance Policy Form Checklist and Affirmative Requirements
28 TAC §§4.601 - 4.608, 4.611, and 4.613 - 4.628

Subchapter J. Life - Indeterminate Premium Reduction Policies
28 TAC §§4.1001, 4.1002, 4.1004, 4.1005, 4.1008, 4.1010, and 4.1011

Subchapter K. Life - Standards for Acceleration-of-Life-Insurance Benefits for Individual and Group Policies and Riders
28 TAC §§4.1101 - 4.1104 and 4.1106 - 4.1116

Subchapter L. Life - Insurance Sold in Connection with Prepaid Funeral Contracts
28 TAC §4.1201

Subchapter O. Life - Variable Life Insurance
28 TAC §§4.1502 - 4.1510

Subchapter P. Life - Required Reinstatement Relating to Mental Incapacity of the Insured for Individual Life Policies Without Nonforfeiture Benefits
28 TAC §§4.1602 - 4.1606 and 4.1609 - 4.1613

Subchapter Q. Life - Nonforfeiture Standards for Individual Life Insurance in Employer Pension Plans
28 TAC §§4.1702 - 4.1707

Subchapter U. Variable Annuities
28 TAC §§4.2102 - 4.2106

Subchapter W. Annuity Disclosures

Division 1. Annuity Contract Disclosures
28 TAC §§4.2302, 4.2304, and 4.2306 - 4.2312

Division 2. Annuity Suitability Disclosures
28 TAC §4.2322

Subchapter AA. Mortality Tables

Division 1. Annuity Mortality Tables
28 TAC §*§*4.2701, 4.2702, 4.2705, and 4.2706

Division 2. Smoker-Nonsmoker Composite Mortality Tables
28 TAC §§4.2712 - 4.2716

Division 3. 2001 CSO Mortality Table
28 TAC §§4.2721 - 4.2726

Division 4. Preferred Mortality Tables
28 TAC §§4.2731 - 4.2734

Subchapter BB. Life and Annuity Reserves

Division 1. Actuarial Opinion and Memorandum Regulation
28 TAC §§4.2801 - 4.2808

Division 2. Strengthened Reserves Under Insurance Code §425.067
28 TAC §4.2811

Division 3. Valuation of Life Insurance Policies
28 TAC §§4.2821 - 4.2827 and 4.2829

Division 4. Preneed Life Insurance Minimum Mortality Standards for Determining Reserve Liabilities and Nonforfeiture Values
28 TAC §§4.2831 - 4.2836

INTRODUCTION. The commissioner of insurance adopts the repeal of 28 TAC §4.1117. The commissioner of insurance adopts the amendments to 28 TAC §§4.201 - 4.206, 4.601 - 4.608, 4.611, 4.613 - 4.628, 4.1001, 4.1002, 4.1004, 4.1005, 4.1008, 4.1010, 4.1011, 4.1101 - 4.1104, 4.1106 - 4.1116, 4.1201, 4.1502 - 4.1509, 4.1602 - 4.1606, 4.1609 - 4.1613, 4.1703, 4.1705 - 4.1707, 4.2102 - 4.2106, 4.2302, 4.2304, 4.2306 - 4.2312, 4.2322, 4.2701, 4.2702, 4.2705, 4.2706, 4.2712 - 4.2716, 4.2721 - 4.2726, 4.2731 - 4.2734, 4.2801 - 4.2808, 4.2811, 4.2821 - 4.2823, 4.2825 - 4.2827, 4.2829, and 4.2831 - 4.2836 without changes to the proposed text published in the September 22, 2023, issue of the *Texas Register* (48 TexReg 5466).

Sections 4.1510, 4.1702, 4.1704, and 4.2824 are adopted with nonsubstantive changes to the proposed text. In §4.1510, the Texas Department of Insurance (TDI) has removed an unnecessary reference to "Subchapter O" in a citation; in §4.1702 and §4.1704, TDI has revised an incorrect date in the title of two mortality tables by replacing "1908" with "1980"; and in §4.2824, TDI has corrected punctuation. In addition, TDI has revised the Subchapter BB, Division 2 title to replace "pursuant to" with "under."

REASONED JUSTIFICATION. On July 28, 2023, the *Texas Register* published notice (48 TexReg 4127) of the administrative transfer of certain subchapters concerning life insurance and annuity products from Chapter 3 to new Chapter 4 in Title 28 of the Texas Administrative Code.

The administrative transfer revised each subchapter and section designation included in the transfer to reflect its new location in Chapter 4, but no rule text was amended during the transfer. This adoption order updates internal section and figure citations made obsolete by the administrative transfer.

As part of the administrative transfer notice, a comparison table illustrating the new organization and designations of subchapters, divisions, and sections in Chapter 4 was published in the *Texas Register*. The transfer table is available on TDI's website at www.tdi.texas.gov/rules/2023/index.html.

In addition to amendments that correct citations, nonsubstantive changes include:

- adding or amending Insurance Code section titles and citations for accessibility and consistency with agency rule drafting style preferences;

- updating TDI contact information, including mailing, physical, and website addresses; and

- correcting punctuation, capitalization, and grammar to reflect current agency drafting style and plain language preferences, as appropriate.

Specifically, amendments to multiple sections include the deletion of "shall" or replacement of "shall" with "must" or another context-appropriate word. The purpose of changing the word "shall" is to provide plain language clarification of the rule text, consistent with current agency style and guidance on the TDI website. Resources TDI uses for plain language guidance include plainlanguage.gov, which provides federal plain language guidelines, and the National Archives guidelines for clear legal documents. Both sources advise using alternatives to the word "shall" to provide clarity for readers.

The adoption replaces "pursuant to" with "under" or "in accordance with," as appropriate; replaces "subchapter" or "chapter" with "title" in citations to other sections in Title 28 of the Texas Administrative Code; and removes "the" when not needed before "Insurance Code." These amendments, along with other nonsubstantive amendments discussed in the following paragraphs, reflect current agency drafting style, adhere to plain language practices, and promote consistency in TDI rule text.

In addition, the administrative transfer and adopted amendments (1) enhance accessibility through thoughtful reorganization, (2) promote readability through nonsubstantive plain language amendments, (3) preserve the capacity of Chapter 4 with deliberate organization, and (4) restore the capacity of Chapter 3 for future rulemaking projects.

This adoption also includes nonsubstantive amendments to provisions related to the National Association of Insurance Commissioners (NAIC) rules, regulations, directives, or standards. Because the rules relate to NAIC rules, regulations, directives, or standards, Insurance Code §36.004 requires TDI to consider whether authority exists to enforce or adopt the provisions. TDI has determined that §36.004 does not prohibit the amendments because they are nonsubstantive updates that do not change or expand previously adopted requirements.

The adopted repeal and amendments to the sections are described in detail in the following paragraphs, organized by subchapter.

Subchapter C. Consumer Notices for Life Insurance Policy and Annuity Contract Replacements.

Section 4.201. Purpose. The amendments add the title to the Insurance Code §1114.006 citation and remove "the" before "Insurance Code."

Section 4.202. Definitions. The amendments add the title to the Insurance Code Chapter 4054 citation and remove the word "shall."

Section 4.203. Consumer Notice Content and Format Requirements. The amendments update section and figure citations made obsolete after the administrative transfer. The amendments also update the TDI mailing address where persons may

request forms specified in the subchapter, amend punctuation, and replace "pursuant to" with "under."

Section 4.204. Consumer Notice Regarding Replacement for Insurers Using Agents. The amendments update figure citations made obsolete after the administrative transfer and replace "shall" with "must." No amendments are adopted to the content of the figure.

Section 4.205. Direct Response Consumer Notices. The amendments update figure citations made obsolete after the administrative transfer and replace "shall" with "must." No amendments are adopted to the contents of the figures.

Section 4.206. Filing Procedures for Substantially Similar Consumer Notices. The amendments remove previous §4.206(a), which provided the filing procedure for an insurer subject to Insurance Code Chapter 1114 beginning on December 27, 2007, and ending January 31, 2008, because it is obsolete. The adopted amendments redesignate the remaining subsections and remove the other effective dates in the section.

The amendments also update figure citations made obsolete after the administrative transfer and add or correct titles to the Insurance Code Chapter 1114 and §1701.054 citations. The adoption also replaces multiple citations to filing requirements found in 28 TAC Chapter 3, Subchapter A, with a general citation to 28 TAC Chapter 3, Subchapter A. The amendments also replace "shall" with "must" and "prior to" with "before" and correct grammar by adding "been" to §4.206(a)(1).

Subchapter F. Individual Life Insurance Policy Form Checklist and Affirmative Requirements.

Section 4.601. Payment of Premiums. The amendments replace "which" with "that," "shall" with "will," "thereof to" with "at," and "his" with "the."

Section 4.602. Grace Period. The amendment replaces "shall" with "must."

Section 4.603. Entire Contract. The amendments remove the word "shall" and replace "which" with "that."

Section 4.604. Incontestable Clause. The amendments add the title to the Insurance Code §1101.006 citation, replace the citation and title of §3.118(e) with §4.621(e), replace "which" with "that," and remove "whatsoever."

Section 4.605. Statements of the Insured. The amendments add the title to the Insurance Code §705.004 citation and replace "which" with "that."

Section 4.606. Misstatement of Age. The amendments replace "shall be such as" with "is the amount that" and amend punctuation.

Section 4.607. Policy Loans. The amendments add the title to the Insurance Code Chapter 1110 citation; amend punctuation; remove "of," "herein," and one instance of "thereon"; replace "which" with "that," "thereto" with "to the policy," "therefor" with "for the loan," and "thereon" with "on the loan"; and add "of the policy" and "in this subchapter" to clarify the sentence given the removal of "thereon" and "herein" from the subsection.

Section 4.608. Automatic Nonforfeiture Benefits. The amendment adds the title to the Insurance Code Chapter 1105 citation.

Section 4.611. Reinstatement. The amendments replace "which" with "that," "shall" with "must," "shall be" with "is," and "shall not have" with "has not."

Section 4.613. Family Group Special Requirements. The amendments replace "shall" with "must" and "which" with "that."

Section 4.614. Dependent Child Riders and Family Term Riders. The amendments add the corresponding titles to the Insurance Code §1101.006 and §1105.007 citations, amend punctuation, and replace "prior to" with "before."

Section 4.615. Requirements for a Package Consisting of a Deferred Life Policy with an Accidental Death Rider Attached. The amendments add the title to the Insurance Code Chapter 1701 citation and replace "which" with "that."

Section 4.616. Substitute or Change of Insured Riders. The amendments add the word "and" at the end of §4.616(d)(3) to clarify that all elements in §4.616(d) must be clearly described. The adoption also replaces the word "shall" with "must" and amends punctuation.

Section 4.617. Preliminary Term Life Insurance. The amendments add "and" after §4.617(1) to clarify that both requirements apply to a contract of life insurance containing a preliminary term insurance rider. The amendments also correct the spelling of "contestability."

Section 4.618. Conversion Provision. The amendments add "and" after §4.618(3) to clarify that a conversion provision in a policy must comply with the requirements in the section. The adoption also replaces "shall" with "must."

Section 4.619. Limitations of Lawsuits. The amendment replaces "shall accrue" with "accrues."

Section 4.620. Backdating Policies. The amendments replace "which" with "that," "that which" with "what," "his" with "their," and "prior to" with "before" and remove "thereby."

Section 4.621. Settlement at Maturity. The amendments remove "either of" to reflect that §4.621(c) contains more than two paragraphs, amend punctuation, and replace "which would" with "that."

Section 4.622. Tontine Provisions. The amendments replace "which" with "that."

Section 4.623. Assignment Provisions. The amendments replace "which" with "that."

Section 4.624. Provisions Relating to Dividends, Coupon Benefits, or Other Guaranteed Returns. The amendments add the title to the Insurance Code §841.253 citation and replace "which" with "that."

Section 4.625. Premiums Paid in Advance. The amendments amend punctuation and replace "which" with "that" and "therein" with "in the policy."

Section 4.626. Annuity Contracts. The amendments update section citations made obsolete after the administrative transfer by replacing "Sections 3.101 - 3.128" with "All sections in Subchapter F" and replacing the word "title" with "chapter." The adoption also replaces "which" with "that."

Section 4.627. Certain Prohibited Provisions. The amendments replace "which" with "that."

Section 4.628. Renewal Premium on Term Policies. The amendment replaces "shall" with "must."

Subchapter J. Life - Indeterminate Premium Reduction Policies.

The adoption adds "Life -" to the title of Subchapter J to clarify the applicability of the subchapter.

Section 4.1001. Purpose and Scope. The amendments add the title to the Insurance Code Chapter 541 citation and replace "which" with "that" and "subsequent to" with "after." The adoption also adds "and" after §4.1001(a)(1) to clarify that the subchapter applies to life insurance policies that have both characteristics in §4.1001(a).

Section 4.1002. Policy Form Submission. The amendments replace "its" with "the insurer's" to clarify the subject of §4.1002(a)(1), amend punctuation, and replace "which" with "that."

Section 4.1004. Summary of Provisions. The amendments replace "which" with "that" and "subsequent to" with "after."

Section 4.1005. Relation of Initial to Later Premium Charge. The amendment replaces "which" with "that."

Section 4.1008. Minimum Nonforfeiture Values. The amendments add the title to the Insurance Code Chapter 1105 citation and replace "code" with "Insurance Code." The adoption also removes "wherein" and "are required" and adds "which requires" for clarity.

Section 4.1010. Artificial Maximum Premiums Prohibited. The amendments add the titles to the Insurance Code Chapters 1105 and 425, Subchapter B, citations. The adoption also replaces "subsequent to" with "after" and amends punctuation.

Section 4.1011. General Enforcement. The amendment adds the title to the Insurance Code Chapter 541 citation.

Subchapter K. Life - Standards for Acceleration-of-Life-Insurance Benefits for Individual and Group Policies and Riders.

The adoption adds "Life -" to the title of Subchapter K to clarify the applicability of the subchapter.

Section 4.1101. Purpose; Severability. The amendments remove the capitalization of the first word of paragraphs (1) through (5) of §4.1101(a) to reflect the punctuation of the subsection. The adoption also amends punctuation, removes "shall," and replaces "shall remain" with "remains."

Section 4.1102. Acceleration-of-Life-Insurance: Scope of Benefits. The amendments update section citations made obsolete after the administrative transfer, amend punctuation, and remove "shall" and "either." The adoption also replaces "which" with "that," "Acceleration-of-life-insurance" with "Acceleration-of-Life-Insurance," "that" with "That," and "shall" with "must" or "will."

Section 4.1103. Required Policy Definitions; Evidence of Total and Permanent Disability. The amendments update a section citation made obsolete after the administrative transfer and add the titles to the Insurance Code §1111.052 and §1201.003 citations. The adoption also removes "the" before "Insurance Code" and replaces "shall" with "must." The adoption also clarifies §4.1103(a) by removing "either" and amending punctuation throughout the section.

Section 4.1104. Standards for Medical Diagnoses. The amendments replace "shall" with "must."

Section 4.1106. Methods for Determining Benefits and Allowable Charges and Fees. The amendments replace the capitalized catchlines with lowercased catchlines and amend punctuation. The adoption also replaces "shall" with "must" or "may," "which" with "that," "annum" with "year," "one percent" with "1%," "90 day" with "90-day," "Commissioner" with "commissioner," and "regards" with "regard."

Section 4.1107. Limitations on Reduction of Cash Values. The amendments update a section citation made obsolete after the administrative transfer and replace "Lien Method " with "lien method" and "shall" with "may." The adoption also removes "the" before "Insurance Code," amends punctuation, and adds the title to the Insurance Code Chapter 1105 citation.

Section 4.1108. Pro Rata Reduction of Loan upon Acceleration of Benefits. The amendments update a section citation made obsolete after the administrative transfer and replace "Lien Method" with "lien method."

Section 4.1109. Effect of Acceleration of Benefits on Nonforfeiture Calculations. The amendments add the title to the Insurance Code Chapter 1105 citation, replace "shall" with "must," and remove "the" before "Insurance Code."

Section 4.1110. Calculation of Reserves. The amendments update a section citation made obsolete after the administrative transfer, remove "the" before "Insurance Code," and add titles to the citations for Insurance Code Chapter 425, §425.058, and §425.069. The adoption also replaces "shall" with "must," "which" with "that," and "Lien Method" with "lien method."

Section 4.1111. Unfair, Discriminatory, or Deceptive Practices Prohibited. The amendments add a comma after "Discriminatory" in the section title and add commas in §4.1111(b) for consistency with the amendment to the section title.

The adoption also removes the parentheses around the title to Insurance Code Chapter 541, removes "the" before "Insurance Code," and replaces "shall" with "may."

Section 4.1112. Notice and Disclosure Requirements for Life Insurance Contracts Containing Acceleration-of-Life-Insurance Benefits. The amendments

capitalize "Acceleration-of-Life-Insurance" in the section title and update section citations made obsolete after the administrative transfer.

The adoption also corrects punctuational errors and replaces "shall" with "must," "which" with "that," "section" with "subsection," and "shall be" with "is."

Section 4.1113. Notice and Disclosure Requirements for Marketing Materials. The amendments update section citations made obsolete after the administrative transfer, amend punctuation, and replace "shall" with "must" and "which" with "that." The adoption also adds an "and" at the end of §4.1113(a)(2) to clarify that a disclosure required under the section must include information in §4.1113(a)(1) - (3).

Section 4.1114. Requirements for Acceleration-of-Life-Insurance Benefits That Fund Long-Term Care Expenses. The amendments update section citations made obsolete after the administrative transfer, capitalize "Acceleration-of-Life-Insurance" in the section title, clarify that the citation to Subchapter Y is found in Chapter 3 of Title 28, and correct the title for Chapter 3, Subchapter Y.

The amendments also replace "To" with "to" in the title citation to §4.1115 and "chapter" with "title" and correct capitalization throughout the section for consistency with the punctuation used.

Section 4.1115. Requirements for Benefits Represented to Be Qualified for Favorable Federal Tax Treatment. The amendments update section citations made obsolete after the administrative transfer and correct cited section titles in the rule text. The adoption also replaces "To" with "to" in the title of §4.1115; replaces "his or her" with "their," "shall" with "must" or "may," "long term" with "long-term," "prior to" with "before," and "which" with "that"; removes "shall"; adds "of this paragraph" in §4.1115(b)(2)(B); and amends punctuation.

Section 4.1116. Disclosure Related to Tax Qualification of Benefits and Benefits' Effect on Public Assistance. The amendments update section citations made obsolete after the administrative transfer and remove redundant citations to a section title previously cited in §4.1116. The adoption removes the phrase "a life insurance contract" in §4.1116(b) because it is redundant and amends punctuation throughout the section.

The amendments also replace "back-slashes" with "slashes," "acceleration-of-life insurance" with "acceleration-of-life-insurance," and "regards" with "regard."

Section 4.1117. Effective Date. Section 4.1117 is repealed because the section states the amendments become effective 20 days after the date the adopted rule is filed with the Office of the Secretary of State. This is standard practice for rules under Government Code §2001.036(a) and, as a result, the section is unnecessary.

Subchapter L. Life - Insurance Sold in Connection with Prepaid Funeral Contracts.

The adoption adds "Life -" to the title of Subchapter L to clarify the applicability of the subchapter.

Section 4.1201. Introduction to Joint Memorandum of Understanding. The amendments add the title to the Occupations Code §651.159 citation and update a section citation made obsolete after the administrative transfer.

Subchapter O. Life - Variable Life Insurance.

The adoption adds "Life -" to the title of Subchapter O to clarify the applicability of the subchapter.

Section 4.1502. Definitions. The amendments add a title to the Insurance Code Chapter 1152 citation, add "with" in §4.1502(10), amend punctuation, and replace "which" with "that" and "pursuant to" with "under."

Section 4.1503. Qualifications of Insurer to Issue Variable Life Insurance. The amendments update section citations made obsolete after the administrative transfer, add a title to the Insurance Code Chapter 1152 citation, and correct a title and citation to Chapter 21, Subchapter B, Division 1.

The amendments also remove "concerning notice and hearing" because that citation is outdated and remove "a" before the phrase "life insurance business in this state" to correct the grammar of the sentence. The amendments amend punctuation and replace "subsection" with "section," "which" with "that," "prior to" with "before," "pursuant to" with "under," and "contractholder" with "contract holder."

Section 4.1504. Insurance Contract and Filing Requirements. The amendments add titles to the citations for Insurance Code Chapters 1105 and 1110 and "Chapter 3" to a citation in §4.1504(1)(A). The amendments also replace "chapter" with "title" in relation to the citation to Chapter 3, Subchapter A, and remove a redundant reference to the title of §4.1509.

The amendments also add "and" at the end of §4.1504(3)(P)(v) and §4.1504(4)(A)(iii) to reflect that all the elements listed in those paragraphs must be included under §4.1504(3)(P) and §4.1504(4)(A), and add "or" at the end of §4.1504(5)(C)(iv) to reflect that contracts may offer the dividend options in §4.1504(5)(C)(i) - (v).

The amendments also update section citations made obsolete after the administrative transfer and replace multiple outdated words or terms with language that conforms to current agency drafting style and plain language preferences. These changes

remove "of" and "therefor"; amend punctuation; and replace "which" with "that," "contractholder" with "contract holder," "his or her" with "the insured's," "which result" with "that results," "pursuant to" with "under," "prior to" with "before," "thereof" with "of those provisions," "thereon" with "on the contract," and "subsequent to" with "after."

Section 4.1505. Reserve Liabilities for Variable Life Insurance. The amendments add a title to the Insurance Code Chapter 425, Subchapter B, citation and replace "paid up" with "paid-up" and "which" with "that."

Section 4.1506. Separate Accounts. The amendments add titles to the Insurance Code Chapters 1105 and 1152 citations, update section citations made obsolete after the administrative transfer, and correct a reference to the title of a cited administrative code citation.

The adoption adds "and" at the end of §4.1506(7)(F) to clarify that the insurer must disclose in writing all charges that may be made against the separate account including, but not limited to, the elements in §4.1506(7). The adoption also adds "and" at the end of §4.1506(10)(C)(iii) to clarify the information to be included under §4.1506(10)(C). The adoption also removes an "or" at the end of §4.1506(1)(B)(i) because it is redundant. These amendments clarify the rule requirements but are nonsubstantive in nature and do not change the requirements under the rule.

The adoption also amends punctuation and replaces "pursuant to" with "under," "prior to" with "before," "which" with "that," "thereunder" with "under the contract" or "adopted under that section," "which evidences" with "evidencing," and "contractholders" with "contract holders."

Section 4.1507. Information Furnished to Applicants. The amendments update a section citation made obsolete after the administrative transfer and amend punctuation.

The adoption also replaces "which" with "that," "contractholder" with "contract holder," "the manner in which" with "how," "prior to" with "before," and "shall" with "must," "may," or "will."

Section 4.1508. Application. The amendments add "and" after §4.1508(2) to clarify that the application for a variable life contract must contain all the elements in the section and replace "shall" with "must" and "which" with "that."

Section 4.1509. Reports to Contract Holders. The amendments update a section citation made obsolete after the administrative transfer and add an "and" at the end of §4.1509(2)(D) to clarify that a statement or statements provided annually to contract holders must contain the elements listed in the paragraph.

The adoption also replaces "contractholder" with "contract holder" in the section title and in rule text and replaces "shall" with "must," "pursuant to" with "under," "of" with "or," which" with "that," "prior to" with "before," "therein" with "in the statement" and "his or her" with "their."

Section 4.1510. Separability. The amendments replace the range of section citations with the corresponding citation to Subchapter O and change "title" to chapter." The adoption also removes "thereby," amends the title of Subchapter O for consistency with adopted changes to the subchapter's title, and replaces "thereof" with "of such provisions" and "shall" with "will."

The text as proposed has been changed to correct an error in §4.1510 by removing "of Subchapter O" in a citation because it is unnecessary.

Subchapter P. Life - Required Reinstatement Relating to Mental Incapacity of the Insured for Individual Life Policies Without Nonforfeiture Benefits.

The adoption adds "Life -" to the title of Subchapter P to clarify the applicability of the subchapter.

Section 4.1602. Applicability. The amendments update a section citation made obsolete after the administrative transfer, remove punctuation, and replace "which" with "that."

Section 4.1603. Severability. The amendment removes "shall."

Section 4.1604. Definitions. The amendments remove "shall"; amend punctuation; and replace "Incapacity" with "incapacity" and "Commissioner of Insurance" with "commissioner of insurance."

Section 4.1605. Eligibility Requirements. The amendments remove the language "set forth in paragraphs (1) - (4) of this subsection" at the end of the first sentence in §4.1605 to simplify and clarify the provision. The section is not broken into subsections and there are only four paragraphs in the section, so it is not necessary to list each paragraph. The amendments add the word "following" to clarify the sentence given the removal and replace "shall" with "must" and "prior to" with "before."

Section 4.1606. Payment of Past Due Premiums. The amendment replaces "annum" with "year."

Section 4.1609. Notification and Disclosure Requirements. The amendments update section citations made obsolete after the administrative transfer, remove a cited section title that is redundant, amend punctuation, and replace "thereto" with "to the policy" and "which" with "that."

Section 4.1610. Reinstatement Procedures. The amendment replaces "shall" with "must."

Section 4.1611. Reduced Benefits. The amendments replace "shall" with "must."

Section 4.1612. Form Filing Procedures. The amendments update section citations made obsolete after the administrative transfer and remove two redundant section title citations. The amendments also add "Chapter 3" to the citation in §4.1612(c) and amend the title of Subchapter A in §4.1612(c).

Section 4.1613. Notice and Disclosure Form. The amendments update section and figure citations made obsolete after the administrative transfer. The amendments also remove a redundant title citation and replace "shall" with "must." No amendments are adopted to the contents in the figures.

Subchapter Q. Life - Nonforfeiture Standards for Individual Life Insurance in Employer Pension Plans.

The adoption adds "Life -" to the title of Subchapter Q to clarify the applicability of the subchapter.

Section 4.1702. Definitions. The amendments remove "shall," correct punctuation, and replace "National Association of Insurance Commissioners" with "NAIC" for consistency. The amendments also correct the case law citation in §4.1702(8) by italicizing the names of the parties for consistency with §4.1703.

The text as proposed has been changed to correct an error in §4.1702(3) by replacing "1908 CET Table (M)" with "1980 CET Table (M)."

Section 4.1703. Standard. The amendments change the *Norris* case law citation in §4.1703(d) to reflect the same case law citation used in §4.1702(8) for consistency. The amendments also remove an unnecessary reference to a list of insurance code sections, update the TDI mailing address; add the titles to the citations for Insurance Code Chapter

425, Subchapter B, and Chapter 1105, Subchapter B; remove "herein"; and replace "paid up" with "paid-up" and "which" with "that."

Section 4.1704. Alternate Rule. The amendments update a section citation made obsolete after the administrative transfer, remove an unnecessary reference to a list of insurance code sections, and add titles to the citations for Insurance Code Chapter 425, Subchapter B, and Chapter 1105, Subchapter B. The amendments also update the TDI mailing address and replace "which" with "that."

The text as proposed has been changed to correct an error in §4.1704(a)(1) by replacing "1908 CSO Table" with "1980 CSO Table."

Section 4.1705. Unfair Discrimination. The amendment adds a title to the Insurance Code §541.057 citation.

Section 4.1706. Severability. The amendments remove "thereby" and replace "shall" with "will" and "thereof" with "of these provisions."

Section 4.1707. 2001 CSO Mortality Table. The amendments replace the sections cited with a citation to "Subchapter AA, Division 3" and replace "shall" with "must," "pursuant to" with "under," and "title" with "chapter."

Subchapter U. Variable Annuities.

Section 4.2102. Definitions. The amendments add a title to the Insurance Code Chapter 1152 citation, amend punctuation, and replace "which" with "that," "pursuant to" with "under," and "contractholder" with "contract holder."

Section 4.2103. Qualifications of Insurer to Issue Variable Annuities. The amendments replace "To" with "to" in the section title and update a section citation made obsolete after the administrative transfer.

The amendments also amend punctuation and replace "he or she" with "the commissioner"; "State Board of Insurance" with "Department of Insurance"; "which" with "that"; and "shall" with "must," "may," or "will."

Section 4.2104. Separate Accounts. The amendments add a title to the Insurance Code Chapter 1152 citation and update section citations made obsolete after the administrative transfer. The amendments also remove redundant instances of "or" at the end of §4.2104(a)(2)(A) and §4.2104(j)(1) and add "and" at the end of §4.2104(j)(3)(C) to clarify that the insurer must include all the information in paragraph (3), if applicable.

The amendments also replace "To" with "to" in a title citation, amend punctuation, and replace "which" with "that," "contractholders" with "contract holders," "prior to" with "before," "pursuant to" with "under," and "thereunder" with "adopted under that section" or "under the contract," as appropriate.

Section 4.2105. Contract Requirements. The amendments replace outdated Insurance Article citations with current Insurance Code citations and their corresponding titles. The amendments also replace a citation and title to "Board Order 40701" with "Chapter 3, Subchapter A" and its corresponding title citation.

The amendments also amend punctuation throughout, remove "thereunder" and "the" before "Internal Revenue Code," and replace "which," "as of which," or "of which" with "that"; "him or her" or "his or her" with "the commissioner" or "the contract holder," as appropriate; "chapter" with "title"; "prior to" with "before"; "contractholder" with "contract holder"; "pursuant to" with "under"; "shall have" with "has"; "previous to" with "before"; "subparagraph" with "subparagraphs"; and "shall" with "must," "may," "will," or "do."

Section 4.2106. Separability. The amendments remove "thereby" and replace "thereof" with "of these sections" and "shall" with "will."

Subchapter W. Annuity Disclosures.

Division 1. Annuity Contract Disclosures.

Section 4.2302. Applicability and Scope. The amendments remove "the" before Insurance Code and Finance Code for consistency, add titles to the Insurance Chapter 102 citation and the Finance Code Chapter 154 citation, and amend punctuation.

Section 4.2304. Definitions. The amendments update a section citation made obsolete after the administrative transfer and add titles to the Insurance Code Chapter 102 and 4054 citations. The amendments also remove "the" before Insurance Code and "shall" throughout the section and replace "subchapter" with "title."

Section 4.2306. Guaranteed and Non-Guaranteed Elements. The amendments update section citations made obsolete after the administrative transfer, replace "Non-guaranteed" with "Non-Guaranteed" in the section title, and replace "subchapter" with "title."

Section 4.2307. Effect on Other Law. The amendments replace "pursuant to" with "under."

Section 4.2308. Required Consumer Notices. The amendments update section citations made obsolete after the administrative transfer and add the title to the Insurance Code §1152.110 citation. The amendments remove "the" before Insurance Code, amend punctuation, and replace "subchapter" with "title," "Internet" with "internet," "which" with "and," "prior to" with "before," and "shall" with "must" or "will."

Section 4.2309. Disclosure Document. The amendment replaces "shall" with "must."

Section 4.2310. Buyer's Guide. The amendments correct punctuation and replace "NAIC" with "National Association of Insurance Commissioners (NAIC)" and "SEC's" with "Securities and Exchange Commission (SEC)."

Section 4.2311. Free Look Period. The amendments replace "shall" with "must" and "shall mean" with "means."

Section 4.2312. Report to Contract Owners. The amendment replaces "shall" with "must."

Division 2. Annuity Suitability Disclosures.

Section 4.2322. Required Forms. The amendments add "(NAIC)" at the end of the first use of "National Association of Insurance Commissioners" and then replace all instances of "National Association of Insurance Commissioners" with "NAIC." The adoption also removes "Texas" before "Insurance Code" for consistency with current agency rule drafting style.

Subchapter AA. Mortality Tables.

Division 1. Annuity Mortality Tables.

Section 4.2701. Purpose. The amendments update section and figure citations made obsolete after the administrative transfer. No amendments are adopted to the contents in the figures.

Section 4.2702. Definitions. The amendments update a section citation made obsolete after the administrative transfer, replace "Actuaries'" with "Actuaries" and "table"

with "Table," and amend punctuation. The amendments also add "(NAIC)" at the end of the first use of "National Association of Insurance Commissioners" and then replace all instances of "National Association of Insurance Commissioners" with "NAIC."

Section 4.2705. Application of the 1994 GAR Table. The amendments update a figure citation made obsolete after the administrative transfer. No amendments are adopted to the content in the figure.

Section 4.2706. Application of the 2012 IAR Mortality Table. The amendments update figure citations made obsolete after the administrative transfer. Amendments to figure citations are adopted in both the rule text and the text of Figure: 28 TAC §4.2706.

Division 2. Smoker-Nonsmoker Composite Mortality Tables.

Section 4.2712. Definitions. The amendments update punctuation and remove "shall."

Section 4.2713. Alternate Tables. The amendments update section citations made obsolete after the administrative transfer, remove an unnecessary reference to a list of insurance code sections in two places, and add the title to the Insurance Code, Chapter 1105, Subchapter B, citation. The amendments also remove a redundant title to a section cited earlier in §4.2713, amend punctuation, update a TDI mailing address, remove "herein," and replace "paid up" with "paid-up."

Section 4.2714. Conditions. The amendment adds the title to the Insurance Code §425.068 citation.

Section 4.2715. Severability. The amendments remove "thereby" and replace "thereof" with "of these sections" and "shall" with "will."

Section 4.2716. 2001 CSO Mortality Table. The amendments update section citations made obsolete after the administrative transfer and replace "shall" with "must," "pursuant to" with "under," and "title" with "chapter."

Division 3. 2001 CSO Mortality Table.

Section 4.2721. Purpose. The amendments update a section citation made obsolete after the administrative transfer and add titles to the citations for Insurance Code Chapter 425, Subchapter B; §425.058; and §1105.055.

Section 4.2722. Definitions. The amendments update punctuation, remove "shall," and capitalize "Mortality."

Section 4.2723. 2001 CSO Mortality Table. The amendments update section citations made obsolete after the administrative transfer and add titles to the citations for Insurance Code Chapter 425, Subchapter B; §425.058; and §1105.055. The adoption also corrects a citation from Insurance Code "§1055.055(h)" to "§1105.055(h)" in §4.2723(b).

The amendments also remove a redundant title to a section cited earlier in §4.2723; replace "Commissioner of Insurance" with "commissioner," "title" with "chapter," and "pursuant to" with "under"; and update a TDI mailing address and the TDI website where the 2001 CSO Mortality Table may be accessed.

Section 4.2724. Conditions. The amendments update section citations made obsolete after the administrative transfer and add the title to the Insurance Code §425.068 citation. The amendments also replace "Chapter 3, Subchapter EE" with "Chapter 4, Subchapter BB, Division 3" in a title citation and correct inconsistent capitalization in §4.2724(a)(1) - (3) to reflect the punctuation used in the section.

Section 4.2725. Applicability of the 2001 CSO Mortality Table to Chapter 4, Subchapter BB, Division 3 of this Title. The amendments update section citations made obsolete after the administrative transfer and replace "Chapter 3, Subchapter EE" with "Chapter 4, Subchapter BB, Division 3" in the section title and rule text. The amendments also amend punctuation, replace "shall be" with "is" and "shall" with "may," and remove "shall," as appropriate.

Section 4.2726. Gender-Blended Tables. The amendments add titles to the citations for Insurance Code Chapter 541 and Chapter 425, Subchapter B; and update the TDI mailing address and the TDI website where the blended tables developed by the American Academy of Actuaries CSO Task Force may be accessed.

Division 4. Preferred Mortality Tables.

Section 4.2731. Purpose. The amendments update a section citation made obsolete after the administrative transfer and add titles to the Insurance Code Chapter 425, Subchapter B and §425.058 citations.

Section 4.2732. Definitions. The amendments remove "shall" and amend punctuation.

Section 4.2733. 2001 CSO Preferred Class Structure Table. The amendments update section citations made obsolete after the administrative transfer and add the title to the Insurance Code Chapter 425, Subchapter B citation. The amendments also replace "pursuant to" with "under" and "prior to" with "before" and update the TDI mailing address and the TDI website where the 2001 CSO Preferred Class Structure Mortality Table may be accessed.

Section 4.2734. Conditions. The amendments update punctuation and replace "NAIC" with "National Association of Insurance Commissioners (NAIC)," "prior to" with "before," and "shall" with "must" or "will."

Subchapter BB. Life and Annuity Reserves.

Division 1. Actuarial Opinion and Memorandum Regulation.

Section 4.2801. Purpose. The amendments remove the language "described in paragraphs (1) - (3) of this section" at the end of the first sentence in §4.2801 to simplify and clarify the provision. The section is not broken into subsections and there are only three paragraphs in the section, so it is not necessary to list out each paragraph. The amendments also add the word "following" to clarify the sentence given the removal and add the title to the Insurance Code §425.054 citation.

Section 4.2802. Scope and Applicability. The amendments update section citations made obsolete after the administrative transfer and add the title to the Insurance Code Chapter 425, Subchapter B citation. The amendments also replace "thereof" with "of the statement of opinion," "shall apply" with "applies," "shall have" with "has," "shall be" with "is," "which" with "that," "his or her" with "their," and "shall" with "must."

Section 4.2803. Commissioner Discretion. The amendments update section citations made obsolete after the administrative transfer and replace "which" with "that."

Section 4.2804. Definitions. The amendments update section citations made obsolete after the administrative transfer and add titles to the Insurance Code §884.307 and §884.402 citations. The adoption also amends punctuation; removes "shall"; and replaces "pursuant to" with "under," "his or her" with "their," and "which includes" with "including."

Section 4.2805. General Requirements. The amendments update a section citation made obsolete after the administrative transfer and add titles to the Insurance Code §§425.054, 425.064, 425.065, 425.068, and 425.069 citations.

Section 4.2806. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis. The amendments update figure and section citations made obsolete after the administrative transfer and add the title to the Insurance Code Chapter 425, Subchapter B citation. The adoption also updates section citations in Figure: 28 TAC §4.2806(b)(2). No other amendments were proposed or are adopted to the contents in the figures.

The amendments replace "be at least" with "include the following" in §4.2806(f)(1)(C)(ii) for clarity and amend punctuation. The adoption also capitalizes the words beginning each paragraph in §4.2806(f)(1) to reflect the amended punctuation and replaces "subsequent to" with "before" and "being" with "may be" in §4.2806(f)(1)(B) to clarify that before an alternative statement may be issued, the company must file certain requirements.

The amendments also correct a reference to the title of 28 TAC §7.18 and replaces "NAIC" with "National Association of Insurance Commissioners," "that which" with "what," "which" with "that," and "he or she" or "his or her" with "the appointed actuary" or "their."

Section 4.2807. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary. The amendments update section citations made obsolete after the administrative transfer and add titles to the citations for Insurance Code Chapters 401 and 425, Subchapter B. The adoption replaces citations to Insurance Code §§425.054 - 425.057 with Chapter 425, Subchapter B.

The amendments replace a colon at the end of a statement with "the following" and a period and correct capitalization for consistency with the subsection's organization.

The adoption also updates a TDI mailing address; removes "the" before Insurance Code; amends punctuation; and replaces "which" with "that," "his or her" with "the appointed actuary's," and "their" with "the other actuaries.'"

Section 4.2808. Asset Adequacy Analysis Exemption. The amendments update section citations made obsolete after the administrative transfer, capitalize "Commissioner" as it appears in the title for §4.2803, and replace "pursuant to" with "under" and "shall" with "must."

Division 2. Strengthened Reserves Under Insurance Code §425.067. The text as proposed has been changed by replacing "Pursuant to" with "Under."

Section 4.2811. Strengthened Reserves Under Insurance Code §425.067. The amendments add titles to the Insurance Code §425.053 and §425.067 citations and replace "pursuant to" with "under" in the section title.

Division 3. Valuation of Life Insurance Policies.

Section 4.2821. Purpose. The amendments revise capitalization to reflect current agency drafting style.

Section 4.2822. Adoption of Tables of Select Mortality Factors. The amendments update a figure citation made obsolete after the administrative transfer and replace "age last birthday" with "age-last-birthday," "age nearest birthday" with "age-

nearest-birthday," and "which" with "that." No amendments are adopted to the content in the figure.

Section 4.2823. Applicability. The amendments update section citations made obsolete after the administrative transfer and add the title to the Insurance Code Chapter 425, Subchapter B citation. The adoption also amends punctuation and replaces "Nonlevel" with "nonlevel" and "shall" with "does" or "must."

Section 4.2824. Definitions. The amendments update section and figure citations made obsolete after the administrative transfer; remove a redundant title already cited; update punctuation; and replace "subchapter" with "title," "shall" with "must" or "may," and "one percent" with "1%." These amendments are made in the rule text and in the text of Figure: 28 TAC §4.2824(2).

Amendments also add or correct titles to the citations for Insurance Code Chapter 425, Subchapter B and §§425.061, 425.064, and 425.068; remove "shall" and instances of "the" before Insurance Code; replace "one year" with "one-year"; and correct capitalization throughout the section. These nonsubstantive amendments are meant to align the section with other similar sections.

The text of §4.2824(9)(B) as proposed has been changed to insert a missing closing parenthesis.

Section 4.2825. General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves. The amendments update section citations made obsolete after the administrative transfer; correct a title citing to Insurance Code Chapter 425, Subchapter B; and remove a redundant title already cited.

The amendments correct capitalization and add "or" at the end of §4.2825(b)(3)(G)(iii) to reflect that, if select mortality factors are elected, it may be those found in §4.2825(b).

The amendments also remove "the" before "Insurance Code"; amend punctuation; and replace "shall" with "must, "percent" with "%," "prior to" with "before," and "subchapter" or "chapter" with "title."

Section 4.2826. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums of Guaranteed Nonlevel Benefits (Other than Universal Life Policies). The amendments update section citations made obsolete after the administrative transfer; add the title to the Insurance Code Chapter 425, Subchapter B citation; and remove a redundant title already cited. The amendments also update punctuation and replace "prior to" with "before," "subsequent to" with "after," "twenty-four" with "24," and "twenty-five" with "25."

Section 4.2827. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyholder to Keep a Policy in Force Over a Secondary Guarantee Period. The amendments update section citations made obsolete after the administrative transfer; correct capitalization in §4.2827(d) to reflect the subsection organization; amend punctuation; and replace "one year" with "one-year," "which" with "that," and "shall" with "must."

Section 4.2829. 2001 CSO Mortality Table. The amendments update section citations made obsolete after the administrative transfer by replacing "§§3.9101 - 3.9106" with "Subchapter AA, Division 3" and replace "shall" with "must," "title" with "chapter," and "pursuant to" with "under."

Division 4. Preneed Life Insurance Minimum Mortality Standards for Determining Reserve Liabilities and Nonforfeiture Values.

Section 4.2831. Purpose and Applicability. The amendments update a section citation made obsolete after the administrative transfer and replace "of the Insurance Code" with titles to the Insurance Code §425.058 and §1105.055 citations. The amendments also replace "chapter" with "title" and add "Insurance Code" before the Insurance Code citations.

Section 4.2832. Definitions. The amendments add titles to the Finance Code Chapter 541 and §541.002 citations, remove "shall" and "the" before Finance Code, amend punctuation, and replace "which" with "that."

Section 4.2833. Minimum Valuation Mortality Standards. The amendments update a section citation made obsolete after the administrative transfer and replace "subchapter" with "title" and "shall be" with "is."

Section 4.2834. Minimum Valuation Interest Rate Standards. The amendments correct the title for the Insurance Code Chapter 425, Subchapter B and Chapter 1105 citations; remove "the" before Insurance Code; and replace "shall be" with "are."

Section 4.2835. Minimum Valuation Method Standards. The amendments update the titles for the Insurance Code Chapter 425, Subchapter B and Chapter 1105 citations; update punctuations; replace "shall be" with "is"; and remove "the" before "Insurance Code."

Section 4.2836. Transitional Use of the 2001 CSO Mortality Table. The amendments update section citations made obsolete after the administrative transfer by

replacing "§§3.9101 - 3.9106" with "Subchapter AA, Division 3." The adoption also replaces "shall" with "must."

SUMMARY OF COMMENTS. TDI did not receive any comments on the proposed repeal and amendments.

Subchapter C. Consumer Notices for Life Insurance Policy and Annuity Contract Replacements
28 TAC §§4.201 - 4.206

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.201 - 4.206 under Insurance Code §§1114.006, 1114.007, and 36.001.

Insurance Code §1114.006 provides that the commissioner by rule adopt or approve model documents to be used for consumer notices under Insurance Code Chapter 1114.

Insurance Code §1114.007 authorizes the commissioner to adopt reasonable rules in the manner prescribed by Insurance Code Chapter 36, Subchapter A, to accomplish and enforce the purposes of Insurance Code Chapter 1114.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.201. Purpose.

The purpose of this subchapter is to specify the content and procedural requirements for consumer notices for life insurance policy and annuity contract replacements as required by Insurance Code §1114.006, concerning Consumer Notice Documents.

§4.202. Definitions.

When used in this subchapter, the words "agent" and "producer" mean, unless the context clearly indicates otherwise, an individual who holds a license under Insurance Code Chapter 4054, concerning Life, Accident, and Health Agents, and who sells, solicits, or negotiates life insurance or annuities in this state.

§4.203. Consumer Notice Content and Format Requirements.

(a) The text contained in Figure: 28 TAC §4.204(b), Figure: 28 TAC §4.205(1), and Figure: 28 TAC §4.205(2) must be in at least 10-point type and presented in the same order as indicated in each figure and without any change to the specified text, including bolding effects, except as provided in subsections (b), (c), and (d) of this section.

(b) Under §4.206 of this title (relating to Filing Procedures for Substantially Similar Consumer Notices), in lieu of using the notices contained in Figure: 28 TAC §4.204(b) or Figure: 28 TAC §4.205(1), an insurer may file a notice with the department that is substantially similar to the text contained in Figure: 28 TAC §4.204(b) or Figure: 28 TAC §4.205(1) for review and approval by the commissioner. The commissioner will approve the notice if, in the commissioner's opinion, the notice protects the rights and interests of applicants to at least the same extent as the notices adopted in Figure: 28 TAC §4.204(b) or Figure: 28 TAC §4.205(1). An insurer required to send the notice specified in Figure: 28

TAC §4.205(2) may not file a notice that is substantially similar to that figure for review and approval by the commissioner.

(c) Commissioner approval of a notice is not required if a notice promulgated or approved under this subchapter is used and amendments to that notice are limited to the omission of references not applicable to the product being sold or replaced. For purposes of this subchapter, a reference in any notice required under this subchapter to a product that is being sold or replaced is applicable if the reference could be applicable under any possible circumstances and therefore may not be omitted from the required notice.

(d) An insurer may add a company name and identifying form number to notices specified under this subchapter without obtaining commissioner approval.

(e) The promulgated forms specified in this subchapter are available upon request from the Life and Health Division, Life and Health Lines, MC: LH-LHL, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030, or by accessing the department website at www.tdi.texas.gov/forms.

§4.204. Consumer Notice Regarding Replacement for Insurers Using Agents.

(a) An agent who initiates an application for a life insurance policy or annuity contract must submit to the insurer, with or as part of the application, a statement signed by both the applicant and the agent as to whether the applicant has existing life insurance policies or annuity contracts.

(b) If the applicant states that the applicant does have existing policies or contracts, the agent must present and read to the applicant, not later than at the time of taking the application, a notice regarding replacement that contains the text contained in Figure: 28 TAC §4.204(b), or substantially similar notice filed with the department and approved

under this subchapter. The notice must be signed by both the applicant and the agent attesting that the notice has been read aloud by the agent or that the applicant did not wish the notice to be read aloud, in which case the agent is not required to read the notice aloud.

Figure: 28 TAC §4.204(b)

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older--are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

§4.205. Direct Response Consumer Notices.

In the case of a life insurance or annuity application initiated as a result of a direct response solicitation, the insurer must inquire whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue, or change an existing life insurance policy or annuity contract. The inquiry may be included with, or submitted as a part of, each completed application for such policy or contract.

(1) If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer

must send a notice that contains the text in Figure: 28 TAC §4.205(1), or a substantially similar notice filed with the department and approved under this subchapter.

Figure: 28 TAC §4.205(1)

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
___ YES ___NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older--are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

(2) If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer must send the applicant, with the policy or contract, a new policy or contract notice that contains the statements in Figure: 28 TAC §4.205(2).

Figure: 28 TAC §4.205(2)

NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one--or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

§4.206. Filing Procedures for Substantially Similar Consumer Notices.

(a) An insurer may not use, issue, or deliver a notice that is substantially similar to a promulgated consumer notice specified in Figure: 28 TAC §4.204(b) or Figure: 28 TAC §4.205(1) until it has been approved.

(1) An insurer subject to Insurance Code Chapter 1114, concerning Replacement of Certain Life Insurance Policies and Annuities, using agents must either use the text of the notice contained in Figure: 28 TAC §4.204(b), which is not subject to filing and approval, or a consumer notice substantially similar to the text contained in Figure: 28 TAC §4.204(b), which has been filed under this section and approved.

(2) In the case of an applicant responding to a direct response solicitation, an insurer subject to Insurance Code Chapter 1114 must either use the text contained in Figure: 28 TAC §4.205(1), which is not subject to filing and approval, or a consumer notice substantially similar to the text contained in Figure: 28 TAC §4.205(1), which has been filed under this section and approved.

(b) A filing of a consumer notice that is substantially similar to a promulgated consumer notice specified in Figure: 28 TAC §4.204(b) or Figure: 28 TAC §4.205(1) must be filed in accordance with the submission requirements of Chapter 3, Subchapter A of

this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(c) Insurers subject to Chapter 1114 who elect not to use a consumer notice specified in this subchapter must file a notice that is substantially similar to a promulgated consumer notice specified in Figure: 28 TAC §4.204(b) or Figure: 28 TAC §4.205(1) no later than 60 days before use. A consumer notice that is substantially similar to a promulgated consumer notice specified in Figure: 28 TAC §4.204(b) or Figure: 28 TAC §4.205(1) is subject to Insurance Code §1701.054, concerning Approval of Form. Insurers that have filed and received approval of a consumer notice may continue to use the approved consumer notice unless and until such time as the commissioner withdraws approval of the notice.

Subchapter F. Individual Life Insurance Policy Form Checklist and Affirmative Requirements
28 TAC §§4.601 - 4.608, 4.611, and 4.613 - 4.628

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.601 - 4.608, 4.611, and 4.613 - 4.628 under Insurance Code §§541.401, 543.001(c), 1701.060 and 36.001.

Insurance Code §541.401 provides that the commissioner may adopt and enforce reasonable rules necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §543.001(c) provides that the commissioner may adopt and enforce rules as provided by Insurance Code Chapter 541, Subchapter I to accomplish the purposes of §543.001(b)(1), prohibiting misrepresentation, as those purposes relate to life insurance companies.

Insurance Code §1701.060 authorizes the commissioner to adopt reasonable rule necessary to implement the purposes of Insurance Code Chapter 1701.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.601. Payment of Premiums.

(a) The policy must provide that premiums are payable in advance. The policy may provide that the premium is payable at the home office; it may provide that the premium is payable to an agent of the company; or it may provide that the premium is payable at the home office of the company or to an agent of the company.

(b) The policy must provide that a receipt signed by one or more of the officers of the company will be delivered upon payment of the premium. The policy must designate the officers who may sign the receipt. Any manner of "designation" is acceptable if it will enable the policyholder to determine that the receipt has been signed by an authorized person.

(c) A policy that permits a change in the manner of payment of premium (e.g., from annual to semiannual, quarterly, etc.):

(1) may either specify the amount of premiums required for the periods authorized or the formula for the determination of such premiums; or

(2) may define the amounts by appropriate reference to rates being charged at the date of issue.

(d) The policy may provide that any unpaid premiums or installments at the end of the current policy year will be deducted from the proceeds payable on death.

§4.602. Grace Period.

(a) The policy must provide for a grace period of at least one month for the payment of every premium after the first, during which period the policy must remain in full force and effect. If the grace period is expressed in days, at least 31 days of grace must be granted.

(b) The policy may provide for an interest charge on the unpaid premium during the grace period. If an interest charge is provided for, the interest rate must be specified.

(c) The policy may stipulate that if the insured should die during the grace period, the overdue premium or overdue installment will be deducted from any settlement under the policy. If an interest charge is provided against the overdue payment, the accrued interest may also be deducted.

(d) This section is not applicable to single premium policies.

§4.603. Entire Contract.

(a) The policy must provide that the policy, or policy and application, constitute the entire contract between the parties. Regardless of any statement to the contrary, the policy will be deemed incomplete if it attempts to incorporate by reference the provisions of any instrument that changes or adds to the terms of the policy.

(b) Some policy forms contain a provision that the application, if attached, constitute a part of the contract. If a policy containing such a provision is submitted

without the application, the approval will authorize its issuance only without the application.

§4.604. Incontestable Clause.

(a) The policy must provide that it will be incontestable not later than two years from its date as provided in Insurance Code §1101.006, concerning Incontestability. If a reinstatement is contested for misrepresentation, then no representation other than one causing the reinstatement may be used to contest the policy. Any contest of the reinstatement may be for a material and fraudulent misrepresentation only and reinstatement may not be contested more than two years after it is effectuated, provided that this provision does not affect the company's right to contest a policy for a representation respecting the initial policy issuance or a different reinstatement during the incontestable period applicable to such issuance or reinstatement. Accidental death benefits and disability benefits need not be subject to such provision.

(b) Any provision that could lengthen the contestable period of a policy beyond two years from its date is prohibited. For example, the policy may not state that it is incontestable after two years "while the policy is continuously in force."

(c) The policy may contain provisions that allow its validity to be contested at any time for:

(1) nonpayment of premium; or

(2) violation of the conditions of the policy relating to naval or military services in time of war. Note: War clauses are discussed in §4.621(e) of this title (relating to Settlement at Maturity).

(d) If the form under review contains no reference to contest after reinstatement, it will also be acceptable.

(e) If more than one person is insured, the policy form must state that it is incontestable with respect to each insured.

§4.605. Statements of the Insured.

(a) The policy must provide that all statements made by the insured will, in the absence of fraud, be deemed representations and not warranties. The policy may provide that statements made on behalf of the insured will also, in the absence of fraud, be deemed representations and not warranties.

(b) Policy applications sometimes contain agreements that call attention to some, or all, of the elements that must be proved in avoiding the policy for misrepresentation. Such agreements are acceptable, provided:

(1) they do not attempt to burden the insured's representations with the legal consequences of warranties;

(2) they do not attempt to require the insured to prove the nonexistence of grounds upon which the insurer could contest the policy; and

(3) they do not attempt to permit the insurer to avoid liability on grounds less stringent than under Insurance Code §705.004, concerning Policy Provision: Misrepresentation in Policy Application, or other applicable law.

§4.606. Misstatement of Age.

(a) The policy must provide that if the age of the insured has been understated, the amount payable under the policy is the amount that the premium paid would have purchased at the correct age. The word "misstated" may be used instead of "understated."

(b) If more than one life is insured (e.g., by inclusion of premium payor benefits or under family group plan), the amount payable on the death of deceased may be adjusted because of a misstatement in the age of a surviving insured if the actuarial construction of the contract so requires.

§4.607. Policy Loans.

(a) A policy loan provision is not required in term insurance policies, nor in pure endowments issued or granted as original policies or in exchange for lapsed or surrendered policies.

(b) Loans must be made available at any time while the policy is in force after premiums for three full years have been paid and a cash value is available.

(c) The loan clause must provide for proper assignment of the policy to the company.

(d) The policy must be the sole security for the loan.

(e) Insurance Code Chapter 1110, concerning Interest Rates on Certain Policy Loans, deals with interest rates. Insurers may comply with Chapter 1110 by refiling reprinted and renumbered policies with a new loan provision or by filing a loan endorsement that may be attached to newly issued policies on and after an effective date specified by the insurer. The maximum rate of interest must be specified in the policy or

loan endorsement. The policy may provide that interest may be made payable in advance to the end of the current policy year.

(f) The loan clause must provide for lending a sum equal to or, at the option of the policy owner, less than the cash value of the policy and any dividend additions to the policy.

(g) The policy may provide that the company may deduct from such loan value any existing indebtedness on the policy and any unpaid balance of the premium for the current policy year and may collect interest in advance on the loan to the end of the current year.

(h) The policy may provide that loans may be deferred for not more than six months after application for the loan is made. The six-month period may commence with the date of receipt of the request by the company, if the policy so provides.

(i) The loan clause must provide that failure to repay any such advance, or to pay interest on the loan, will not void the policy until the total indebtedness to the company equals or exceeds the cash value of the policy. The policy may not be terminated merely for failure to pay loan interest when due. Since the policy may be voided when the indebtedness equals or exceeds the cash value, this provision may be so worded that benefits cease upon the precise moment that the indebtedness equals such value.

(j) No condition other than as provided in this subchapter will be exacted as a prerequisite to any such loan.

§4.608. Automatic Nonforfeiture Benefits.

(a) Nonforfeiture values are governed by Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance.

(b) Occasionally, the cash value (because of the inclusion of accumulated dividends, coupon benefits, or other guaranteed returns) is more than sufficient to purchase the maximum amount of extended term insurance available under the policy. In such cases, the policy must clearly provide for the equitable disposition of the entire cash value.

(c) Automatic nonforfeiture benefits are not applicable to single premium policies.

§4.611. Reinstatement.

(a) All policies that have nonforfeiture benefits must provide that if, in the event of default in premium payments, the value of the policy must be applied for the purchase of other insurance, and if such insurance is in force and the original policy has not been surrendered to the company and cancelled, the policy may be reinstated within three years, or longer at the option of the company, from such default upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest. Evidence of insurability need not be restricted to evidence of good health only.

(b) If more than one life is insured, evidence of insurability may be required on each individual as a condition precedent to reinstatement of the policy, but the policy may provide for reinstatement of only those lives which are insurable.

(c) This section is not applicable to single premium policies.

§4.613. Family Group Special Requirements.

(a) A family group life insurance policy is considered to be any life insurance policy, other than a regular joint life insurance policy, that grants benefits upon the death of each of the insured members of the family. This does not include individual policies with payor death benefits or beneficiary death benefits when such benefits are provided as a part of

the basic policy, or by supplementary agreement and when such additional benefits are designed primarily to promote the continuance of the basic policy. The requirements pertaining to family group policies may not be avoided, however, by merely adding insureds under an individual contract by means of riders or supplementary agreements.

(b) There must be included on the face of the policy the name and age of each insured; the name of the beneficiary; the maximum amount that is payable to the payee in the policy in the case of death of such insured person or persons; and designation of all paragraphs or provisions limiting or reducing the payment to less than the maximum provided in the policy. Suicide clauses are the most common type of reduction provision. The suicide clause, if used, should clearly indicate any effect that the suicide of one insured would have on the insurance of other insureds.

(c) Premiums deductible by the terms of the policy and indebtedness to the company on the policy are considered as counterclaims by the company against the beneficiary. It is not necessary that provisions for such deductions be placed on the face of the policy.

(d) The "face" of the policy means the first page of the policy.

(e) If the policy provides for coverage that will become effective on the lives of persons who become members of the family group (by birth or adoption) after the policy is issued, information relative to these future members need not be stated on the face of the policy. The policy form will be acceptable if the provisions relative to these additional members are clear and unambiguous.

§4.614. Dependent Child Riders and Family Term Riders.

(a) The rider must specify the effect on the rider of the death of the insured(s) under the base policy before the expiry date(s) of the rider. The following are acceptable:

(1) the rider may terminate, in which case no incontestability provision is required;

(2) the rider may convert to paid-up term insurance;

(3) if paid-up term insurance can be surrendered for its cash value, the rider must contain the "surrender within 30 days" statement required by Insurance Code §1105.007, concerning Computation of Cash Surrender Value Following Default; or

(4) the premium for the rider may be waived to the expiry date(s).

(b) If paid-up term insurance is available on the death of the insured under the base policy, the rider or the policy may not provide an incontestable provision for the rider less favorable than specified in Insurance Code §1101.006, concerning Incontestability, with respect to the coverage for each insured from the date the coverage for that insured becomes effective.

(c) The rider or policy must specify the effect on the rider should the insured(s) under the base policy commit suicide.

§4.615. Requirements for a Package Consisting of a Deferred Life Policy with an Accidental Death Rider Attached.

(a) The application must contain a statement that discloses the deferred nature of the insurance and that reflects the amount of insurance in force during the deferred period. It may not state only the ultimate amount.

(b) The brief description on the face page and filing back, if any, must call attention to the deferred nature of the insurance, and in no way refer to the accidental death benefit.

(c) If a separate premium is charged for the accidental death benefit, the schedule page must reflect the gross premium broken down in such a manner as to reflect the gross premium for the deferred life insurance and the accidental death benefit independently.

(d) The policy schedule page must reflect the reduced death benefit payable each year the reduction in benefits is maintained, as well as the ultimate face amount payable after the full face amount becomes available. This provision may be in the form of actual figures, a percentage of the ultimate face amount, the premiums plus interest, if applicable, or other provision not in violation of Insurance Code Chapter 1701, concerning Policy Forms, or other laws.

(e) The death benefit during the period of deferred insurance must be as great as the sum of the gross premiums paid (with or without interest). The death benefit may be based on the gross annual premium even though other modes are available under the policy.

(f) The accidental death benefit must be made a part of the entire contract.

(g) The contract of deferred insurance and accidental death benefit must reflect a different form number from any other contract of deferred insurance the company offers.

§4.616. Substitute or Change of Insured Riders.

(a) The rider must contain a statement requiring submission of an application signed by both the owner and the substitute insured.

(b) The rider may require evidence of insurability of the substitute insured.

(c) The following must be clearly specified:

(1) policy date;

(2) face amount;

(3) premium structure, including a description of the determination of premiums for a substitute insured; and

(4) the plan of insurance.

(d) The disposition of the following items must be clearly described:

(1) indebtedness under the old policy;

(2) inclusion or exclusion of any supplementary benefits upon exchange;

(3) dividends, if a participating policy; and

(4) adjustments of reserves and cash values.

§4.617. Preliminary Term Life Insurance.

The following requirements apply to a contract of life insurance containing a preliminary term insurance rider:

(1) a grace period must be allowed for payment of the first premium due on the principal policy; and

(2) the date of commencement of the preliminary term insurance, which is the date of inception of the contract as a whole, must be used to measure the period of contestability and suicide.

§4.618. Conversion Provision.

A conversion provision in a policy must comply with the following:

(1) the conversion provision must state the plan and face amount of the new policy;

(2) the text of the provision must state what premium rates will apply to the new policy;

(3) the text of the provision must discuss the settlement of cash values under the original contract if the policy is converted on a date other than the expiry date; and

(4) the provision must specify that evidence of insurability is not required.

§4.619. Limitations of Lawsuits.

The policy must not contain a provision limiting the time within which any action at law or in equity may be commenced to less than two years after the cause of action accrues.

§4.620. Backdating Policies.

(a) The policy must not contain a provision by which it is issued or takes effect more than six months before the original application for the insurance was made, if the insured would rate at an age younger than their age at the date when the application was made, according to their age at the nearest birthday.

(b) The restrictions against backdating are not violated by the exercise of conversion privileges contained in the original policy and that relate back to the original issue date of the policy, even though the conversion privilege by its terms is such that the amount of insurance at the conversion may exceed what was in force before conversion.

§4.621. Settlement at Maturity.

(a) If the policy provides that proceeds may be paid in installments, it must contain a representative table showing the amounts of such installments.

(b) If the settlement options provision indicates that modes of payment other than monthly may be available, then the amount of such payments must be determinable from the text. If the settlement option indicates a commuted value or present value, to be paid upon death of a payee, the interest rate used to determine this value must be given.

(c) No policy may contain a provision for any mode of settlement at maturity of less value than the amount insured on the face of the policy, plus dividend additions, if any, less any indebtedness to the company on the policy, and less any premium that may, by the terms of the policy, be deducted. The policy may provide an exception to this general rule, and reduce the amount of insurance payable on maturity if death occurs from the following causes:

(1) suicide, while sane or insane;

(2) by following stated hazardous occupations; or

(3) from aviation activities under conditions specified by the policy.

(d) Status clauses that attempt an exception if death occurs while the insured is engaged in the hazardous occupation or aviation activity are prohibited.

(e) Military service may be classed as a hazardous occupation, and benefits may be reduced under authority of this exception. In the alternative, the insurer may, in the incontestable clause, make provisions for contesting the validity of the policy for violations of conditions relating to naval and military services in time of war.

(f) Policies with graded death benefits, such as juvenile policies, will not be approved if they provide for reduction in the amount insured on the face of the policy.

Such policies can properly be written by providing the lower amount of insurance in the face of the policy, and making appropriate provisions for increases; or, in the alternative, the in-force insurance at the various durations may be stated in the face of the policy.

(g) The policy must not provide for deduction of all indebtedness of the holder of the contract to the company. The only allowable deduction for indebtedness is an indebtedness on account of and secured by the policy.

§4.622. Tontine Provisions.

Any life insurance policy that is a tontine policy or that contains a tontine provision will be disapproved. Provisions by which dividends during the participating period are not allocated or paid annually are prohibited as being within the tontine principle unless the policyholder acquires, on termination of the policy, a vested interest in the dividends that have accrued.

§4.623. Assignment Provisions.

There is no prohibition against a provision that permits the assignment of the policy benefits or proceeds. However, policies that make provision for dividends, coupon accumulations, or other guaranteed returns, and that also contain provision for the assignment of these funds to a third party for the purpose of establishing an investment for the policyholder are prohibited.

§4.624. Provisions Relating to Dividends, Coupon Benefits, or Other Guaranteed Returns.

(a) Any provision by which the insurer undertakes to pay specific amounts will be treated as definite contract benefits and valued in accordance with Insurance Code §841.253, concerning Life Insurance Company's Payment of Dividends.

(b) Any policy that contains a provision promising to pay "dividends" from specified sources must clearly state that the payment of such dividends must be made from profits or expense loading.

(c) Any policy that provides for the payment of dividends, coupon benefits, or other guaranteed returns must specify the disposition that will be made of such accumulations if no option is exercised by the policyholder either on their maturity or in the event of default in premium payments. Acceptable dispositions are that they be:

(1) applied to the purchase of additional insurance;

(2) left to accumulate at interest;

(3) withdrawn in cash; or

(4) applied to the payment of premiums.

§4.625. Premiums Paid in Advance.

(a) The policy may contain provisions under which the company will accept advance payments of premiums; but in no event may the company undertake to accept deposits that would exceed the maximum amount required to pay all future premiums that will become due under the policy, including any options contained in the policy. The contract may permit the insured to withdraw excess deposits in cash, but any provisions that would cause a forfeiture of principal or exact a surrender charge are prohibited. The

contract must state the interest rate used to discount the future premiums and must provide for disposition of any unused premiums on surrender of the contract or death of the insured.

(b) This section is not applicable to single premium policies.

§4.626. Annuity Contracts.

All sections in Subchapter F of this chapter (relating to Individual Life Insurance Policy Form Checklist and Affirmative Requirements) apply to the review of ordinary life insurance policies and are not applicable to annuity contracts. Any contract that provides death benefits in excess of the total premium paid, without interest or with interest at a specified rate, or the cash value at time of death, if greater, will be considered a life insurance policy. This requirement cannot be avoided by combining riders or endorsements to a basic annuity, as all pertinent instruments collectively constitute the contract.

§4.627. Certain Prohibited Provisions.

(a) Any policy that contains a title, heading, or other indication of its provisions that is misleading will be disapproved. For example, a title, heading, etc., will be misleading if it contradicts the provisions of the policy. A life insurance policy may not be described or referred to as a "bond," nor may premiums be described or referred to as "deposits."

(b) The policy may not contain the words "Approved by the Texas Department of Insurance," "Approved by TDI," "Approved by the commissioner of insurance," or words of a similar import or nature.

§4.628. Renewal Premium on Term Policies.

Renewable term policies may specify rates for renewal terms in dollars and cents, by reference to rates in use by the company on the original issue date or by reference to the rates in use by the company on the renewal date. If such rates are specified by reference to the rates in effect on the date of issue, such rates must be submitted with the policy.

Subchapter J. Life - Indeterminate Premium Reduction Policies
28 TAC §§4.1001, 4.1002, 4.1004, 4.1005, 4.1008, 4.1010, and 4.1011

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.1001, 4.1002, 4.1004, 4.1005, 4.1008, 4.1010, and 4.1011 under Insurance Code §§543.001(c), 1701.060, and 36.001.

Insurance Code §543.001(c) provides that the commissioner may adopt and enforce reasonable rules as provided by Insurance Code Chapter 541, Subchapter I to accomplish the purposes of §543.001(b)(1), prohibiting misrepresentation, as those purposes relate to life insurance companies.

Insurance Code §1701.060 specifies that the commissioner may adopt rules necessary to implement the purpose of Insurance Code Chapter 1701.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.1001. Purpose and Scope.

(a) This subchapter is promulgated to regulate life insurance policies that have the following characteristics:

(1) the premium for the policy is guaranteed for an initial period of time but after such initial period, a maximum premium charge is specified in the policy; thereafter, the insurer reserves the right to charge a lesser unspecified amount (this type of policy is hereinafter referred to as "an indeterminate premium reduction policy"); and

(2) one of the purposes of the policy is to provide insureds with insurance coverage at a lower initial premium than would be obtainable from the insurer if the premiums were required to be unchangeable by the insurer for the life of the policy.

(b) A major purpose of this subchapter is to promote an accurate presentation and description to the insurance-buying public of the indeterminate premium reduction policy. Adequate disclosure is one of the principal objectives of the sections. The sections attempt to ensure that prospective insureds receive a fair, adequate, and accurate impression of the true nature of the indeterminate premium reduction policy. Some of the sections also give notice of certain legal interpretations. The sections are supplementary to and cumulative of other statutes and rules including those promulgated under authority of Insurance Code Chapter 541, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices. This subchapter is applied and interpreted in accordance with the foregoing purposes.

§4.1002. Policy Form Submission.

(a) No indeterminate premium reduction policy may be approved for use in Texas unless the insurer files with the Texas Department of Insurance, in conjunction with such indeterminate premium reduction policy, a statement:

(1) that, to the best of the insurer's knowledge and belief, the policy submitted is in compliance with this subchapter;

(2) that advertising and solicitation will be in compliance with this subchapter;

(3) that any premium redetermination will not reflect a distribution of company surplus nor a return of previously collected premiums; and

(4) that any nonguaranteed premium rates used to market the policy are lower than rates that the insurer is willing to guarantee in a fixed premium policy with the same or similar benefits for insureds of essentially the same class of risk.

(b) A nonguaranteed premium means any charge for insurance, including any percentage deviation from a maximum charge, that an insurer or insurance agent mentions or illustrates as a possible charge for coverage other than the maximum guaranteed premium specified in the policy.

§4.1004. Summary of Provisions.

(a) Upon application for an indeterminate premium reduction policy or group certificate, a separate form containing a summary that adequately describes the contractual premium provisions must be signed by the applicant and submitted to the insurer in conjunction with the application. A portion of the summary must include the following information:

(1) the fact that the premium might be changed in the policy;

(2) the frequency of the possible changes;

(3) the fact that the nonguaranteed premium (if used in solicitation or advertising) is not guaranteed but the full maximum could be charged; and

(4) for participating policies, a statement that dividends are only payable if declared by the insurer. If it is not likely that dividends will be paid, a statement to that effect must be included.

(b) The summary required by these sections must be kept with a copy of the application after its receipt by the insurer and maintained in the insurer's files during the existence of the contract.

§4.1005. Relation of Initial to Later Premium Charge.

If the policy offers an initial premium that is different from the maximum guaranteed premium specified in the policy for later policy years, no solicitation or advertisement may display or state the smaller premium in such a fashion that the larger premium charge is rendered obscure or deemphasized. The smaller premium may not be displayed more prominently than the larger premium charge.

§4.1008. Minimum Nonforfeiture Values.

The minimum basis for cash values is stated in Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance, which requires the adjusted premiums to be computed as a "uniform percentage of the respective premiums specified by the policy." Maximum guaranteed premiums in the policy are specified premiums as defined by the Insurance Code. Cash values, if any, will not be required to be redetermined

when premiums are reduced for in-force policies. Minimum nonforfeiture values for indeterminate premium group policies on other than the term plan must be calculated in accordance with this section.

§4.1010. Artificial Maximum Premiums Prohibited.

(a) No insurer may incorporate an increment into a maximum premium in an indeterminate premium reduction policy in order to be able to show an increased reduction in later policy years or to reduce cash values, if any, as provided in Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance, or reserves as provided in Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law.

(b) As a condition precedent to policy form approval, there must accompany each submission of an indeterminate premium reduction policy a certification by a qualified actuary to the following: that the maximum premiums specified in the policy do not incorporate an increment as specified in subsection (a) of this section. An approval of a policy form after receipt of the foregoing certification may not be construed as a determination by the Texas Department of Insurance that the certification is true and accurate.

§4.1011. General Enforcement.

A failure to follow and abide by the representations and disclosure provisions required by this subchapter in marketing the indeterminate premium reduction policy is grounds for a withdrawal of approval of the insurer's previously approved indeterminate premium reduction policy forms and is grounds for disapproval of subsequently filed

indeterminate premium reduction policy forms. The provisions of this section are additional to and cumulative of all other enforcement provisions provided by law including Insurance Code Chapter 541, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices.

Subchapter K. Life - Standards for Acceleration-of-Life-Insurance Benefits for Individual and Group Policies and Riders
28 TAC §§4.1101 - 4.1104 and 4.1106 - 4.1116

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.1101 - 4.1104 and 4.1106 - 4.1116 under Insurance Code §§1111.053, 1701.060, and 36.001.

Insurance Code §1111.053 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111, Subchapter B.

Insurance Code §1701.060 specifies that the commissioner may adopt rules necessary to implement the purpose of Insurance Code Chapter 1701.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.1101. Purpose; Severability.

(a) The commissioner enacts this subchapter to:

(1) expand the circumstances under which insurers can offer acceleration-of-life-insurance benefits, thus enhancing financial choices for insureds facing terminal or life-threatening illnesses or conditions;

(2) implement revised statutory requirements for certain group and individual life insurance contracts;

(3) set uniform standards for offering acceleration-of-life-insurance benefits that will be applicable to all group and individual life insurance plans, creating a level playing field for insurers and key protections for consumers;

(4) allow insurers, with proper disclosures, to offer benefits that will qualify for favorable tax treatment under federal law, as well as benefits that may not qualify for favorable tax treatment, but that are available to a broader class of insureds; and

(5) ensure that acceleration-of-life-insurance benefit provisions that fund long-term care expenses conform basic definitions and eligibility triggers to those in rules setting minimum standards for long-term care insurance contracts.

(b) If a court of competent jurisdiction holds that any provision of this subchapter is inconsistent with any statutes of this state, is unconstitutional or for any other reason is invalid, the remaining provisions remain in full effect. If a court of competent jurisdiction holds that the application of any provision of this subchapter to particular persons, or in particular circumstances, is inconsistent with any statutes of this state, is unconstitutional or for any other reason is invalid, the provision remains in full effect as to other persons or circumstances.

§4.1102. Acceleration-of-Life-Insurance: Scope of Benefits.

(a) An acceleration-of-life-insurance benefit provision provides a special benefit under a life insurance contract that prepays all or a portion of the death benefit based on a long-term care illness, specified disease, or terminal illness.

(b) The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Life insurance contract--An individual life insurance policy, a group life insurance policy or certificate of insurance, or a rider to an individual or group life insurance policy or group certificate of insurance.

(2) Long-term care illness--An illness or physical condition that results in the inability to perform the activities of daily living or the substantial and material duties of any occupation. Evidence of a long-term care illness includes, but is not limited to, illnesses or conditions that require:

(A) confinement in a convalescent nursing home, residential care or intermediate nursing facility, defined consistently with the provisions of §3.3812 of this title (relating to Policy Standards for Provider); or

(B) adult day care services, as defined and provided consistently with §3.3804(b) of this title (relating to Definitions), and home health care services, as defined and provided consistently with §3.3804(b) of this title.

(3) Specified disease--An illness or physical condition that is likely to cause permanent disability or premature death, including, but not limited to, the following:

(A) AIDS;

(B) a malignant tumor;

(C) a condition requiring organ transplantation;

(D) a coronary artery disease resulting in acute infarction or requiring surgery;

(E) a permanent neurological deficit resulting from cerebral vascular accident; or

(F) a condition of similar severity as specified in the life insurance contract that would be expected to impair the insured's quality or length of life in the absence of appropriate medical attention.

(4) Terminal illness--An illness or physical condition, including a physical injury, that can reasonably be expected to result in death in two years or less.

(c) Any portion of the death benefit remaining after reduction of the death benefit due to payment of any acceleration-of-life-insurance benefit referred to in this section and related charges, interest or liens, as allowed by §4.1106(3) of this title (relating to Methods for Determining Benefits and Allowable Charges and Fees) must be paid upon the death of the insured.

(d) Prepayment of acceleration-of-life-insurance benefits may be in a single sum or in installments.

(e) The acceleration-of-life-insurance benefits, related charges, interest, discounts, or liens allowed under this subchapter, and the balance of the death benefit of the life insurance contract will constitute full settlement on maturity of the face amount of the contract.

(f) Specific additional requirements for life insurance contracts that pay for long-term care expenses through acceleration-of-life-insurance benefit provisions are contained in §4.1114 of this title (relating to Requirements for Acceleration-of-Life-Insurance Benefits That Fund Long-Term Care Expenses).

§4.1103. Required Policy Definitions; Evidence of Total and Permanent Disability.

(a) Acceleration-of-life-insurance benefits, and the illness, condition, care, or confinement necessary to evidence that the insured has a long-term care illness, specified

disease, or terminal illness, must be clearly defined in the life insurance contract consistently with this subchapter.

(b) Such illness, condition, care, or confinement is evidence of total and permanent disability for purposes of meeting the standards for providing acceleration-of-life-insurance benefits set forth in Insurance Code §1111.052, concerning Authority to Pay Accelerated Term Life Benefits, and §1201.003, concerning Applicability of Chapter, and §4.1102 of this title (relating to Acceleration-of-Life-Insurance: Scope of Benefits).

§4.1104. Standards for Medical Diagnoses.

The acceleration-of-life-insurance benefit provision may require a medical diagnosis of conditions and/or documentation of care or confinement as defined in the life insurance contract to establish eligibility for acceleration-of-life-insurance benefits. This may include a written medical opinion, satisfactory to the company, that the insured has a terminal illness, a long-term care illness, or a specified disease. If additional diagnoses by a physician selected by the company are required, the acceleration-of-life-insurance benefit provision, or a disclosure statement attached to the front of the policy or rider, must specify that the additional diagnoses are at the expense of the company and how conflicting diagnoses will be reconciled. The specific standards sufficient to meet such eligibility requirements must be defined in the life insurance contract, and any acceleration-of-life-insurance benefit must be conditioned only upon such requirement or requirements as defined.

§4.1106. Methods for Determining Benefits and Allowable Charges and Fees.

The acceptable methods for determining an acceleration-of-life-insurance benefit, and allowable charges and fees associated with the benefit, are as specified in this section.

(1) Additional premium or cost of insurance charge method. The acceleration-of-life-insurance benefit provision must specify and define any separately identifiable additional premium or cost-of-insurance charge, if applicable to the life insurance contract, for any acceleration-of-life-insurance benefit, and, upon payment of such benefit, reduce the death benefit of the contract in an amount equal to the acceleration-of-life-insurance benefit paid.

(2) Actuarial discount methods. The acceleration-of-life-insurance benefit provision must specify or define any administrative fee, not to exceed $150, and any sound and reasonable actuarial discount, calculated in accordance with either subparagraph (A) or (B) of this paragraph, as applicable, that may reduce the amount of the acceleration-of-life-insurance benefit in instances where no additional premium or cost-of-insurance charge is payable in advance by the policy or certificate holder. Upon payment of such benefit, the death benefit of the life insurance contract will be reduced by no more than an amount equal to the acceleration-of-life-insurance benefit paid, plus the actuarial discount and any administrative fee deducted to provide the benefit. Each subsequently approved acceleration-of-life-insurance benefit request may provide for an administrative fee and discount, subject to the limits defined in this paragraph. The acceleration-of-life-insurance benefit may be calculated based on either the present value actuarial discount as described in subparagraph (A) of this paragraph, or, in regard to an insured with a terminal illness, on the interest-only actuarial discount as described in subparagraph (B) of this paragraph.

(A) Present value actuarial discount. The acceleration-of-life-insurance benefit may be based upon the present value of future benefits provided under the life insurance contract, less the present value of future premiums, plus the present value of future dividends, if applicable. The actuarial discount used to reach this present value calculation must be appropriate to the life insurance contract design and based on sound actuarial principles. For an insured with a terminal illness, the present value actuarial discount may not reduce the amount of benefits accelerated by more than 15% of the face amount of such benefits. For other insureds eligible for acceleration-of-life-insurance benefits, the interest rate used to derive the present value actuarial discount applied to the face amount of the benefits accelerated may not exceed the greater of:

(i) the current yield on 90-day treasury bills;

(ii) the current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages, or any successor thereto;

(iii) the life insurance contract's guaranteed cash value interest rate plus 1% per year; or

(iv) an alternate rate approved by the commissioner.

(B) Interest-only actuarial discount. This discount may be applied only in regard to the death benefit of an insured with a terminal illness. The interest-only actuarial discount may not reduce the amount of the acceleration-of-life-insurance benefit by more than 10% per year.

(3) Lien method. In instances where no additional premium or cost of insurance charge is payable in advance by the policy or certificate holder, and the acceleration-of-life-insurance benefit is not reduced by a present value or interest-only actuarial discount, the insurer may consider the acceleration-of-life-insurance benefit, any

administrative expense charges, any due and unpaid premiums and any accrued interest as a lien against the death benefit of the life insurance contract, in accordance with the following.

(A) The acceleration-of-life-insurance provision must specify or define any administrative fee, not to exceed $150, and any interest charge on the amount of the acceleration-of-life-insurance benefit.

(B) Access to cash value, if any, may be restricted to any excess of the cash value over the sum of the lien and any outstanding loans. Future access to additional policy loans and any partial withdrawals may also be limited to any excess of the cash values over the sum of the lien and any other outstanding policy loans.

(C) The lien cannot exceed the value of the death benefit of the life insurance contract. The contract must state that coverage will terminate at such time as the lien equals the value of the death benefit.

(D) The interest rate and interest rate methodology used in the calculation must be based on sound actuarial principles and disclosed in the contract and actuarial memorandum. The interest rate accrued on the portion of the lien equal to the cash value of the life insurance contract at the time of the benefit acceleration must be no more than the policy loan interest rate stated in the contract. Each subsequently approved acceleration-of-life-insurance benefit request may provide for an administrative fee and lien, subject to the limits set forth in this paragraph. The maximum interest rate used may not exceed the greater of:

(i) the current yield on 90-day treasury bills;

(ii) the current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages, or any successor thereto;

(iii) the policy's guaranteed cash value interest rate plus 1% per year; or

(iv) an alternate rate approved by the commissioner.

§4.1107. Limitations on Reduction of Cash Values.

Except as otherwise authorized under the lien method for determining benefits under §4.1106(3) of this title (relating to Methods for Determining Benefits and Allowable Charges and Fees), if the cash values are reduced by the acceleration-of-life-insurance benefit, related charges, and interest, the reduction may not be unjust and may not exceed an amount equal to the pro rata portion of the cash value associated with the death benefit used in providing the acceleration-of-life-insurance benefit. Future cash values may not be less than the minimum cash values required by Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance, for the reduced future guaranteed death benefits. These minimum cash values are equal to the present value of the reduced future guaranteed benefits less the present value of future adjusted premiums, decreased by the amount of any indebtedness, including liens, under the life insurance contract. The mortality and interest used in calculating the minimum cash values will be as provided in Insurance Code Chapter 1105, for life insurance coverage, disregarding any acceleration-of-life-insurance benefits.

§4.1108. Pro Rata Reduction of Loan upon Acceleration of Benefits.

Unless the insurer is using the lien method for determining benefits under §4.1106(3) of this title (relating to Methods for Determining Benefits and Allowable Charges and Fees), if there is a loan on the life insurance contract, the insurer may deduct

up to a pro rata portion of the loan from the amount of the acceleration-of-life-insurance benefit.

§4.1109. Effect of Acceleration of Benefits on Nonforfeiture Calculations.

An acceleration-of-life-insurance benefit provision or rider must be disregarded in ascertaining nonforfeiture benefits under Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance.

§4.1110. Calculation of Reserves.

(a) Reserves for an acceleration-of-life-insurance benefit must be based on tables of disablement, morbidity, or mortality appropriate for determining liability for the benefits provided. Such disablement or morbidity tables must be certified as appropriate by a member of the American Academy of Actuaries and approved by the Texas Department of Insurance under Insurance Code §425.058(k), concerning Computation of Minimum Standard: General Rule, and §425.069, concerning Reserve Computation: Indeterminate Premium Plans and Certain Other Plans. Reserves for the death benefits or other supplementary benefits provided by a life insurance contract that includes an acceleration-of-life-insurance benefit must be calculated disregarding such benefit, using mortality and interest rates as provided in Insurance Code Chapter 425, concerning Reserves and Investments for Life Insurance. The basis of reserves for any life insurance contract that contains an acceleration-of-life-insurance benefit provision must accompany the filing of the contract with the Texas Department of Insurance.

(b) Reserves for an acceleration-of-life-insurance benefit under the lien method for determining benefits under §4.1106(3) of this title (relating to Methods for Determining

Benefits and Allowable Charges and Fees), including accrued interest, represent assets of the company for statutory reporting purposes. For any life insurance contract on which the lien exceeds the policy's statutory reserve liability, such excess must be held as a non-admitted asset.

§4.1111. Unfair, Discriminatory, or Deceptive Practices Prohibited.

(a) Acceleration-of-life-insurance benefit provisions are subject to Insurance Code Chapter 541, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices, and rules promulgated under Chapter 541.

(b) Insurers offering acceleration-of-life-insurance benefits may not engage in unfair, discriminatory, or deceptive practices in relation to the offer, sale, or administration of acceleration-of-life-insurance benefits, including, but not limited to, the following practices:

(1) reclassification of the insured as a result of payment of the benefit specified in an acceleration-of-life-insurance benefit provision to a class of risk less favorable than the class of risk to which the insured originally belonged;

(2) unfair discrimination among insureds with differing qualifying events; or

(3) unfair discrimination among insureds with similar qualifying events.

§4.1112. Notice and Disclosure Requirements for Life Insurance Contracts Containing Acceleration-of-Life-Insurance Benefits.

(a) Except as otherwise stated in this section, every life insurance contract containing an acceleration-of-life-insurance benefit provision is subject to the notice and disclosure requirements in paragraphs (1) - (5) of this subsection.

(1) Except as otherwise provided in this paragraph, the face of every such life insurance contract must contain a prominent notice printed, over-printed or stamped, as appropriate, substantially as follows: "Death benefits, cash values, and loan values will be reduced if an acceleration-of-life-insurance benefit is paid." This statement must be appropriately modified for contracts that have no cash or loan values, or in which the cash value is not reduced.

(2) The title of any acceleration-of-life-insurance benefit must be descriptive of the coverage provided and must use such terms as "acceleration-of-life-insurance benefit," "accelerated benefit," or words of similar import.

(3) At the time of the payment of a lump sum acceleration-of-life-insurance benefit, or, if periodic payments are being made, no less frequently than every 12 months, the insurer must send a statement to the owner or holder of the life insurance contract, specifying:

(A) the amount of benefits paid (or the amount of benefits paid since the last report);

(B) the effect of the acceleration-of-life-insurance benefit payment on the death benefit, face amount, specified amount, accumulation values, cash values, loan amounts, future charges, and future premiums; and

(C) the amount of benefits remaining available for acceleration.

(4) Notice that the owner of the life insurance contract will receive the statement described in paragraph (3) of this subsection must be included in the acceleration-of-life-insurance benefit provisions of the life insurance contract.

(5) As appropriate, the disclosures contained in either subsection (a) or (b) of §4.1116 of this title (relating to Disclosures Related to Tax Qualification of Benefits and

Benefits' Effect on Public Assistance), and the disclosure contained in subsection (c) of §4.1116, or disclosures substantially similar to these disclosures, must be included on or attached to the front page of each life insurance contract subject to this subchapter, except as provided in subsection (e) of §4.1116.

(b) The notice and disclosure requirements in subsection (a) must be provided only with the document actually containing the acceleration-of-life-insurance provisions. For example, if acceleration-of-life insurance benefits are provided through a rider to a life policy, the disclosures must only be provided with the rider, not the policy.

§4.1113. Notice and Disclosure Requirements for Marketing Materials.

(a) Any "invitation to contract," as defined in §21.102 of this title (relating to Scope), used in the marketing, solicitation, or sale of a life insurance contract containing an acceleration-of-life-insurance provision must clearly and concisely disclose the following:

(1) the illness, condition, care, or confinement necessary to trigger eligibility for any acceleration-of-life-insurance benefit;

(2) the effect that an acceleration-of-life-insurance benefit provision will have on the death benefit and other values available under the life insurance contract; and

(3) the tax-related disclosures contained in either subsection (a) or (b) of §4.1116 of this title (relating to Disclosures Related to Tax Qualification of Benefits and Benefits' Effect on Public Assistance), as appropriate, and the disclosure contained in subsection (c) of §4.1116, or disclosures substantially similar to these disclosures.

(b) No insurer or agent, in marketing a life insurance contract that provides acceleration-of-life-insurance benefits, may mention, illustrate, or refer to the contract as an alternative or substitute for catastrophic major medical health insurance.

§4.1114. Requirements for Acceleration-of-Life-Insurance Benefits That Fund Long-Term Care Expenses.

When a life insurance contract provides for payment of long-term care expenses funded through an acceleration-of-life-insurance benefit provision, the long-term care provisions of the contract must meet the following requirements of Chapter 3, Subchapter Y of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies that Provide Long-Term Care Benefits Within the Policy):

(1) terms must be defined consistently with §3.3804 of this title (relating to Definitions);

(2) definitions and descriptions of providers must be consistent with the requirements of §3.3812 of this title (relating to Policy Standards for Provider);

(3) to the extent that the acceleration-of-life-insurance provisions provide for payment of home health or adult day care expenses, such provisions must meet applicable standards contained in §3.3815 of this title (relating to Standards for Home Health and Adult Day Care Benefits);

(4) conditions triggering eligibility for benefits must comply with §3.3818 of this title (relating to Standards for Eligibility for Benefits); and

(5) to the extent that the acceleration-of-life-insurance benefit is intended to fund long-term care expenses that will qualify for favorable tax treatment under federal law, the long-term care provisions of the contract must further comply with the provisions of §4.1115 of this title (relating to Requirements for Benefits Represented to Be Qualified for Favorable Federal Tax Treatment) that are applicable to expenses paid for a "qualified long-term care illness," as defined in §4.1115, and any additional federal requirements for favorable tax treatment.

§4.1115. Requirements for Benefits Represented to Be Qualified for Favorable Federal Tax Treatment.

(a) On or after the effective date of this subchapter, no life insurance contract providing for acceleration-of-life-insurance benefits may be represented to be tax-qualified under federal law governing taxation of such benefits unless such benefits meet the requirements set forth in subsections (b) - (d) of this section.

(b) Acceleration-of-life-insurance benefits described as tax-qualified must be limited to insureds who have a "qualified terminal illness" or a "qualified long-term care illness," as those terms are defined (and terms used within the definitions are defined) in paragraphs (1) - (3) of this subsection.

(1) An insured has a "qualified terminal illness" if a physician certifies that, as of the date of the certification, the insured has a terminal illness, as defined in §4.1102(b) of this title (relating to Acceleration-of-Life-Insurance: Scope of Benefits).

(2) An insured has a "qualified long-term care illness" if the insured has a "long-term care illness" as defined in §4.1102(b) of this title, and a licensed health care practitioner, acting within the scope of their license, certifies, within 12 months before the

approval of the insured's request to exercise the acceleration-of-life-insurance provision, that the insured's illness or physical condition has caused the insured to:

(A) be unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to functional incapacity;

(B) be disabled at a level similar to the level described in subparagraph (A) of this paragraph, as determined by rules promulgated by the United States Secretary of the Treasury, in consultation with the United States Secretary of Health and Human Services, under section 7702B of the Internal Revenue Code of 1986, as amended by the Health Insurance Portability and Accountability Act of 1996; or

(C) require substantial supervision to protect the insured from threats to the insured's health and safety due to the impairment of cognitive ability.

(3) The following words and terms, when used in this section, have the following meanings unless the context clearly indicates otherwise.

(A) Activities of daily living--Bathing, continence, dressing, eating, toileting and transferring, as those terms are defined in §3.3804(b) of this title (relating to Definitions).

(B) Impairment of cognitive ability--The deterioration or loss in intellectual capacity requiring substantial supervision for protection of self and others, as established by the clinical diagnosis of any licensed practitioner in this state authorized to make such a diagnosis. Such diagnosis must include the patient's history and physical, neurological, psychological and/or psychiatric evaluations, and laboratory findings.

(C) Substantial supervision--Continual supervision (that may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is

necessary to protect a cognitively impaired individual from threats to the individual's health or safety.

(c) Any acceleration-of-life-insurance benefit paid to an insured with a qualified long-term care illness is limited in use to payment for instances in which the individual has incurred expenses for qualified long-term care services, as defined in section 7702B of the Internal Revenue Code of 1986, as amended by the Health Insurance Portability and Accountability Act of 1996. Such payments will not fail to meet this test solely because they are made on a per diem or periodic basis without regard to expenses incurred during the period.

(d) Any acceleration-of-life-insurance benefit provision providing for payment of expenses incurred for qualified long-term care services by an insured with a qualified long-term care illness:

(1) may not pay or reimburse expenses incurred under Medicare or that would be reimbursable under Medicare but for the application of a deductible or coinsurance amount, except expenses that are reimbursable under Medicare only as a secondary payor;

(2) may coordinate benefits with Medicare benefits; and

(3) must meet all requirements of §4.1114 of this title (relating to Requirements for Acceleration-of-Life-Insurance Benefits That Fund Long-Term Care Expenses).

§4.1116. Disclosure Related to Tax Qualification of Benefits and Benefits' Effect on Public Assistance.

(a) Except as provided in subsection (e) of this section, on or after the effective date of this subchapter, if an insurer markets, delivers, issues for delivery, or renews a life insurance contract in Texas that provides only acceleration-of-life-insurance benefits that are intended to qualify for favorable tax treatment under federal law, the contract, and any invitation to contract as provided under §4.1113 of this title (relating to Notice and Disclosure Requirements for Marketing Materials), must include a disclosure substantially similar to the disclosure set forth in this subsection. When a series of words are separated by slashes (e.g., policy/certificate/rider), the insurer should choose the most appropriate word or words under the circumstances. DISCLOSURE: "The acceleration-of-life-insurance benefits offered under this policy/certificate/rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the acceleration-of-life-insurance benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law."

(b) Except as provided in subsection (e) of this section, on or after the effective date of this subchapter, if an insurer markets, delivers, issues for delivery, or renews a life insurance contract in Texas that contains an acceleration-of-life-insurance benefits provision that meets the requirements of this subchapter, but that allows benefits to be accelerated in circumstances in which such benefits would not qualify for favorable tax treatment under federal law, the contract, and any invitation to contract as provided under

§4.1113 of this title, must include a disclosure substantially similar to the disclosure set forth in this subsection. When a series of words are separated by slashes (e.g., policy/certificate/rider), the insurer should choose the most appropriate word or words under the circumstances. DISCLOSURE: "The acceleration-of-life-insurance benefits offered under this policy/certificate/rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law."

(c) Except as provided in subsection (e) of this section, on or after the effective date of this subchapter, if an insurer markets, delivers, issues for delivery, or renews a life insurance contract in Texas that provides acceleration-of-life-insurance benefits, the contract, and any invitation to contract as provided under §4.1113 of this title, must include a disclosure substantially similar to the disclosure set forth in this subsection. DISCLOSURE: "Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of

such a payment will affect you, your spouse and your family's eligibility for public assistance."

(d) The disclosure requirements of this section must be provided only with the document actually containing the acceleration-of-life-insurance provisions. For example, if acceleration-of-life-insurance benefits are provided through a rider to a life policy, the disclosures must only be provided with the rider, not the policy.

(e) In regard to certificates of coverage for group life insurance policies, the disclosures required by this section must be provided only to certificate holders obtaining group life coverage on or after the effective date of this subchapter.

Subchapter K. Standards for Acceleration-of-Life-Insurance Benefits for Individual and Group Policies and Riders
Repeal of 28 TAC §4.1117

STATUTORY AUTHORITY. The commissioner adopts the repeal of §4.1117 under Insurance Code §§1111.053, 1701.060, and 36.001.

Insurance Code §1111.053 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111, Subchapter B.

Insurance Code §1701.060 specifies that the commissioner may adopt rules necessary to implement the purpose of Insurance Code Chapter 1701.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§4.1117. Effective Date.

Subchapter L. Life - Insurance Sold in Connection with Prepaid Funeral Contracts 28 TAC §4.1201

STATUTORY AUTHORITY. The commissioner adopts amendments to §4.1201 under Occupations Code §651.159 and Insurance Code §36.001.

Occupations Code §651.159 provides the commissioner adopt a memorandum of understanding with the Texas Funeral Service Commission and the Texas Department of Banking.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.1201. Introduction to Joint Memorandum of Understanding.

(a) Occupations Code §651.159, concerning Memorandum of Understanding: Prepaid Funeral Services, mandates the Texas Department of Insurance, the Texas Funeral Service Commission, and the Texas Department of Banking to adopt by rule a joint memorandum of understanding relating to prepaid funeral services and transactions that:

(1) outlines the responsibilities of each agency in regulating these services and transactions;

(2) establishes procedures to be used by each agency in referring complaints to one of the other agencies;

(3) establishes procedures to be used by each agency in investigating complaints;

(4) establishes procedures to be used by each agency in notifying the other agencies of a complaint or of the investigation of a complaint;

(5) describes actions the agencies regard as deceptive trade practices;

(6) specifies the information the agencies provide consumers and when that information is to be provided; and

(7) sets the administrative penalties each agency imposes for violations.

(b) Any revisions to the joint memorandum of understanding will be adopted by rule by each agency.

(c) The joint memorandum of understanding entered into by the three agencies is found at §4.1202 of this title (relating to Joint Memorandum of Understanding).

Subchapter O. Life - Variable Life Insurance
28 TAC §§4.1502 - 4.1510

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.1502 - 4.1510 under Insurance Code §1152.002 and §36.001.

Insurance Code §1152.002 authorizes the commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 1152, including rules establishing requirements for agent licensing, standard policy provisions, and disclosure.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.1502. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Affiliate of an insurer--Any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

(2) Agent--Any person, corporation, partnership, or other legal entity that is licensed by this state as a life insurance agent.

(3) Assumed investment rate--The rate of investment return that would be required to be credited to a variable life contract, after deduction of charges for taxes, investment expenses, and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

(4) Benefit base--The amount to which the net investment return is applied.

(5) Cash surrender value--The net cash surrender value plus any amounts outstanding as contract loans.

(6) Commissioner--The commissioner of insurance of this state.

(7) Contract cost factors--Those amounts that affect the price per thousand of life insurance coverage or other benefits. They include interest, mortality, expense charges, and fees, including any surrender charges, but not persistency assumptions.

(8) Contract processing day--The day on which charges authorized in the contract are deducted from the contract value.

(9) Contract value--The amount to which interest is credited, and against which separately identified mortality charges, expense charges, fees, and other charges are debited.

(10) Control (including the terms "controlling," "controlled by," and "under common control with")--The possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than 10% of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the commissioner that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest with notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(11) Flexible premium contract--Any variable life contract other than a scheduled premium variable life contract as defined in the definition of scheduled premium variable life contract.

(12) General account--All assets of the insurer other than assets in separate accounts established under Insurance Code Chapter 1152, concerning Separate Accounts, Variable Contracts, and Related Products, or under the corresponding sections of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

(13) Incidental insurance benefit--All insurance benefits in a variable life contract, other than the variable death benefit and the minimum death benefit, including, but not limited to, accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term riders.

(14) Minimum death benefit--The amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life contract regardless of the investment performance of the separate account.

(15) Net cash surrender value--The maximum amount payable to the contract owner upon surrender.

(16) Net investment return--The rate of investment return in a separate account to be applied to the benefit base.

(17) Person--An individual, corporation, partnership, association, trust, or fund.

(18) Scheduled premium contract--Any variable life contract under which both the amount and timing of premium payments are fixed by the insurer.

(19) Separate account--A separate account established under Insurance Code Chapter 1152, or under the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(20) Structural changes--Those changes that are separate from the automatic workings of the contract. Such changes usually would be initiated by the contract owner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

(21) Variable death benefit--The amount of the death benefit, other than incidental benefits payable under a variable life contract dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

(22) Variable life contract--Any individual variable life insurance contract that provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such contract, under Insurance Code Chapter 1152, or under the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

§4.1503. Qualifications of Insurer to Issue Variable Life Insurance.

The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this state or having the authority to issue variable life insurance in this state.

(1) Licensing and approval to do business in this state. An insurer may not deliver or issue for delivery in this state any variable life insurance contracts unless:

(A) the insurer is licensed or organized to do life insurance business in this state; and

(B) after having complied with the provisions of Insurance Code Chapter 1152, concerning Separate Accounts, Variable Contracts, and Related Products, the commissioner has authorized, either as part of the insurer's original certificate of authority or by charter amendment, the insurer to issue, deliver, and use variable life contracts, and only after the commissioner has considered, among other things, the following:

(i) whether the plan of operation for the issuance of variable life contracts is sound;

(ii) whether the general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably assure competent operation of the variable life business of the insurer in this state; and

(iii) whether the present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such contracts is not likely to render its operation hazardous to the public or its contract holders in this state. The commissioner will consider, among other things:

(I) the history of operation and financial condition of the insurer;

(II) the qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(III) the applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life contracts. The state of entry of an alien insurer will be deemed its state of domicile for this purpose; and

(IV) if the insurer is a subsidiary of, or is affiliated by common management or ownership with, another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meets these standards.

(2) Filing for approval to do business in this state. Before any insurer may deliver or issue for delivery any variable life contract in this state, it must file with the Texas Department of Insurance the following information, and any other information specifically requested, for the consideration of the commissioner, on making the determination required by paragraph (1)(B) of this section:

(A) copies of and a general description of the variable life contracts it intends to issue;

(B) a general description of the methods of operation of the variable life insurance business of the insurer, including methods of distribution of contracts and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial, or distributive services to the insurer;

(C) with respect to any separate account maintained by an insurer for any variable life contract, a statement of the investment policy the insurer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy. The statement of investment policy must include a description of the investment objectives intended for the separate account;

(D) a description of any investment advisory services contemplated as required by §4.1506 of this title (relating to Separate Accounts);

(E) a copy of the statutes and regulations of the state of domicile of a foreign or alien insurer under which it is authorized to issue variable life contracts;

(F) biographical data not previously filed with the commissioner with respect to officers and directors of the insurer on the appropriate biographical form used in Texas;

(G) a statement of the insurer's actuary describing the mortality and expense risks that the insurer will bear under the contract; and

(H) the provisions of subparagraphs (A) - (G) of this paragraph will be deemed to have been satisfied to the extent that the information required by the commissioner is provided in form identical to the insurer's registration statement filed under 15 United States Code §77a, et seq.

(3) Standards of suitability. Every insurer seeking approval to enter into the variable life insurance business in this state must establish and maintain a written statement specifying the standards of suitability to be used by the insurer. Such standards of suitability must specify that no recommendation will be made to an applicant to purchase a variable life contract and that no variable life contract will be issued in the absence of reasonable grounds to believe that the purchase of such contract is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or the agent making the recommendation.

(4) Use of sales material. An insurer authorized to transact variable life insurance business in this state may not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state unless it complies with Chapter 21, Subchapter B, Division 1 of this title (relating to Insurance Advertising). An insurer issuing flexible premium variable life contracts must provide, to all prospective purchasers, an illustration of cash surrender values before or at the time of delivery of the contract. Any illustration of cash surrender values delivered to an applicant or prospective applicant under this section must:

(A) include a hypothetical gross investment return of 0.0%, and when other hypothetical gross investment returns are included, the current gross investment return must, to the extent permitted by federal law, be included;

(B) give equal prominence to both guaranteed and non-guaranteed aspects of the contract if guarantees are included in the contract;

(C) prominently display, by way of written statement, the hypothetical nature of the illustration as it relates to investment returns;

(D) prominently state that a contract may terminate due to insufficient premiums and/or poor investment performance; and

(E) prominently show, by way of written statement, that excessive loans or withdrawals may cause the contract to lapse due to insufficient cash surrender value and, at the option of the insurer, prominently display the effects of loans or withdrawals on contract values.

(5) Requirements applicable to contractual services. Any material contract between an insurer and suppliers of consulting, investment, administrative, sales,

marketing, custodial, or other services with respect to variable life insurance operations must be in writing and provide that the supplier of such services furnish the commissioner with any information or reports in connection with such services that the commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with these regulations, and any other applicable law or regulations.

(6) Reports to the commissioner. Any insurer authorized to transact the business of variable life insurance in this state must submit to the commissioner, in addition to any other materials that may be required by this subchapter or any other applicable laws or rules:

(A) an annual statement of the business of its separate account or accounts in such forms as may be prescribed by the National Association of Insurance Commissioners;

(B) before use in this state, any information furnished to applicants as provided for in §4.1507 of this title (relating to Information Furnished to Applicants);

(C) before use in this state, the form of any of the reports to contract holders as provided for in §4.1509 of this title (relating to Reports to Contract Holders); and

(D) such additional information concerning its variable life insurance operations or its separate accounts as the commissioner deems necessary.

(7) Treatment of material reported under paragraph (6) of this section. Receipt of the material specified in paragraph (6) of this section does not imply approval or acceptance of the material. The commissioner will require the redistribution of any

previously distributed material that is found to be false, misleading, deceptive, or inaccurate in any material respect.

(8) Authority of the commissioner to disapprove. Any material required to be filed with the commissioner, or approved by the commissioner, will be subject to disapproval if at any time it is found by the commissioner not to comply with the standards established by these rules.

§4.1504. Insurance Contract and Filing Requirements.

The commissioner will not approve any variable life insurance form filed under these rules unless it conforms to the requirement of applicable law.

(1) Filing of variable life contracts. All variable life contracts, and all riders, endorsements, applications, and other documents that are to be attached to and made a part of the contract and that relate to the variable nature of the contract, must be filed with the commissioner and approved or exempted, as applicable, by the commissioner before delivery or issuance for delivery in this state.

(A) Each variable life contract, rider, endorsement, and application must be filed in accordance with Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). A flexible premium variable life contract submission must be accompanied by the following:

(i) a mathematical demonstration comparing the specimen contract's cash surrender values, assuming the contract's assumed investment rate, if any, or in the absence of an assumed investment rate, on a rate not to exceed the maximum interest rate allowed by Insurance Code Chapter 1105, concerning Standard Nonforfeiture

Law for Life Insurance, to the minimum cash surrender value described in paragraph (2)(F) of this section. The specimen contract should be for the minimum initial face amount permitted to be issued to a male age 35. The demonstration should not assume changes in face amount that are optional to the contract holder. The maturity date and the premium paying period should be the maximum permitted by the contract. The premium for each year should be the greater of the minimum premium permitted for that year or the premium that will allow the contract to mature at the maturity date assuming guaranteed charges and the assumed investment rate, if any, or, in the absence of an assumed investment rate, a rate not to exceed the maximum interest rate permitted by Insurance Code Chapter 1105;

(ii) an actuarial description that sets forth maximum expense charges, loads, and surrender charges, applicable to the contract at issue and upon a change in basic coverage for all ages, bands, and classes of risk, will be provided in conjunction with the contract.

(B) The commissioner may approve variable life contracts and related forms with provisions the commissioner deems to be not less favorable to the contract holder and the beneficiary than those required by these rules.

(2) Mandatory contract benefit and design requirements. Variable life contracts delivered or issued for delivery in this state must comply with the following minimum requirements.

(A) Mortality and expense risks must be borne by the insurer. The expense charges must be subject to the maximums stated in the contract. The charge for mortality must be stated in the contract and may not exceed a mortality rate for the attained age of the insured in a table specified for the calculation of cash surrender values

in Insurance Code Chapter 1105. Provided, for insurance issued on a substandard basis, the charge for mortality may be the mortality rate for the attained age of the insured in such other tables as may be specified by the company and approved by the Texas Department of Insurance.

(B) For scheduled premium contracts, a minimum death benefit must be provided in an amount at least equal to the initial face amount of the contract so long as premiums are duly paid (subject to paragraph (4) of this section).

(C) The contract must reflect the investment experience of one or more separate accounts established and maintained by the insurer. The insurer must demonstrate that the reflection of investment experience in the variable life contract is actuarially sound.

(D) Each variable life contract must be credited with the full amount of the net investment return applied to the benefit base.

(E) Any changes in variable death benefits of each variable life contract must be determined at least annually.

(F) The cash surrender value of each variable life contract must be determined at least monthly. The method of computation of cash surrender values and other nonforfeiture benefits, as described in the contract and in a statement filed with the commissioner in this state in which the contract is delivered, or issued for delivery, must be in accordance with recognized actuarial procedures that recognize the variable nature of the contract. The method of computation must be such that if the net investment return credited to the contract at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the contract, then the resulting cash surrender values and other nonforfeiture benefits

must be at least equal to the minimum values required by Insurance Code Chapter 1105, for a general account contract with such premiums and benefits. The assumed investment rate may not exceed the maximum interest rate permitted under Insurance Code Chapter 1105. If the contract does not contain an assumed investment rate, this demonstration must be based on a rate not to exceed the maximum interest rate permitted under Insurance Code Chapter 1105. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not limited to, a guarantee that the amount payable at death or maturity is at least equal to the amount that otherwise would have been payable if the net investment return credited to the contract at all times from the date of issue had been equal to the assumed investment rate.

(3) Mandatory contract provisions. Every variable life contract filed for approval in this state must contain at least the following.

(A) The cover page or pages corresponding to the cover page of each contract must contain:

(i) a prominent statement in either contrasting color or in boldface type that the amount or duration of death benefit may be variable or fixed under specified conditions;

(ii) a prominent statement in either contrasting color or in boldface type that cash surrender values may increase or decrease in accordance with the experience of the separate account, subject to any specified minimum guarantees;

(iii) a statement describing any minimum death benefit required under paragraph (2)(B) of this section;

(iv) the method, or a reference to the contract provision that describes the method, for determining the amount of insurance payable at death;

(v) a captioned provision that the contract holder may return the variable life contract within 10 days of receipt of the contract by the contract holder, and receive a refund equal to the premiums paid;

(vi) such other items as are currently required for fixed benefit life contracts and that are not inconsistent with this subchapter.

(B) A grace period in accordance with this subparagraph.

(i) For scheduled premium contracts, a provision for a grace period of not less than 31 days from the premium due date that must provide that when the premium is paid within the grace period, cash surrender values will be the same, except for the deduction of any overdue premium, as though the premium were paid on or before the due date.

(ii) For flexible premium contracts, a provision for a grace period beginning on the contract processing day when the total charges authorized by the contract that are necessary to keep the contract in force until the next contract processing day exceed the amounts available under the contract to pay such charges in accordance with the terms of the contract. Such grace period must end on a date not less than the later of the date 61 days after the contract processing day when the grace period begins, or the date that is 31 days after the mailing date of the report to contract holders required by §4.1509(3) of this title (relating to Reports to Contract Holders). The death benefit payable during the grace period will equal the death benefit in effect immediately before such period less any overdue charges. If the contract processing days occur monthly, the insurer may require payment of an amount equal to the greater of:

(I) not more than three times the charges that were due on the contract processing day on which the amounts available under the contract were insufficient to pay all charges authorized by the contract that are necessary to keep such contract in force until the next contract processing day; or

(II) the amount necessary to keep such contract in force for a period of three calendar months from the contract processing day on which the amounts available under the contract were insufficient to pay all charges authorized by the contract.

(C) For scheduled premium contracts, a provision that the contract will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising after the end of the grace period following the date of default together with accrued interest on the contract to the date of reinstatement and payment of an amount not exceeding the greater of:

(i) all overdue premiums at an interest rate not exceeding the contract loan interest rate in effect for the period during and after the lapse of the contract, and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding the contract loan interest rate in effect for the period during and after the lapse of the contract; or

(ii) 110% of the increase in cash surrender value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at

a rate not exceeding the contract loan interest rate in effect for the period during and after the lapse of the contract.

(D) A full description of the benefit base and the method of calculation and application of any factors used to adjust variable benefits under the contract.

(E) A provision designating the separate account to be used and stating that:

(i) the assets of such separate account must be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life contracts supported by the separate account; and

(ii) the assets of such separate account must be valued at least as often as any contract benefits vary but at least monthly.

(F) A provision specifying what documents constitute the entire insurance contract.

(G) A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on the insured's behalf, are considered as representations and not warranties.

(H) An identification of the owner of the insurance contract.

(I) A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation.

(J) A statement of any conditions or requirements concerning the assignment of the contract.

(K) A description of any adjustments in benefits under the contract to be made in the event of misstatement of age or sex of the insured.

(L) A provision that the contract will be incontestable by the insurer after it has been in force for two years during the lifetime of the insured, provided, however, that any increase in the amount of the contract's death benefits after the contract issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, will be incontestable after any such increase has been in force, during the lifetime of the insured, for two years from the date of issue of such increase.

(M) A provision stating that the investment policy of the separate account may not be changed without the approval of the insurance commissioner of the state of domicile of the insurer, and that the approval process is on file with the commissioner of this state.

(N) A provision that the payment of variable death benefits in excess of any minimum death benefits, cash surrender values, contracts loans, or partial withdrawals (except when used to pay the premiums) or partial surrenders may be deferred:

(i) for up to two months for death benefit payments or six months for all other payments from the date of request, if such payments are based on contract values that do not depend on the investment performances of the separate accounts; or

(ii) for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists that may make such payment impractical.

(O) If settlement options are provided, at least one such option must be provided on a fixed basis only.

(P) A detailed and complete definition for the basis for computing the contract value and the cash surrender value of the contract. For flexible premium variable life contracts, the definition must include the following:

(i) the guaranteed maximum expense charges and loads;

(ii) any limitation on the crediting of additional interest. Interest credits may not remain conditional for a period longer than 12 months;

(iii) any assumed investment rate or rates;

(iv) the guaranteed maximum mortality charges;

(v) any other guaranteed charges; and

(vi) any surrender or partial withdrawal charges.

(Q) Premiums or charges for incidental insurance benefits must be stated separately.

(R) Any other contract provisions required by this subchapter.

(S) Such other items as are currently required for fixed benefit life insurance contracts and are not inconsistent with this subchapter.

(T) A provision for nonforfeiture insurance benefits. The insurer may establish either a reasonable minimum cash surrender value amount or a reasonable

death benefit that may be purchased under any nonforfeiture option, below which any nonforfeiture option will not be available.

(U) If a flexible premium contract does not provide for a guarantee of death benefit coverage, but does provide for a "maturity date," "end date," or similar date, then the contract must also contain a statement, in close proximity to that date, that it is possible that the coverage may not continue to the maturity date even if scheduled premiums are paid in a timely manner.

(4) Contract loan provision. Every variable life contract, other than term insurance contracts and pure endowment contracts, delivered or issued for delivery in this state must contain provisions that are not less favorable to the contract holders than the following.

(A) A provision for contract loans after the contract has been in force for one full year that provides the following:

(i) at least 75% of the contract's cash surrender value may be borrowed;

(ii) the amount borrowed must bear interest at a rate not to exceed that permitted by Insurance Code Chapter 1110, concerning Interest Rates on Certain Policy Loans;

(iii) any indebtedness must be deducted from the proceeds payable on death; and

(iv) any indebtedness must be deducted from the cash surrender value upon surrender or in determining any nonforfeiture benefit.

(B) For scheduled premium contracts, whenever the indebtedness exceeds the cash surrender value, the insurer must give notice of any intent to cancel the

contract if the excess indebtedness is not repaid within 31 days after the date of mailing of such notice. For flexible premium contracts, whenever the total charges authorized by the contract that are necessary to keep the contract in force until the next following contract processing day exceed the amounts available under the contract to pay such charges, a report must be sent to the contract holder containing the information specified by §4.1509(3) of this title.

(C) The contract may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the contract holder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110% of the corresponding increase in cash surrender values and by furnishing such evidence of insurability as the insurer may require.

(D) The contract may specify a reasonable minimum amount that may be borrowed at any time, but such minimum may not apply to any automatic premium loan provision.

(E) No contract loan provision is required if the contract is under extended insurance nonforfeiture option.

(F) The contract loan provisions must be constructed so that variable life insurance contract holders who have not exercised such provisions are not disadvantaged by the exercise of those provisions.

(G) Amounts paid to the contract holders upon the exercise of any contract loan provision must be withdrawn from the separate account and must be returned to the separate account upon repayment except that a stock insurer may provide the amounts for contract loans from the general account.

(5) Other contract provisions. The following provisions may in substance be included in a variable life contract or related form delivered or issued for delivery in this state:

(A) an exclusion for suicide within two years of the issue date of the contract, provided, however, that to the extent of the increased death benefits only, the contract may provide an exclusion for suicide within two years of any increase in death benefits that results from an application or request of the owner after the contract issue date;

(B) incidental insurance benefits may be offered on a fixed or variable basis;

(C) contracts issued on a participating basis must offer to pay dividend amounts in cash. In addition, such contracts may offer the following dividend options:

(i) the amount of the dividend may be credited against premium payments;

(ii) the amount of the dividend may be applied to provide amounts of additional fixed or variable benefit life insurance;

(iii) the amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(iv) the amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance; or

(v) the amount of the dividend may be deposited as a variable deposit in the separate account or separate accounts;

(D) a provision allowing the contract holder to elect in writing in the application for the contract or thereafter an automatic premium loan on a basis not less favorable than that required of contract loans under paragraph (4) of this section, except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed;

(E) a provision allowing the contract holder to make partial withdrawals; and/or

(F) any other contract provision approved by the commissioner.

§4.1505. Reserve Liabilities for Variable Life Insurance.

(a) Reserve liabilities for variable life insurance contracts must be established under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(b) For scheduled premiums contracts, reserve liabilities for the guaranteed minimum death benefit must be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and be maintained in the general account of the insurer and must not be less than the greater of the following minimum reserve:

(1) the aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life contract, assuming an immediate one-third depreciation in the current value of the assets in the separate account followed by a net investment return equal to the assumed investment rate; or

(2) the aggregate total of the "attained age level" reserves on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract must not be less than zero and must equal the "residue," as described in subparagraph (A) of this paragraph, of the prior year's "attained age level" reserve in the contract, with any such "residue," increased or decreased by a payment computed on an attained-age basis as described in subparagraph (B) of this paragraph.

(A) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract may not be less than zero and must be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence must be based in the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(B) The payment referred to in this paragraph must be computed so that the present value of a level of that amount each year over the future premium paying period of the contract is equal to (i) minus (iii), where:

(i) is the present value of the future guaranteed minimum death benefits;

(ii) is the present value of the future death benefits that would be payable in the absence of such guarantee; and

(iii) is any "residue," as described in subparagraph (A) of this paragraph, of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid-up, the payment must equal (i) minus (ii) minus (iii). The amounts of the future death benefits referred to in clause (ii) of this paragraph must be computed assuming a net investment return of the separate account that may differ from the assumed investment rate and/or the valuation interest but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

(3) The valuation interest rate and mortality table used in computing the two minimum reserves described in paragraph (2)(A) and (B) of this subsection must conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the insurer may employ suitable approximations and estimates, including, but not limited to, groupings and averages.

(c) For flexible premium contracts, reserve liabilities for any guaranteed minimum death benefit must be maintained in the general account of the insurer and may not be less than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate. The valuation interest rate and mortality table used in computing this additional reserve, if any, must conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the insurer may employ suitable approximations and estimates, including, but not limited to, groupings and averages.

(d) Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits must be maintained in the general

account, and reserve liabilities for all variable aspects of the variable incidental insurance benefits must be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

§4.1506. Separate Accounts.

The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer.

(1) Establishment of separate accounts. Any domestic life insurance company issuing variable life contracts must establish one or more separate accounts under Insurance Code Chapter 1152, concerning Separate Accounts, Variable Contracts, and Related Products.

(A) If no law or other regulation provides for the custody of separate account assets and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets must be in writing and the commissioner has authority to review and approve of both the terms of any such contract and the proposed custodian before the transfer of custody.

(B) In connection with the handling of separate account assets, such insurer may not, without prior written approval of the commissioner, employ in any material manner any person who:

(i) within the last 10 years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of 18 United States Code §§1341, 1342, or 1343, as amended;

(ii) within the last 10 years had been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(iii) within the last 10 years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state laws involving fraud, deceit, or knowing misrepresentation.

(C) All persons with access to the cash, securities, or other assets allocated to or held by the separate account must be under bond in the amount of not less than $100,000.

(2) Amounts in the separate account. The insurer must maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance contracts or the benefit base for such contracts.

(3) Investments by the separate account.

(A) No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(i) in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made; and

(ii) such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

(B) The separate account must have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under contracts funded by the account.

(4) Limitations on ownership.

(A) A separate account may not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investment of such account in such security valued as required by these rules, would exceed 10% of the value of the assets of the separate account. Upon appropriate documentation by the company that evidences that a waiver of this limitation will not render the operation of the separate account hazardous to the public or contract holders in this state, the commissioner may in writing waive this limitation.

(B) No separate account may purchase or otherwise acquire the voting securities of any issuer if, as a result of such acquisition, the insurer and its separate accounts in the aggregate will own more than 10% of the total issued and outstanding voting securities of such issuer. Upon appropriate documentation by the company evidencing that a waiver of this limitation will not render the operation of the separate account hazardous to the public or the contract holders in this state, the commissioner may in writing waive this limitation.

(C) The percentage limitations specified in subparagraph (A) of this paragraph may not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered under 15 United States Code §§80b-1 - 80b-21, as amended, or other pools of investment assets if the investments and

investment policies of such investment companies or asset pools comply substantially with the provisions of paragraph (3) of this section and other applicable portions of this regulation.

(5) Valuation of separate account assets. Investments of the separate account must be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

(6) Separate account investment policy. The investment policy of a separate account operated by a domestic insurer filed under §4.1503(2)(C) of this title (relating to Qualifications of Insurer to Issue Variable Life Insurance) may not be changed without first filing such change with the commissioner.

(A) Any change filed under this paragraph will be effective 60 days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of such 60-day period of the commissioner's disapproval of the proposed change. At any time, the commissioner may, after notice and public hearing, disapprove any change that has become effective under this paragraph.

(B) The commissioner may disapprove the change if the commissioner determines that the change would be detrimental to the interests of the contract holders participating in such separate accounts.

(7) Charges against separate account. The insurer must disclose in writing, before or contemporaneously with delivery of the contract, all charges that may be made against the separate account, including, but not limited to, the following:

(A) taxes or reserves for taxes attributable to investment gains and income of the separate account;

(B) actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

(C) actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities. The tabular costs of insurance may not exceed the mortality rate for the attained age of the insured in the table specified for the calculation of cash surrender values in Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance, provided, for insurance issued on a substandard basis, the charge for mortality may be the mortality rate for the attained age of the insured in such other table as may be specified by the company and approved by the Texas Department of Insurance;

(D) charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(E) a charge, at a rate specified in the contract, for mortality and expense guarantees;

(F) any amounts in excess of those required to be held in the separate accounts; and

(G) charges for incidental insurance benefits.

(8) Standards of conduct. Every insurer seeking approval to enter into the variable life insurance business in this state must adopt by formal action of its board of directors a written statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such standards of conduct are binding on the insurer and those to whom it refers. A code of ethics meeting the requirements of 15 United

States Code §80a-17, as amended, and applicable rules and regulations adopted under that section satisfies the provisions of this paragraph.

(9) Conflicts of interest. Rules under any provision of the Insurance Code or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest also apply to members of any separate account's committee or other similar body.

(10) Investment advisory services to a separate account. An insurer may not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance contracts unless:

(A) the person providing such advice is registered as an investment advisor under 15 United States Code §§80b-1 - 80b-21, as amended;

(B) the person providing such advice is an investment manager under 29 United States Code §1001, et seq., as amended, with respect to the assets of each employee benefit plan allocated to the separate account; or

(C) the insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed advisor:

(i) the name and form of the organization, and its principal place of business;

(ii) the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, of such individual;

(iii) a written standard of conduct complying in substance with requirements of paragraph (8) of this section that has been adopted by the investment

advisor and is applicable to the investment advisor, its officers, directors, and affiliates; and

(iv) a statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

(I) has been convicted within 10 years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director of an insurance company, a banker, an insurance agent, a securities broker, or an investment advisor involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of 18 United States Codes §§1341, 1342, or 1343, as amended;

(II) has been permanently or temporarily enjoined by an order, judgment, or decree of any court of competent jurisdiction from acting as an investment advisor, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(III) has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under such laws; or

(IV) has been censored, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended, or been barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities; and

(D) such investment advisory contract must be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than 60 days' written notice to the investment advisor. The commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if the commissioner deems continued operation under the contract to be hazardous to the public or the insurer's contract holders.

§4.1507. Information Furnished to Applicants.

An insurer delivering or issuing for delivery in this state any variable life insurance contracts must deliver to the applicant for such contract and obtain a written acknowledgment of receipt from such applicant coincident with or before the execution of the application, the following information. The requirements of this section will be deemed to have been satisfied to the extent that a disclosure containing information required by this section is delivered, either in the form of a prospectus included in the requirements of 15 United States Code §77a, et seq., that was declared effective by the Securities and Exchange Commission; or all information and reports required by 29 United States Code §1001 et seq., if the policies are exempted from the registration requirements of 15 United States Code §77a, et seq.:

(1) a summary explanation in nontechnical terms, of the principal features of the contract, including a description of how the variable benefits will reflect the investment experience of the separate account and the factors that affect such variation. Such explanation must include notices of the provision required by §4.1504(3)(A)(v) and (3)(F) of this title (relating to Insurance Contract and Filing Requirements);

(2) a statement of the investment policy of the separate account, including:

(A) a description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

(B) any restrictions or limitations on how the operations of the separate account are intended to be conducted;

(3) a statement of the net investment return of the separate account for each of the last 10 years or such lesser period as the separate account has been in existence;

(4) a statement of the charges levied against the separate account during the previous year;

(5) a summary of the method to be used in valuing assets held by the separate account;

(6) a summary of the federal income tax aspects of the contract applicable to the insured, the contract holder, and the beneficiary;

(7) illustrations of benefits payable under the variable life insurance contract. Such illustrations must be prepared by the insurer and may not include projections of past investment experience into the future or attempted predictions of future investments experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

§4.1508. Application.

The application for a variable life contract must contain:

(1) a prominent statement that the death benefit may be variable or fixed under specified conditions;

(2) a prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees); and

(3) questions designed to elicit information that enables the insurer to determine the suitability of variable life insurance for the applicant.

§4.1509. Reports to Contract Holders.

Any insurer delivering or issuing for delivery in this state any variable life contracts must mail to each variable life insurance contract holder at their last known address the following reports.

(1) Within 30 days after each anniversary of the contract, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or contract loan, any interest charge, any optional payments allowed under §4.1504(4) of this title (relating to Insurance Contract and Filing Requirements) under the contract computed as the contract anniversary date. Provided, however, that such statement may be furnished within 30 days after a specified date in each contract year so long as the information contained in the statement is computed as of a date not more than 60 days before the mailing of such notice. This statement must state that, in accordance with the investment experience of the separate account, the cash surrender values and the variable death benefit may increase or decrease, and must prominently identify any value described in the statement that may be recomputed before the next statement required by this section. If the contract guarantees that the variable death benefit on the next contract anniversary

date will not be less than the variable death benefit specified in such statement, the statement must be modified to so indicate. For flexible premium contracts, the report must contain a reconciliation of the change since the previous report in contract value and cash surrender value, if different, because of payments made less deduction for expense charges, withdrawals, investment experience, insurance charges, and any other charges made against the contract value. In addition, the report must show the projected contract value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that:

(A) planned periodic premiums, if any, are paid as scheduled;

(B) guaranteed costs of insurance are deducted; and

(C) the net return is equal to the assumed rate or, in the absence of an assumed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the contract may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(2) Annually, a statement or statements including:

(A) a summary of the financial statement of the separate account based on the annual statement last filed with the commissioner;

(B) the net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five years when available;

(C) a list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the commissioner;

(D) any charges levied against the separate account during the previous year; and

(E) a statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment advisor of the separate account.

(3) For flexible premium contracts, a report must be sent to the contract holder if the amounts available under the contract on any contract processing day to pay the charges authorized by the contract are less than the amount necessary to keep the contract in force until the next following contract processing day. The report must indicate the minimum payment required under the terms of the contract to keep it in force and the length of the grace period for payment of such amount.

§4.1510. Separability.

If any provision of this chapter (relating to Life - Variable Life Insurance) or the application of such provisions to any person or circumstance is for any reason held to be invalid, the remainder of the sections and the application of such provision to other persons or circumstances will not be affected.

Subchapter P. Life - Required Reinstatement Relating to Mental Incapacity of the Insured for Individual Life Policies Without Nonforfeiture Benefits 28 TAC §§4.1602 - 4.1606 and 4.1609 - 4.1613

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.1602 - 4.1606 and 4.1609 - 4.1613 under Insurance Code §1106.010 and §36.001.

Insurance Code §1106.010 provides the commissioner adopt reasonable rules to implement Insurance Code Chapter 1106.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.1602. Applicability.

This subchapter applies to all individual life policies that do not provide nonforfeiture benefits issued to Texas residents by insurers licensed in this state, including stipulated premium companies and fraternal benefit societies, that lapse due to the mental incapacity of the insured and that qualify for reinstatement under the eligibility requirements set forth in §4.1605 of this title (relating to Eligibility Requirements).

§4.1603. Severability.

Where any term or section of this subchapter is determined by a court of competent jurisdiction to be inconsistent with the statutes of this state or to be unconstitutional, the remaining terms and provisions of this subchapter remain in effect.

§4.1604. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Commissioner--The commissioner of insurance.

(2) Department--The Texas Department of Insurance.

(3) Insured--The person whose life is insured under the policy. For purposes of this subchapter, the insured is the owner, unless the insured and owner are different parties as set forth in the policy.

(4) Mental incapacity--Lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a decision regarding failure to pay a premium when due and the ability to reach an informed decision in the matter.

(5) Owner--The person who has all the rights and all the responsibilities of the policy.

(6) Policyholder--The owner of the policy.

(7) Proof of mental incapacity--The clinical diagnosis of a physician licensed in this state and qualified to make the diagnosis.

§4.1605. Eligibility Requirements.

An eligible policy that is subject to this subchapter must be reinstated, without evidence of insurability, on payment of past due premiums and interest if it meets the following requirements:

(1) it has been in force continuously for at least five years immediately before the date of lapse;

(2) all premiums have been paid during such period, or within the grace period;

(3) there is a subsequent unintentional default in premium payments caused by the mental incapacity of the insured; and

(4) proof and request for reinstatement are submitted within one year from the date of lapse.

§4.1606. Payment of Past Due Premiums.

The insurer may require, as a condition of reinstatement, payment of past due premiums, plus interest at a rate not to exceed 6.0% per year.

§4.1609. Notification and Disclosure Requirements.

(a) The insurer is required to send notice of the conditions set forth in this subchapter under which the policy may qualify for reinstatement due to the mental incapacity of the insured. The notice must be sent to the owner of any individual life policy that does not provide nonforfeiture benefits if the policy is in force, renewed, or issued on or after September 1, 1995. The notice required to be provided by this subsection must be provided within 90 days following lapse of an eligible policy.

(b) For all policies issued on or after September 1, 1995, disclosure of the conditions set forth in this subchapter under which the policy may qualify for reinstatement due to the mental incapacity of the insured may be made by incorporating the language of §4.1613 of this title (relating to Notice and Disclosure Form), either in the policy or in an endorsement attached to the policy, in lieu of the notice requirements set forth in subsection (a) of this section.

(c) The notice required to be provided by this subsection will be deemed to be in compliance if mailed by first class mail to the last known address of the policyholder or if contained in the policy or included as an endorsement to the policy.

(d) The notice required by this subsection must be provided in the form set forth in §4.1613 of this title.

§4.1610. Reinstatement Procedures.

(a) The insurer must accept a request for reinstatement and proof of mental incapacity that is filed by:

(1) the insured, or the owner, if the insured and owner are not the same party;

(2) the legal guardian of the insured;

(3) other legal representative of the insured; or

(4) the legal representative of the estate of the insured.

(b) Proof of mental incapacity and the request for reinstatement must be submitted within one year after the date of lapse of the policy.

§4.1611. Reduced Benefits.

The insurer must pay the death benefit under an eligible policy if the insured dies within one year of the date of lapse and the requirements for submitting proof of mental incapacity and request for reinstatement are met. The insurer must reduce the death benefit under a policy that is eligible for reinstatement under this subchapter by the amount of premiums due and unpaid on the date of death, plus interest on such premiums at the reinstatement interest rate, if there is an uncontroverted claim for benefits that exceeds the amount of premiums and interest owed.

§4.1612. Form Filing Procedures.

(a) For all new forms subject to this subchapter filed on or after September 1, 1995, the insurer must include with the form filing written notification to the department specifying the method of notification as set forth in §4.1609 of this title (relating to Notification and Disclosure Requirements) by which the notice requirements of §4.1613 of this title (relating to Notice and Disclosure Form) will be met.

(b) For all forms subject to this subchapter approved or filed before September 1, 1995, the insurer must submit to the department a certification, signed by an officer of the company, specifying the method or methods of notification as set forth in §4.1609 of this title by which the notice requirements of §4.1613 of this title will be met.

(c) All policies and endorsements are subject to the filing requirements of Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

§4.1613. Notice and Disclosure Form.

(a) If the elected method of compliance is notification to all existing policyholders as described in §4.1609(b) of this title (relating to Notification and Disclosure Requirements), the notice required by this subchapter must be provided in the following manner:

Figure: 28 TAC §4.1613(a)

NOTICE REGARDING REINSTATEMENT OF A LAPSED POLICY DUE TO THE MENTAL INCAPACITY OF THE INSURED

(Insurance Company's Name)
(Address)

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS IT MAY BE IMPORTANT TO YOU IN THE FUTURE

ELIGIBILITY	If your policy lapses, it may be eligible for reinstatement if all of the following conditions are met:
	(1) The policy has been in force continuously for at least five years immediately prior to the date of lapse;
	(2) All premiums have been paid in a timely manner during this period;
	(3) The lapse results from an unintentional default in premium payments caused by the mental incapacity of the insured; and
	(4) We receive a request for reinstatement and proof of the insured's mental incapacity within one year from the date of the lapse.
PROOF AND REQUEST	To establish proof of the insured's mental incapacity, we must be provided with a clinical diagnosis by a physician licensed in Texas and qualified to make the diagnosis. We will accept the proof and request for reinstatement from:
	(1) you;
	(2) the insured, if you are not the insured;
	(3) the legal guardian of the insured;
	(4) other legal representative of the insured; or
	(5) the legal representative of the estate of the insured.
MENTAL INCAPACITY	Mental incapacity means lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a decision regarding failure to pay a premium when due and the ability to reach an informed decision in the matter.
REINSTATEMENT	We will reinstate an eligible policy within a period of one year after the date of lapse. We will require payment of all unpaid premiums, plus { up to 6%} interest, from the date of lapse to the date of reinstatement.
	(1) Your policy will be treated as if it had been in force continuously since the lapse;
	(2) The policy provisions will apply as if there had been no lapse; and
	(3) You will be required to make any and all future premium payments required by the policy provisions to keep the policy in force.
REDUCED BENEFITS	We will pay the death benefit under an eligible policy if the insured dies within one year from the date of lapse, provided that the requirements for submitting proof of mental incapacity and request for reinstatement are met. We may reduce the death benefit by any unpaid premiums due, plus { up to 6%} interest from the date of lapse to the date of death.
EXCEPTIONS	We are not required to reinstate the policy or pay the death benefit if the insured becomes mentally incapacitated after the grace period contained in the policy expires.
DEFINITIONS	You and Your – The owner of the policy.
	We - { The Name of the Insurer}
	Lapse – The due date of the last premium that remains unpaid after the expiration of the grace period defined in the policy.

(b) If the elected method of compliance is notification within 90 days following the lapse of an eligible policy as described in §4.1609(a) of this title, the notice required by this subchapter must be provided in the following manner:

Figure: 28 TAC §4.1613(b)

NOTICE REGARDING REINSTATEMENT OF A LAPSED POLICY DUE TO THE MENTAL INCAPACITY OF THE INSURED

(Insurance Company's Name)

(Address)

YOUR POLICY HAS LAPSED

ELIGIBILITY	Your policy has lapsed. It may be eligible for reinstatement if all of the following conditions are met:
	(1) The policy has been in force continuously for at least five years immediately prior to the date of lapse;
	(2) All premiums have been paid in a timely manner during this period;
	(3) The lapse resulted from an unintentional default in premium payments caused by the mental incapacity of the insured; and
	(4) We receive a request for reinstatement and proof of the insured's mental incapacity within one year from the date of the lapse.
PROOF AND REQUEST	To establish proof of the insured's mental incapacity, we must be provided with a clinical diagnosis by a physician licensed in this state and qualified to make the diagnosis. We will accept the proof and request for reinstatement from:
	(1) you;
	(2) the insured, if you are not the insured;
	(3) the legal guardian of the insured;
	(4) any other legal representative of the insured;
	(5) the legal representative of the estate of the insured.
MENTAL INCAPACITY	Mental incapacity means lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a decision regarding failure to pay a premium when due and the ability to reach an informed decision in the matter.
REINSTATEMENT	We will reinstate an eligible policy within a period of one year after the date of lapse. We will require payment of all unpaid premiums, plus { up to 6%} interest, from the date of lapse to the date of reinstatement. After reinstatement:
	(1) your policy will be treated as if it had been in force continuously since the lapse;
	(2) the policy provisions will apply as if there had been no lapse; and
	(3) you will be required to make any and all future premium payments required by the policy provisions to keep the policy in force.
REDUCED BENEFITS	We will pay the death benefit under an eligible policy if the insured dies within one year from the date of lapse, provided that the requirements for submitting proof of mental incapacity and request for reinstatement are met. We may reduce the death benefit by any unpaid premiums due, plus { up to 6%} interest from the date of lapse to the date of death.
EXCEPTIONS	We are not required to reinstate the policy or pay the death benefit if the insured becomes mentally incapacitated after the grace period contained in the policy expires.
DEFINITIONS	You and Your – The owner of the policy.
	We - { The Name of the Insurer}
	Lapse – The due date of the last premium that remains unpaid after the expiration of the grace period defined in the policy.

(c) If the elected method of compliance is incorporating the language of this section in the policy or in an endorsement, the insurer may incorporate the text of subsection (a) of this section, omitting the titles referencing "Notice" and substituting an appropriate prominent title, such as "Reinstatement Due to the Mental Incapacity of the Insured."

Subchapter Q. Life - Nonforfeiture Standards for Individual Life Insurance in Employer Pension Plans
28 TAC §§4.1702 - 4.1707

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.1702 - 4.1707 under Insurance Code §§36.004, 541.057, 541.401, 1105.055(h), and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §541.057 prohibits unfair discrimination in the rates, dividends, or any other contract terms and conditions for individuals of the same class and life expectancy in life insurance and annuity contracts.

Insurance Code §541.401 provides that the commissioner may adopt and enforce reasonable rules necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §1105.055(h) specifies that the commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.1702. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) 1980 CET Table--That mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 National Association of Insurance Commissioners (NAIC) amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

(2) 1980 CET Table (F)--That mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

(3) 1980 CET Table (M)--That mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

(4) 1980 CSO Table, with or without Ten-Year Select Mortality Factors--That mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for

Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors.

(5) 1980 CSO Table (F), with or without Ten-Year Select Mortality Factors--That mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

(6) 1980 CSO Table (M), with or without Ten-Year Select Mortality Factors--That mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

(7) 1980 CSO and 1980 CET smoker and nonsmoker mortality tables--The mortality tables derived from the 1980 CSO and 1980 CET mortality tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the NAIC in December 1983.

(8) *Norris* decision--The decision of the United States Supreme Court in the case of *Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans v. Norris*, 463 U.S. 1073 (1983).

§4.1703. Standard.

(a) For any policy of insurance on the life of either a male or female insured, delivered, or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B, concerning Computation of Adjusted Premiums Using Nonforfeiture Net Level Premium Method), and before January 1, 2017, for that policy form, the following tables described in paragraphs (1) and (2) of this subsection may be used as specified in subsection (b) of this section in determining minimum cash surrender values, amounts of paid-up

nonforfeiture benefits, or benefits under extended term insurance provisions included in the policy. For policies issued on or after January 1, 2017, the valuation manual, adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, provides the tables to be used.

(1) A mortality table that is a blend of the 1980 CSO Table (M) and 1980 CSO Table (F), with or without Ten-Year Select Mortality Factors, may, at the option of the company, be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

(2) A mortality table that is of the same blend as used in paragraph (1) of this subsection, but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F), may, at the option of the company, be substituted for the 1980 CET Table.

(b) The following tables are to be considered as the basis for acceptable tables:

(1) 100% male, 0% female for tables to be designated as the "1980 CSO-A" and "1980 CET-A" Tables;

(2) 80% male, 20% female for tables to be designated as the "1980 CSO-B" and "1980 CET-B" Tables;

(3) 60% male, 40% female for tables to be designated as the "1980 CSO-C" and "1980 CET-C" Tables;

(4) 50% male, 50% female for tables to be designated as the "1980 CSO-D" and "1980 CET-D" Tables;

(5) 40% male, 60% female for tables to be designated as the "1980 CSO-E" and "1980 CET-E" Tables;

(6) 20% male, 80% female for tables to be designated as the "1980 CSO-F" and "1980 CET-F" Tables; and

(7) 0% male, 100% female for tables to be designated as the "1980 CSO-G" and "1980 CET-G" Tables.

(c) Values of 1,000 qx for the blended tables as specified in subsection (b)(2) - (6) of this section can be found in "Proceedings of the NAIC," Volume 1, 1984, pages 396 - 400. "Proceedings of the NAIC," Volume 1, 1984, page 457, shows the method by which ten-year select mortality factors may be obtained. The tables specified in subsection (b)(1) of this section are the same as the 1980 CSO Table (M) or the 1980 CET Table (M), as applicable. The tables specified in subsection (b)(7) of this section are the same as the 1980 CSO Table (F) or the 1980 CET Table (F), as applicable. The tables specified in subsection (b)(2) - (6) of this section are adopted by reference. Copies of those tables may be obtained by contacting Life and Health Division, Life and Health Actuarial, MC: LH-ACT, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The tables in subsection (b)(1) and (7) of this section are already adopted by statutory law under alternate names.

(d) The tables specified in subsection (b)(1) and (7) of this section may not be used with respect to policies issued on or after January 1, 1985, except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other or except for certain policies converted from group insurance. Such group conversions issued on or after January 1, 1986, must use mortality tables based on the blend of lives by sex expected for such policies if such group conversions are considered as extensions of the decision in *Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans v. Norris,* 463 U.S. 1073 (1983). This consideration has not been clearly defined by court or legislative action in all jurisdictions, as of the date of promulgation of this section.

(e) Notwithstanding any other provision of this subchapter, an insurer may not use these blended tables unless the *Norris* decision is known to apply to the policies involved, or unless there exists a bona fide concern on the part of the insurer that the *Norris* decision might reasonably be construed to apply by a court having jurisdiction.

§4.1704. Alternate Rule.

(a) In determining minimum cash surrender value and amounts of paid-up nonforfeiture benefits for any policy of insurance on either a male or a female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B, concerning Computation of Adjusted Premiums Using Nonforfeiture Net Level Premium Method), and before January 1, 2017, for that policy form, in addition to the mortality tables that may be used according to §4.1703 of this title (relating to Standard), the tables in paragraphs (1) and (2) of this subsection may be used. For policies issued on or after January 1, 2017, the valuation manual, adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, provides the tables to be used.

(1) A mortality table that is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, with or without 10-year select mortality factors, may, at the option of the company, be substituted for the 1980 CSO Table, with or without 10-year select mortality factors.

(2) A mortality table that is of the same blend as used in paragraph (1) of this subsection but applied to form a blend of the male and female rates of mortality according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table or 1980 CET Nonsmoker Mortality Table may, at the option of the company, be substituted for the 1980 CET Table.

(b) The following blended mortality tables are considered as the basis for acceptable tables according to subsection (a) of this section:

(1) 100% male, 0% female for smoker tables to be designated as the 1980 CSO-SA and 1980 CET-SA Tables;

(2) 80% male, 20% female for smoker tables to be designated as the 1980 CSO-SB and 1980 CET-SB Tables;

(3) 60% male, 40% female for smoker tables to be designated as the 1980 CSO-SC and 1980 CET-SC Tables;

(4) 50% male, 50% female for smoker tables to be designated as the 1980 CSO-SD and 1980 CET-SD Tables;

(5) 40% male, 60% female for smoker tables to be designated as the 1980 CSO-SE and 1980 CET-SE Tables;

(6) 20% male, 80% female for smoker tables to be designated as the 1980 CSO-SF and 1980 CET-SF Tables;

(7) 0% male, 100% female for smoker tables to be designated as the 1980 CSO-SG and 1980 CET-SG Tables;

(8) 100% male, 0% female for nonsmoker tables to be designated as the 1980 CSO-NA and 1980 CET-NA Tables;

(9) 80% male, 20% female for nonsmoker tables to be designated as the 1980 CSO-NB and 1980 CET-NB Tables;

(10) 60% male, 40% female for nonsmoker tables to be designated as the 1980 CSO-NC and 1980 CET-NC Tables;

(11) 50% male, 50% female for nonsmoker tables to be designated as the 1980 CSO-ND and CET-ND Tables;

(12) 40% male, 60% female for nonsmoker tables to be designated as the 1980 CSO-NE and 1980 CET-NE Tables;

(13) 20% male, 80% female for nonsmoker tables to be designated as the 1980 CSO-NF and 1980 CET-NF Tables; and

(14) 0% male, 100% female for nonsmoker tables to be designated as the 1980 CSO-NG and 1980 CET-NG Tables.

(c) The Texas Department of Insurance adopts and incorporates into this subchapter by reference the tables to which subsection (b) of this section refers as tables to be used in conjunction with the section adopted under this subchapter. Copies of these tables can be obtained from the Life and Health Division, Life and Health Actuarial, MC: LH-ACT, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

(d) The tables specified in subsection (b)(1), (7), (8), and (14) of this section may not be used except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other.

(e) Notwithstanding any other provision of this subchapter, an insurer may not use the blended mortality tables in subsection (b) of this section unless the *Norris* decision is known to apply to the policies involved, or unless there exists a bona fide concern on the

part of the insurer that the *Norris* decision might reasonably be construed to apply by a court having jurisdiction.

§4.1705. Unfair Discrimination.

It is not a violation of Insurance Code §541.057, concerning Unfair Discrimination in Life Insurance and Annuity Contracts, for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis, as permitted by this subchapter.

§4.1706. Severability.

If any provision of these sections or the application of these provisions to any person or circumstance is for any reason held to be invalid, the remainder of the provisions of this subchapter and the application of such provisions to other persons or circumstances will not be affected.

§4.1707. 2001 CSO Mortality Table.

The 2001 CSO Mortality Table must be used for purposes of this subchapter under the requirements of Subchapter AA, Division 3 of this chapter (relating to 2001 CSO Mortality Table).

Subchapter U. Variable Annuities
28 TAC §§4.2102 - 4.2106

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2102 - 4.2106 under Insurance Code §§1152.002, 1152.101, and 36.001.

Insurance Code §1152.002 specifies that the commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 1152, including rules establishing requirements for agent licensing, standard policy provisions, and disclosure.

Insurance Code §1152.101 states that the commissioner has sole authority to regulate the issuance and sale of a variable contract under Insurance Code Chapter 1152 and rules adopted under Insurance Code §1152.002.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2102. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Agent--Any person, corporation, partnership, or other legal entity that is licensed as a life insurance agent.

(2) Commissioner--The commissioner of insurance of this state.

(3) Flexible premium contract--Any variable annuity contract other than a scheduled premium variable annuity contract.

(4) General account--All assets of the insurer other than assets in separate accounts established under Insurance Code Chapter 1152, concerning Separate Accounts, Variable Contracts, and Related Products, or under the corresponding section of the

insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable annuities.

(5) Net investment return--The rate of investment return to be credited to the variable annuity contract in accordance with the terms of the contract after deductions for tax charges, if any, and for asset charges either at a rate not in excess of that stated in the contract, or in the case of a contract issued by a nonprofit corporation under which the contract holder participates fully in the investment, mortality, and expense experience of the account, in an amount not in excess of the actual expense not offset by other deductions. The net investment return to be credited to a contract must be determined at least monthly.

(6) Scheduled premium contract--Any variable contract under which both the timing and amount of premium payments are fixed.

(7) Separate account--A separate account established under Insurance Code Chapter 1152, or under the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(8) Variable annuity contract--Any individual annuity contract or group annuity contract or certificate issued in connection with a group annuity master contract that provides for benefits that vary according to the investment experience of a separate account established and maintained by the insurer as to such contract, under Insurance Code Chapter 1152. Annuity benefits may be payable in fixed or variable amounts or both.

§4.2103. Qualifications of Insurer to Issue Variable Annuities.

The following requirements are applicable to all insurers either seeking authority to issue variable annuities in this state or having the authority to issue variable annuity products in this state.

(1) Licensing and approval to do business in this state. An insurer may not deliver or issue for delivery in this state any variable annuity unless:

(A) the insurer is licensed or organized to do a life insurance business in this state; and

(B) after notice and hearing, the commissioner has authorized, either as part of the insurer's original certificate of authority or by charter amendment, the insurer to issue, deliver, and use variable annuity contracts, and only after the commissioner has considered, among other things, the following:

(i) whether the plan of operation for the issuance of variable annuity contracts is sound;

(ii) whether the general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably assure competent operation of the variable annuity business of the insurer in this state; and

(iii) whether the present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such contracts is likely to render its operation hazardous to the public or its contract holders in this state. The commissioner will consider, among other things:

(I) the history of operation and financial condition of the insurer;

(II) the qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(III) the applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable annuity contracts. The state of entry of an alien insurer will be deemed its state of domicile for this purpose; and

(IV) if the insurer is a subsidiary of or is affiliated by common management or ownership with another company, its relationship to such other company, and the degree to which the requesting insurer, as well as the other company, meets the standards specified in this subparagraph.

(2) Filing for approval to do business in this state. Before any insurer may deliver or issue for delivery any variable annuity contract in this state, it must file with the Department of Insurance the following information and any other information specifically requested, for the consideration of the commissioner, on making the determination required by paragraph (1)(B) of this section:

(A) copies of and a general description of the variable annuity contracts it intends to issue;

(B) a general description of the methods of operation of the variable annuity business of the insurer, including methods of distribution of contracts and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial, or distributive services to the insurer;

(C) with respect to any separate account maintained by an insurer for any variable annuity, a statement of the investment policy the insurer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy. The statement of investment policy must include a description of the investment objectives intended for the separate account;

(D) a description of any investment advisory services contemplated as required by §4.2104 of this title (relating to Separate Accounts);

(E) a copy of the statutes and regulations of the state of domicile of a foreign or alien insurer under which it is authorized to issue variable annuity contracts;

(F) biographical data not previously filed with the commissioner with respect to officers and directors of the insurer on the appropriate biographical form used in Texas; and

(G) a statement of the insurer's actuary describing the mortality and expense risks that the insurer will bear under the contract.

§4.2104. Separate Accounts.

(a) Establishment of separate account. Any domestic life insurance company issuing variable annuity contracts must establish one or more separate accounts under Insurance Code Chapter 1152, concerning Separate Accounts, Variable Contracts, and Related Products.

(1) If no law or other regulation provides for the custody of separate account assets, and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets must be in writing, and the commissioner has

authority to review and disapprove both the terms of any such contract and the proposed custodian before the transfer of custody.

(2) In connection with the handling of separate account assets, such insurer may not, without prior written approval of the commissioner, employ in any material manner any person who:

(A) within the last 10 years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of 18 United States Code §§1341, 1342, or 1343, as amended;

(B) within the last 10 years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(C) within the last 10 years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state laws involving fraud, deceit, or knowing misrepresentation.

(3) All persons with access to the cash, securities, or other assets allocated to or held by the separate account must be under bond in the amount of not less than $100,000.

(b) Amounts in the separate account. The insurer must maintain in each separate account assets with a value at least equal to the valuation reserves for the variable portion of the variable annuity insurance contracts and other contractual liabilities.

(c) Investments by the separate account. No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate

accounts or between any other investment account and one or more of its separate accounts, unless:

(1) in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made; and

(2) such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

(d) Limitations on ownership.

(1) A separate account may not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as required by this subchapter, would exceed 10% of the value of the assets of the separate account. Upon appropriate documentation by the company, which evidences that a waiver of this limitation will not render the operation of the separate account hazardous to the public or the contract holders in this state, the commissioner may in writing waive this limitation.

(2) No separate account may purchase or otherwise acquire the voting securities of any issuer if, as a result of such acquisition, the insurer and its separate accounts in the aggregate will own more than 10% of the total issued and outstanding voting securities of such issuer. Upon appropriate documentation by the company, which evidences that a waiver of this limitation will not render the operation of the separate

account hazardous to the public or the contract holders in this state, the commissioner may in writing waive this limitation.

(3) The percentage limitation specified in paragraph (1) of this subsection may not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered under 15 United States Code §§80b-1 to 80b-21, as amended, or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of subsection (c) of this section and other applicable portions of this regulation.

(e) Valuation of separate account assets. Investments of the separate account must be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

(f) Separate account investment policy. The investment policy of a separate account operated by a domestic insurer filed under §4.2103(2)(C) of this title (relating to Qualifications of Insurer to Issue Variable Annuities) may not be changed without first filing such change with the commissioner.

(1) Any change filed under this subsection will be effective 60 days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of such 60-day period of disapproval of the proposed change. At any time, the commissioner may, after notice and public hearing, disapprove any change that has become effective under this subsection.

(2) The commissioner may disapprove the change if the commissioner determines that the change would be detrimental to the interest of the contract holders participating in such separate account.

(g) Charges against separate accounts. The insurer must disclose in writing, before or contemporaneously with delivery of the contract, all charges that may be made against the separate account, including, but not limited to, the following:

(1) taxes or reserves for taxes attributable to investment gains and income of the separate account;

(2) actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

(3) charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(4) a charge, at a rate specified in the policy, for any mortality and expense guarantees;

(5) any amounts in excess of those required to be held in the separate account; and

(6) charges for incidental insurance benefits.

(h) Standards of conduct. Every insurer seeking approval to enter into the variable annuity business in this state must adopt by formal action of its board of directors a written statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such standards of conduct are binding on the insurer and those to whom it refers. A code of ethics meeting the requirements of 15 United States Code §80a-17, as amended, and applicable rules and regulations adopted under that section will satisfy the provisions of this subsection.

(i) Conflicts of interest. Rules adopted under any provisions of the Insurance Code or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interests also apply to members of any separate account's committee or other similar body.

(j) Investment advisory services to a separate account. An insurer may not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable annuity contracts unless:

(1) the person providing such advice is registered as an investment advisor under 15 United States Code §§80b-1 to 80b-21, as amended;

(2) the person providing such advice is an investment manager under 29 United States Code §1001, et seq., as amended, with respect to the assets of each employee benefit plan allocated to the separate account; or

(3) the insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed advisor:

(A) the name and form of organization, and its principal place of business;

(B) the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, the name and address of such individual;

(C) a written standard of conduct complying in substance with the requirements of subsection (h) of this section that has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates; and

(D) a statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

(i) has been convicted within 10 years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer, or director of an insurance company, a banker, an insurance agent, a securities broker, or an investment advisor involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of 18 United States Code §§1341, 1342, or 1343;

(ii) has been permanently or temporarily enjoined by an order, judgment, or decree of any court of competent jurisdiction from acting as an investment advisor, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(iii) has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under such laws; or

(iv) has been censored, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended, or been barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities; and

(4) such investment advisory contract must be in writing and provide that it is subject to review and termination by the commissioner at any time, and that it may be terminated by the insurer without penalty to the insurer or the separate account upon no

more than 60 days' written notice to the investment advisor. The commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if the commissioner deems continued operation under the contract to be hazardous to the public or the insurer's contract holders.

§4.2105. Contract Requirements.

Variable annuity contracts must conform to the requirements of this section in order to obtain the commissioner's approval.

(1) Filing of variable annuity contracts. All variable annuity contracts, all riders, endorsements, applications, and other documents that are attached to and made a part of the contract and that relate to the variable nature of the contract, must be filed with the commissioner and approved, as applicable, by the commissioner before delivery or issuance for delivery in this state.

(A) Each variable annuity contract and related forms must be filed according to Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(B) The commissioner may approve variable annuity contracts and related forms with provisions the commissioner deems to be not less favorable to the contract holder, certificate holder, and the beneficiary than those required by these sections.

(2) Mandatory contract provisions. Every variable annuity contract must contain at least the following.

(A) The cover page or page corresponding to the cover page of each contract must contain:

(i) a prominent statement that the benefits under the contract are on a variable basis; and

(ii) a prominent statement that the dollar amounts will vary to reflect the investment experience of a separate account or separate accounts.

(B) A full description of the investment increment factors to be used in computing dollar amounts of variable benefits or variable contractual payments of values, and may guarantee that expense and/or mortality results will not adversely affect such dollar amounts. In the case of an individual variable annuity contract under which the expense and mortality results may adversely affect the dollar amount of benefits, the expense and mortality factors must be stipulated in the contract. In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(i) the annual net investment increment assumption may not exceed 5.0% except with the approval of the commissioner;

(ii) to the extent that the level of benefits may be affected by future mortality results, the mortality factor must be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the commissioner, from another table.

(C) A provision designating the separate account to be used and stating that the portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account may not be chargeable with liabilities arising out of any other business the company may conduct.

(D) As appropriate, a provision for a grace period.

(i) For individual variable annuities that provide for the payment of periodic stipulated payments, a grace period of 31 days within which any stipulated payment to the insurer falling due after the first may be made, during which period of grace the contract must continue in force. The contract may include a statement of the basis for determining the date that any such payment received during the period of grace will be applied to produce the values under the contract arising therefrom.

(ii) For group variable annuities, a provision that the contract holder or premium payor is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the contract must continue in force, unless the contract holder or premium payor has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the contract. The contract may provide that the contract holder or premium payor will be liable to the insurer for the payment of pro rata premium for the time the contract was in force during such grace period.

(E) A provision that, at any time within two years from the date of default in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date that the amount to cover such overdue payments and any indebtedness will be applied to produce the values under the contract arising therefrom.

(F) A unique definition of any cash surrender values available under the contract.

(G) A provision for nonforfeiture benefits as defined in paragraph (3) of this section.

(H) A provision defining the documents that make up the entire contract.

(I) An identification of the owner of the contract.

(J) A provision stating that the company must mail to the individual contract holder or group contract holder at least once each year after the first at the contract holder's last address known to the company a statement reporting the investments held in the separate account.

(K) For individual variable annuities, a provision that the company must mail to the contract holder at least once in each contract year, after the first at the contract holder's last address known to the company, a statement reporting the status of the policy as of a date not more than four months before the date of mailing. In the case of an annuity contract under which payments have not yet commenced, the statement must contain:

(i) the number of accumulation units credited to such contract and the dollar value of a unit; or

(ii) the value of the contract holder's account.

(3) Reserves and nonforfeiture benefits.

(A) The reserve liability for variable annuities must be established under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(B) The provisions of this paragraph relating to nonforfeiture benefits do not apply to any:

(i) reinsurance;

(ii) group annuity contract purchases in connection with one or more retirement plan or plans of deferred compensation established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, or other plans providing individual retirement accounts or individual retirement annuities under Internal Revenue Code §408, as now or hereafter amended;

(iii) premium deposit fund;

(iv) investment annuity;

(v) immediate annuity;

(vi) deferred annuity contract after annuity payments have commenced;

(vii) reversionary annuity; or

(viii) to any contract that is to be delivered outside this state through an agent or other representative of the company issuing the contract.

(C) To the extent that any variable annuity contract provides benefits that do not vary in accordance with the investment performance of a separate account before the annuity commencement date, such contract must contain provisions that satisfy the requirements of Insurance Code Chapter 1107, concerning Standard Nonforfeiture Law for Certain Annuities, and may not otherwise be subject to this section.

(D) No variable annuity contract, except as stated in subparagraphs (B) and (C) of this paragraph, may be delivered or issued for delivery in this state unless it

contains in substance the following provisions, or corresponding provisions that in the opinion of the commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract.

(i) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan described in the contract that complies with subparagraph (H) of this paragraph. Such description must include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(ii) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or before the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit as described in the contract that complies with subparagraph (I) of this paragraph. The contract may provide that the company reserves the right, at its option, to defer the determination and payment of any cash surrender benefit for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists that may make such determination and payment impractical.

(iii) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the

company on the contract, or any prior withdrawals from or partial surrenders of the contract.

(E) The minimum values as specified in this section of any paid-up annuity, cash surrender, or death benefits available under a variable annuity contract must be based upon nonforfeiture amounts meeting the requirements of this paragraph. The minimum nonforfeiture amount on any date before the annuity commencement date must be an amount equal to the percentages of net considerations (as specified in subparagraph (F) of this paragraph) increased (or decreased) by the net investment return allocated to the percentages of net considerations, that amount must be reduced to reflect the effect of:

(i) any partial withdrawals from or partial surrenders of the contract;

(ii) the amount of any indebtedness on the contract, including interest due and accrued;

(iii) an annual contract charge not less than zero nor greater than $30 less the amount of any annual contract charge deducted from any gross considerations credited to the contract during such contract year; and

(iv) a transaction charge of $10 for each transfer to another separate account or to another investment division within the same separate account.

(F) The percentages of net considerations used to define the minimum nonforfeiture amount in subparagraph (E) of this paragraph must meet the requirements of this subparagraph.

(i) With respect to contracts providing for periodic considerations, the net considerations for a given contract year used to define the

minimum nonforfeiture amount must be an amount not less than zero and must be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of $30 and less a collection charge of $1.25 per consideration credited to the contract during that contract year. The percentages of net considerations must be 65% for the first contract year and 87.5% for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage must be 65% of the portion of the total net consideration for any renewal contract year that exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%.

(ii) With respect to contracts providing for a single consideration, the net consideration used to define the minimum nonforfeiture amount must be the gross consideration less a contract charge of $75. The percentage of net consideration must be 90%.

(G) Demonstration that a contract's nonforfeiture amounts comply with this paragraph must be based on the following assumptions:

(i) values should be tested at the ends of each of the first 20 contract years;

(ii) a net investment return of 7.0% per year should be used;

(iii) if the contract provides for transfers to another separate account or to another investment division within the same separate account, one transfer per contract year should be assumed;

(iv) with respect to contracts providing for periodic considerations, monthly considerations of $100 should be assumed for each of the first 240 months;

(v) with respect to contracts providing for a single consideration, a $10,000 single consideration should be assumed; and

(vi) if the contract provides for allocation of considerations to both fixed and variable accounts, 100% of the considerations should be assumed to be allocated to the variable account.

(H) Any paid-up annuity benefit available under a variable annuity contract must be such that its present value on the annuity commencement date is at least equal to the minimum nonforfeiture amount on the date. Such present value must be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

(I) For variable annuity contracts that provide cash surrender benefits, the cash surrender benefit at any time before the annuity commencement date may not be less than the minimum nonforfeiture amount next computed after the request for surrender is received by the company. The death benefit under such contracts must be at least equal to the cash surrender benefit.

(J) Any variable annuity contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the annuity commencement date must include a statement in a prominent place in the contract that such benefits are not provided.

(K) Notwithstanding the requirements of this section, a variable annuity contract may provide under the situations specified in clause (i) or clause (ii) of this subparagraph that the company, at its option, may cancel the annuity and pay the contract holder its accumulated value and by such payment be released of any further obligation under such contract:

(i) if at the time the annuity becomes payable the accumulated value is less than $2,000, or would provide an income the initial amount of which is less than $20 per month; or

(ii) if before the time the annuity becomes payable under a periodic payment variable annuity contract no considerations have been received under the contract for a period of two full years, and both:

(I) the total considerations paid before such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract; and

(II) the accumulated value amounts to less than $2,000.

(L) For any variable annuity contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits must be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subparagraph (E) of this paragraph, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other contract benefits additional to life insurance, endowment, and annuity benefits, must be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits required by this section. The inclusion of such additional benefits may not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.

(4) Applications. The application for a variable annuity contract must contain:

(A) a prominent statement that the benefits may increase or decrease in accordance with the experience of a separate account; and

(B) the portion of the premium allocable on the date of issue to any fixed dollar benefits and the portion allocable on the date of issue to the variable benefits.

§4.2106. Separability.

If any provision of these sections or the application of these sections to any person or circumstance is for any reason held to be invalid, the remainder of these sections and the application of such provision to other persons or circumstances will not be affected.

Subchapter W. Annuity Disclosures
Division 1: Annuity Contract Disclosures
28 TAC §§4.2302, 4.2304, and 4.2306 - 4.2312

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2302, 4.2304, and 4.2306 - 4.2312 under Insurance Code §§31.002, 101.051, 1108.002, 1114.007, 1152.002, and 36.001.

Insurance Code §31.002 specifies that in addition to other required duties, TDI will regulate the business of insurance in this state; administer the workers' compensation system of this state as provided by Labor Code, Title 5; and ensure that the Insurance Code and other laws regarding insurance and insurance companies are executed.

Insurance Code §101.051 specifies that acts that constitute the business of insurance in this state include making or proposing to make, as an insurer, an insurance

contract; taking or receiving an insurance application; or issuing or delivering an insurance contract to a resident of this state.

Insurance Code §1108.002 specifies that for the purpose of regulation under the Insurance Code, an annuity contract is considered an insurance policy or contract if the annuity contract is issued by a life, health, or accident insurance company, including a mutual company or fraternal benefit society, or if it is issued under an annuity or benefit plan used by an employer or individual.

Insurance Code §1114.007 authorizes the commissioner to adopt reasonable rules in the manner prescribed by Insurance Code Chapter 36, Subchapter A, to accomplish and enforce the purpose of Insurance Code Chapter 1114.

Insurance Code §1152.002 authorizes the commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 1152, including rules establishing requirements for agent licensing, standard policy provisions, and disclosure.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2302. Applicability and Scope.

(a) This subchapter applies to all group and individual annuity contracts and certificates, except as provided by subsection (b) of this section.

(b) This subchapter does not apply to the following annuity products, except as provided in subsection (c) of this section:

(1) immediate and deferred annuities that contain no non-guaranteed elements;

(2) annuities used to fund:

(A) an employee pension plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(B) a plan described by the Internal Revenue Code of 1986 §§401(a), 401(k), or 403(b), in which the plan, for purposes of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), is established or maintained by an employer;

(C) a governmental or church plan as defined by the Internal Revenue Code of 1986 §414, or a deferred compensation plan of a state or local government or a tax-exempt organization under the Internal Revenue Code of 1986 §457;

(D) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor; or

(E) prepaid funeral benefits, as defined by Finance Code Chapter 154, concerning Prepaid Funeral Services;

(3) a structured settlement annuity;

(4) a charitable gift annuity qualified under Insurance Code Chapter 102, concerning Charitable Gift Annuities; or

(5) a funding agreement.

(c) Notwithstanding the exemptions specified in subsection (b) of this section, this subchapter applies to an annuity used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, if the insurer has been notified that plan participants may choose from among two or more

fixed annuity providers and there is a direct solicitation of an individual employee by an agent for the purchase of an annuity contract. As used in this subsection, "direct solicitation" does not include a meeting held by an agent solely for the purpose of educating or enrolling employees in the plan or arrangement.

§4.2304. Definitions.

(a) Words and terms defined in Insurance Code Chapter 102, concerning Charitable Gift Annuities, have the same meaning when used in this subchapter.

(b) The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Agent--An individual who holds a license under Insurance Code Chapter 4054, concerning Life, Accident, and Health Agents, and who sells, solicits, or negotiates annuities in this state.

(2) Buyer's guide--A document specified as a buyer's guide and adopted by the National Association of Insurance Commissioners (NAIC) to be used in implementation of the NAIC Annuity Disclosure Model Regulation.

(3) Contract owner--The owner named in the annuity contract or, in the case of a group annuity contract, the certificate holder.

(4) Disclosure document--A document intended for consumers that provides information regarding the features and restrictions of a specific annuity product and that satisfies the requirements of §4.2309 of this title (relating to Disclosure Document).

(5) Funding agreement--An agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

(6) Generic name--A short title descriptive of the annuity contract being illustrated or for which an applicant is applying, such as "single premium deferred annuity."

(7) Structured settlement annuity--A "qualified funding asset," as defined by the Internal Revenue Code of 1986 §130(d), or an annuity that would be a qualified funding asset but for the fact that the annuity is not owned by an assignee under a qualified assignment.

§4.2306. Guaranteed and Non-Guaranteed Elements.

(a) For the purposes of this subchapter, "guaranteed element" means an element listed in §4.2305(a)(1) - (7) of this title (relating to Determinable Elements) that is guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements used in its computation are guaranteed.

(b) For the purposes of this subchapter, "non-guaranteed element" means an element listed in §4.2305(a)(1) - (7) of this title that is subject to the insurer's discretion and is not guaranteed at issue. An element is considered non-guaranteed if any underlying element used in its computation is non-guaranteed.

§4.2307. Effect on Other Law.

Compliance with this subchapter is not a defense in any action brought by or for the department alleging a violation of the Insurance Code, or, except for this subchapter, any rule adopted under the Insurance Code.

§4.2308. Required Consumer Notices.

(a) If an application for an annuity contract or certificate is taken in a face-to-face meeting, the applicant must be given at or before the time of application both a disclosure document and the appropriate buyer's guide specified in §4.2310 of this title (relating to Buyer's Guide).

(b) If the application is taken by means other than in a face-to-face meeting, the applicant must be sent, not later than the fifth business day after the date on which the completed application is received by the insurer, both a disclosure document and the appropriate buyer's guide specified in §4.2310 of this title.

(c) If the insurer receives the application as a result of a direct solicitation through the mail, the insurer's providing the appropriate buyer's guide and a disclosure document in a mailing inviting prospective applicants to apply for an annuity contract or certificate satisfies the requirement in subsection (b) of this section that the appropriate buyer's guide and the disclosure document be provided not later than the fifth business day after the date of receipt of the application.

(d) If the application is received through the internet, and if the insurer takes reasonable steps to ensure that the appropriate buyer's guide and a disclosure document are available for viewing and printing on the insurer's website and are opened or acknowledged by the prospective applicant, the provided buyer's guide and disclosure

document will be deemed to satisfy the requirement that the appropriate buyer's guide and the disclosure document be provided not later than the fifth business day after the date of receipt of the application.

(e) A solicitation for an annuity contract that is provided in a manner other than a face-to-face meeting must include a statement that the proposed applicant may contact the insurer for a free annuity buyer's guide.

(f) Insurers receiving an application for private placement contracts as defined by Insurance Code §1152.110(a), concerning Private Placement Contracts, are not required to provide the buyer's guide specified in §4.2310 of this title.

(g) This section applies regardless of whether an insurer is providing a 15-day free look period like that required in §4.2311(a) of this title (relating to Free Look Period) before the adoption of this subchapter or whether the insurer begins providing the 15-day free look period in accordance with §4.2311(a) of this title.

§4.2309. Disclosure Document.

(a) At a minimum, the following information, if applicable, must be included in the disclosure document required to be provided under this subchapter:

(1) the generic name of the contract; the insurer product name, if different from the generic name; the product's form number; and a statement of the fact that the contract is an annuity;

(2) the insurer's name and address;

(3) a description of the contract and the benefits provided under the contract; the description must emphasize the long-term nature of the contract and include examples of the long-term nature as appropriate;

(4) the guaranteed, non-guaranteed, and determinable elements of the contract, any limitations of those elements, and an explanation of how those elements operate;

(5) an explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the initial crediting rate, and the fact that rates may change from time to time and are not guaranteed;

(6) periodic income options, both on a guaranteed and non-guaranteed basis;

(7) any value reductions caused by withdrawals from or surrender of the contract;

(8) how values in the contract can be accessed;

(9) the death benefit, if available, and how the death benefit is computed;

(10) a summary of:

(A) the federal tax status of the contract; and

(B) any penalties applicable on withdrawal of values from the contract;

(11) the impact of any rider, such as a long-term care rider;

(12) a list of the specific dollar amount or percentage charges and fees, with an explanation of how those charges and fees apply; and

(13) information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

(b) An insurer must define terms used in the disclosure document in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure document is directed.

(c) A disclosure document that complies with the Financial Industry Regulatory Authority (FINRA) Conduct Rules and the United States Securities and Exchange Commission (SEC) prospectus requirements satisfies the requirements of this section for disclosure documents. This subsection does not limit the commissioner's ability to enforce the other provisions of this section or require the use of a FINRA-approved disclosure document. This subsection provides a safe harbor under this subchapter for an annuity contract that is regulated by, and complies with, the FINRA Conduct Rules and the SEC prospectus requirements pertaining to disclosure.

§4.2310. Buyer's Guide.

For the purposes of this subchapter, an appropriate buyer's guide is the latest version of the buyer's guide adopted by the National Association of Insurance Commissioners (NAIC) that applies to the particular type of annuity (such as fixed deferred annuity, equity-indexed annuity, or variable annuity) that is the subject of the transaction. If the NAIC has not adopted a buyer's guide for equity-indexed annuities, then the appropriate buyer's guide is the Buyer's Guide to Fixed Deferred Annuities that has been most recently adopted by the NAIC. If the NAIC has not adopted a buyer's guide for variable annuities, then no buyer's guide is required until one year after the date on which this subchapter becomes effective. If the NAIC has not adopted a buyer's guide for variable annuities within one year after the date on which this subchapter becomes effective, then for purposes of this subchapter the appropriate buyer's guide is the latest version of the Securities and Exchange Commission (SEC) Office of Investor Education and Advocacy "Variable Annuities: What You Should Know," SEC Pub. 011.

§4.2311. Free Look Period.

(a) If the buyer's guide and the disclosure document required by this subchapter are not provided at or before the time of application, a free look period of at least 15 calendar days must be provided during which the applicant may return the contract without penalty.

(b) Notice of the free look period required under this section must be provided to consumers in a notice that is included on or attached to the cover page of the delivered annuity contract. The notice must prominently disclose information concerning the 15-day free look period.

(c) The free look period must begin on the date the consumer receives the annuity contract and must run concurrently with any other free look period required under the Texas Administrative Code, the Texas Insurance Code, or another law of this state.

(d) An unconditional refund without penalty for purposes of this section for variable or modified guaranteed annuity contracts means a refund equal to the cash surrender value provided in the annuity contract, plus any fees or charges deducted from the premiums or imposed under the contract.

(e) The refund and free look period requirements in this section do not apply if the prospective owner is an accredited investor, as defined in Regulation D as adopted by the United States Securities and Exchange Commission.

§4.2312. Report to Contract Owners.

(a) For annuities in the payout period with changes in non-guaranteed elements and for the accumulation period of a deferred annuity, the insurer must provide each contract owner with a report, at least annually, on the status of the contract.

(b) The report must contain at least the following information:

(1) the beginning and ending dates of the current reporting period;

(2) the accumulation and cash surrender value, if any, at the end of:

(A) the previous reporting period; and

(B) the current reporting period;

(3) the total amounts, if any, that have been credited, charged to the contract or certificate value, or paid during the current reporting period; and

(4) the amount of any outstanding loans as of the end of the current reporting period.

Subchapter W. Annuity Disclosures
Division 2. Annuity Suitability Disclosures
28 TAC §4.2322

STATUTORY AUTHORITY. The commissioner adopts amendments to §4.2322 under Insurance Code §§36.004, 1115.005, 1115.0514, 1115.0516, and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §1115.005 provides that the commissioner may adopt reasonable rules in the manner prescribed by Insurance Code Chapter 36, Subchapter A, to accomplish and enforce the purpose of Chapter 1115.

Insurance Code §1115.0514 requires that an agent, before the recommendation or sale of an annuity, provide a disclosure to the consumer on a form prescribed by the commissioner by rule.

Insurance Code §1115.0516 requires agent use, at specified times, of disclosure forms prescribed by the commissioner by rule.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2322. Required Forms.

(a) Before the recommendation or sale of an annuity, an agent must provide to the consumer a form that meets the requirements of Insurance Code §1115.0514(b), concerning Disclosure Obligation. The agent must use:

(1) form FIN194 (07/21), which is adopted by reference and is available on the department's form website;

(2) the Insurance Agent (Producer) Disclosure for Annuities form, adopted by the National Association of Insurance Commissioners (NAIC) in the Suitability in Annuity Transactions Model Regulation; or

(3) another form that:

(A) meets the requirements of Insurance Code §1115.0514(b) and is substantially similar to the form specified in paragraph (2) of this subsection;

(B) is understandable to a person with an 8th-grade reading level; and

(C) is written in plain language, consistent with federal plain language recommendations from the Plain Language Action and Information Network.

(b) If, at the time of a recommendation or sale of an annuity, a consumer has not given an agent some or all of the information needed to decide whether the annuity effectively meets the consumer's needs, the agent must obtain a statement signed by the consumer on a form that meets the requirements of Insurance Code §1115.0516(2), concerning Documentation Obligation. The agent must use:

(1) form FIN195 (07/21), which is adopted by reference and is available on the department's form website;

(2) the Consumer Refusal to Provide Information form, adopted by the NAIC in the Suitability in Annuity Transactions Model Regulation; or

(3) another form that:

(A) is substantially similar to the form specified in paragraph (2) of this subsection;

(B) is understandable to a person with an 8th-grade reading level; and

(C) is written in plain language, consistent with federal plain language recommendations from the Plain Language Action and Information Network.

(c) At the time of a recommendation or sale of an annuity, if a consumer decides to enter into an annuity transaction that is not based on the agent's recommendation, the agent must obtain a statement signed by the consumer that meets the requirements of Insurance Code §1115.0516(3). The agent must use:

(1) form FIN196 (07/21), which is adopted by reference and is available on the department's form website;

(2) the Consumer Decision to Purchase an Annuity Not Based on a Recommendation form, adopted by the NAIC in the Suitability in Annuity Transactions Model Regulation; or

(3) another form that:

(A) is substantially similar to the form specified in paragraph (2) of this subsection;

(B) is understandable to a person with an 8th-grade reading level; and

(C) is written in plain language, consistent with federal plain language recommendations from the Plain Language Action and Information Network.

Subchapter AA. Mortality Tables
Division 1. Annuity Mortality Tables
28 TAC §§4.2701, 4.2702, 4.2705, and 4.2706

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2701, 4.2702, 4.2705, and 4.2706 under Insurance Code §§36.004, 425.053, 425.059(d), and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §425.053 authorizes TDI to annually value or cause to be valued the reserves for all outstanding annuity and pure endowment contracts before the operative date of the valuation manual required under Insurance Chapter 425.

Insurance Code §425.059(d) provides that the commissioner may approve by rule a mortality table adopted after 1980 by the National Association of Insurance Commissioners or a modification of one of the tables provided in the section.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2701. Purpose.

The purpose of this subchapter is to approve and adopt the following mortality tables and establish the effective dates of their use in determining the minimum standard of valuation for annuity and pure endowment contracts:

(1) the 1983 Table "a";

Figure: 28 TAC §4.2701(1)

Table Name: 1983 IAM (Table 'a') - Female/Male Table Identity: 829/830 Provider Domain: soa.org
Table Description: 1983 Individual Annuity Mortality (IAM) Table (also known as 1983 Table 'a')

Age	Female	Male	Age	Female	Male
5	0.000194	0.000377	61	0.004908	0.008983
6	0.000160	0.000350	62	0.005413	0.009740
7	0.000134	0.000333	63	0.005990	0.010630
8	0.000134	0.000352	64	0.006633	0.011664
9	0.000136	0.000368	65	0.007336	0.012851
10	0.000141	0.000382	66	0.008090	0.014199
11	0.000147	0.000394	67	0.008888	0.015717
12	0.000155	0.000405	68	0.009731	0.017414
13	0.000165	0.000415	69	0.010653	0.019296
14	0.000175	0.000425	70	0.011697	0.021371
15	0.000188	0.000435	71	0.012905	0.023647
16	0.000201	0.000446	72	0.014319	0.026131
17	0.000214	0.000458	73	0.015980	0.028835
18	0.000229	0.000472	74	0.017909	0.031794
19	0.000244	0.000488	75	0.020127	0.035046
20	0.000260	0.000505	76	0.022654	0.038631
21	0.000276	0.000525	77	0.025509	0.042587
22	0.000293	0.000546	78	0.028717	0.046951
23	0.000311	0.000570	79	0.032328	0.051755
24	0.000330	0.000596	80	0.036395	0.057026
25	0.000349	0.000622	81	0.040975	0.062791
26	0.000368	0.000650	82	0.046121	0.069081
27	0.000387	0.000677	83	0.051889	0.075908
28	0.000405	0.000704	84	0.058336	0.083230
29	0.000423	0.000731	85	0.065518	0.090987
30	0.000441	0.000759	86	0.073493	0.099122
31	0.000460	0.000786	87	0.082318	0.107577
32	0.000479	0.000814	88	0.092017	0.116316
33	0.000499	0.000843	89	0.102491	0.125394
34	0.000521	0.000876	90	0.113605	0.134887
35	0.000545	0.000917	91	0.125227	0.144873
36	0.000574	0.000968	92	0.137222	0.155429
37	0.000607	0.001032	93	0.149462	0.166629
38	0.000646	0.001114	94	0.161834	0.178537
39	0.000691	0.001216	95	0.174228	0.191214
40	0.000742	0.001341	96	0.186535	0.204721
41	0.000801	0.001492	97	0.198646	0.219120
42	0.000867	0.001673	98	0.211102	0.234735
43	0.000942	0.001886	99	0.224445	0.251889
44	0.001026	0.002129	100	0.239215	0.270906
45	0.001122	0.002399	101	0.255953	0.292111
46	0.001231	0.002693	102	0.275201	0.315826
47	0.001356	0.003009	103	0.297500	0.342377
48	0.001499	0.003343	104	0.323390	0.372086
49	0.001657	0.003694	105	0.353414	0.405278
50	0.001830	0.004057	106	0.388111	0.442277
51	0.002016	0.004431	107	0.428023	0.483406
52	0.002215	0.004812	108	0.473692	0.528989
53	0.002426	0.005198	109	0.525658	0.579351
54	0.002650	0.005591	110	0.584462	0.634814
55	0.002891	0.005994	111	0.650646	0.695704
56	0.003151	0.006409	112	0.724750	0.762343
57	0.003432	0.006839	113	0.807316	0.835056
58	0.003739	0.007290	114	0.898885	0.914167
59	0.004081	0.007782	115	1.000000	1.000000
60	0.004467	0.008338			

(2) the 1983 GAM Table;

Figure: 28 TAC §4.2701(2)

Table Name: 1983 GAM Table - Female/Male Table Identity: 825/826 Provider Domain: soa.org
Table Description: 1983 Group Annuity Mortality (GAM) Table
Female - Formerly Table 18-B. Male - Formerly Table 18-A.

Age	Female	Male	Age	Female	Male
5	0.000171	0.000342	58	0.003443	0.007719
6	0.000140	0.000318	59	0.003821	0.008384
7	0.000118	0.000302	60	0.004241	0.009158
8	0.000104	0.000294	61	0.004703	0.010064
9	0.000097	0.000292	62	0.005210	0.011133
10	0.000096	0.000293	63	0.005769	0.012391
11	0.000104	0.000298	64	0.006386	0.013868
12	0.000113	0.000304	65	0.007064	0.015592
13	0.000122	0.000310	66	0.007817	0.017579
14	0.000131	0.000317	67	0.008681	0.019804
15	0.000140	0.000325	68	0.009702	0.022229
16	0.000149	0.000333	69	0.010922	0.024817
17	0.000159	0.000343	70	0.012385	0.027530
18	0.000168	0.000353	71	0.014128	0.030354
19	0.000179	0.000365	72	0.016160	0.033370
20	0.000189	0.000377	73	0.018481	0.036680
21	0.000201	0.000392	74	0.021092	0.040388
22	0.000212	0.000408	75	0.023992	0.044597
23	0.000225	0.000424	76	0.027185	0.049388
24	0.000239	0.000444	77	0.030672	0.054758
25	0.000253	0.000464	78	0.034459	0.060678
26	0.000268	0.000488	79	0.038549	0.067125
27	0.000284	0.000513	80	0.042945	0.074070
28	0.000302	0.000542	81	0.047655	0.081484
29	0.000320	0.000572	82	0.052691	0.089320
30	0.000342	0.000607	83	0.058071	0.097525
31	0.000364	0.000645	84	0.063807	0.106047
32	0.000388	0.000687	85	0.069918	0.114836
33	0.000414	0.000734	86	0.076570	0.124170
34	0.000443	0.000785	87	0.083870	0.133870
35	0.000476	0.000860	88	0.091935	0.144073
36	0.000502	0.000907	89	0.101354	0.154859
37	0.000536	0.000966	90	0.111750	0.166307
38	0.000573	0.001039	91	0.123076	0.178214
39	0.000617	0.001128	92	0.135630	0.190460
40	0.000665	0.001238	93	0.149577	0.203007
41	0.000716	0.001370	94	0.165103	0.217904
42	0.000775	0.001527	95	0.182419	0.234086
43	0.000842	0.001715	96	0.201757	0.248436
44	0.000919	0.001932	97	0.222044	0.263954
45	0.001010	0.002183	98	0.243899	0.280803
46	0.001117	0.002471	99	0.268185	0.299154
47	0.001237	0.002790	100	0.295187	0.319185
48	0.001366	0.003138	101	0.325225	0.341086
49	0.001505	0.003513	102	0.358897	0.365052
50	0.001647	0.003909	103	0.395843	0.393102
51	0.001793	0.004324	104	0.438360	0.427255
52	0.001949	0.004755	105	0.487816	0.469531
53	0.002120	0.005200	106	0.545886	0.521945
54	0.002315	0.005660	107	0.614309	0.586518
55	0.002541	0.006131	108	0.694885	0.665268
56	0.002803	0.006618	109	0.789474	0.760215
57	0.003103	0.007139	110	1.000000	1.000000

(3) the Annuity 2000 Mortality Table;

Figure: 28 TAC §4.2701(3)

Table Name: Annuity 2000 - Female/Male Table Identity: 886/887 Provider Domain: soa.org
Table Description: Annuity 2000 Table – Female/Male

Age	Female	Male	Age	Female	Male
5	0.000171	0.000291	61	0.004242	0.006933
6	0.000141	0.000270	62	0.004668	0.007520
7	0.000118	0.000257	63	0.005144	0.008207
8	0.000118	0.000294	64	0.005671	0.009008
9	0.000121	0.000325	65	0.006250	0.009940
10	0.000126	0.000350	66	0.006878	0.011016
11	0.000133	0.000371	67	0.007555	0.012251
12	0.000142	0.000388	68	0.008287	0.013657
13	0.000152	0.000402	69	0.009102	0.015233
14	0.000164	0.000414	70	0.010034	0.016979
15	0.000177	0.000425	71	0.011117	0.018891
16	0.000190	0.000437	72	0.012386	0.020967
17	0.000204	0.000449	73	0.013871	0.023209
18	0.000219	0.000463	74	0.015592	0.025644
19	0.000234	0.000480	75	0.017564	0.028304
20	0.000250	0.000499	76	0.019805	0.031220
21	0.000265	0.000519	77	0.022328	0.034425
22	0.000281	0.000542	78	0.025158	0.037948
23	0.000298	0.000566	79	0.028341	0.041812
24	0.000314	0.000592	80	0.031933	0.046037
25	0.000331	0.000616	81	0.035985	0.050643
26	0.000347	0.000639	82	0.040552	0.055651
27	0.000362	0.000659	83	0.045690	0.061080
28	0.000376	0.000675	84	0.051456	0.066948
29	0.000389	0.000687	85	0.057913	0.073275
30	0.000402	0.000694	86	0.065119	0.080076
31	0.000414	0.000699	87	0.073136	0.087370
32	0.000425	0.000700	88	0.081991	0.095169
33	0.000436	0.000701	89	0.091577	0.103455
34	0.000449	0.000702	90	0.101758	0.112208
35	0.000463	0.000704	91	0.112395	0.121402
36	0.000481	0.000719	92	0.123349	0.131017
37	0.000504	0.000749	93	0.134486	0.141030
38	0.000532	0.000796	94	0.145689	0.151422
39	0.000567	0.000864	95	0.156846	0.162179
40	0.000609	0.000953	96	0.167841	0.173279
41	0.000658	0.001065	97	0.178563	0.184706
42	0.000715	0.001201	98	0.189604	0.196946
43	0.000781	0.001362	99	0.201557	0.210484
44	0.000855	0.001547	100	0.215013	0.225806
45	0.000939	0.001752	101	0.230565	0.243398
46	0.001035	0.001974	102	0.248805	0.263745
47	0.001141	0.002211	103	0.270326	0.287334
48	0.001261	0.002460	104	0.295719	0.314649
49	0.001393	0.002721	105	0.325576	0.346177
50	0.001538	0.002994	106	0.360491	0.382403
51	0.001695	0.003279	107	0.401054	0.423813
52	0.001864	0.003576	108	0.447860	0.470893
53	0.002047	0.003884	109	0.501498	0.524128
54	0.002244	0.004203	110	0.562563	0.584004
55	0.002457	0.004534	111	0.631645	0.651007
56	0.002689	0.004876	112	0.709338	0.725622
57	0.002942	0.005228	113	0.796233	0.808336
58	0.003218	0.005593	114	0.892923	0.899633
59	0.003523	0.005988	115	1.000000	1.000000
60	0.003863	0.006428			

(4) the 1994 GAR Table; and

Figure: 28 TAC §4.2701(4)

1994 GROUP ANNUITY RESERVING TABLE

	Male		Female			Male		Female	
Age (x)	q_x^{1994}	AA_x	q_x^{1994}	AA_x	Age (x)	q_x^{1994}	AA_x	q_x^{1994}	AA_x
1	0.000592	0.020	0.000531	0.020	31	0.000821	0.005	0.000373	0.008
2	0.000400	0.020	0.000346	0.020	32	0.000839	0.005	0.000397	0.008
3	0.000332	0.020	0.000258	0.020	33	0.000848	0.005	0.000422	0.009
4	0.000259	0.020	0.000194	0.020	34	0.000849	0.005	0.000449	0.010
5	0.000237	0.020	0.000175	0.020	35	0.000851	0.005	0.000478	0.011
6	0.000227	0.020	0.000163	0.020	36	0.000862	0.005	0.000512	0.012
7	0.000217	0.020	0.000153	0.020	37	0.000891	0.005	0.000551	0.013
8	0.000201	0.020	0.000137	0.020	38	0.000939	0.006	0.000598	0.014
9	0.000194	0.020	0.000130	0.020	39	0.000999	0.007	0.000652	0.015
10	0.000197	0.020	0.000131	0.020	40	0.001072	0.008	0.000709	0.015
11	0.000208	0.020	0.000138	0.020	41	0.001156	0.009	0.000768	0.015
12	0.000226	0.020	0.000148	0.020	42	0.001252	0.010	0.000825	0.015
13	0.000255	0.020	0.000164	0.020	43	0.001352	0.011	0.000877	0.015
14	0.000297	0.019	0.000189	0.018	44	0.001458	0.012	0.000923	0.015
15	0.000345	0.019	0.000216	0.016	45	0.001578	0.013	0.000973	0.016
16	0.000391	0.019	0.000242	0.015	46	0.001722	0.014	0.001033	0.017
17	0.000430	0.019	0.000262	0.014	47	0.001899	0.015	0.001112	0.018
18	0.000460	0.019	0.000273	0.014	48	0.002102	0.016	0.001206	0.018
19	0.000484	0.019	0.000280	0.015	49	0.002326	0.017	0.001310	0.018
20	0.000507	0.019	0.000284	0.016	50	0.002579	0.018	0.001428	0.017
21	0.000530	0.018	0.000286	0.017	51	0.002872	0.019	0.001568	0.016
22	0.000556	0.017	0.000289	0.017	52	0.003213	0.020	0.001734	0.014
23	0.000589	0.015	0.000292	0.016	53	0.003584	0.020	0.001907	0.012
24	0.000624	0.013	0.000291	0.015	54	0.003979	0.020	0.002084	0.010
25	0.000661	0.010	0.000291	0.014	55	0.044250	0.019	0.002294	0.008
26	0.000696	0.006	0.000294	0.012	56	0.004949	0.018	0.002563	0.006
27	0.000727	0.005	0.000302	0.012	57	0.005581	0.017	0.002919	0.005
28	0.000754	0.005	0.000314	0.012	58	0.006300	0.016	0.003359	0.005
29	0.000779	0.005	0.000331	0.012	59	0.007090	0.016	0.003863	0.005
30	0.000801	0.005	0.000351	0.010	60	0.007976	0.016	0.004439	0.005

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows: $q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$, where the q_x^{1994} and AA_x are as specified in the 1994 GAR Table

1994 GROUP ANNUITY RESERVING TABLE

	Male		Female			Male		Female	
Age (x)	q_x^{1994}	AA_x	q_x^{1994}	AA_x	Age (x)	q_x^{1994}	AA_x	q_x^{1994}	AA_x
61	0.008986	0.015	0.005093	0.005	91	0.167260	0.004	0.128751	0.003
62	0.010147	0.015	0.005832	0.005	92	0.182281	0.003	0.141973	0.003
63	0.011471	0.014	0.006677	0.005	93	0.198392	0.003	0.155931	0.002
64	0.012940	0.014	0.007621	0.005	94	0.215700	0.003	0.170677	0.002
65	0.014535	0.014	0.008636	0.005	95	0.233606	0.002	0.186213	0.002
66	0.016239	0.013	0.009694	0.005	96	0.251510	0.002	0.202538	0.002
67	0.018034	0.013	0.010764	0.005	97	0.268815	0.002	0.219655	0.001
68	0.019859	0.014	0.011763	0.005	98	0.285277	0.001	0.237713	0.001
69	0.021729	0.014	0.012709	0.005	99	0.301298	0.001	0.256712	0.001
70	0.023730	0.015	0.013730	0.005	100	0.317238	0.001	0.276427	0.001
71	0.025951	0.015	0.014953	0.006	101	0.333461	0.000	0.296629	0
72	0.028481	0.015	0.016506	0.006	102	0.350330	0.000	0.317093	0
73	0.031201	0.015	0.018344	0.007	103	0.368542	0.000	0.338505	0
74	0.034051	0.015	0.020381	0.007	104	0.387885	0.000	0.361016	0
75	0.037211	0.014	0.022686	0.008	105	0.407224	0.000	0.383597	0
76	0.040858	0.014	0.025325	0.008	106	0.425599	0.000	0.405217	0
77	0.045171	0.013	0.028366	0.007	107	0.441935	0.000	0.424846	0
78	0.050211	0.012	0.031727	0.007	108	0.457553	0.000	0.444368	0
79	0.055861	0.011	0.035362	0.007	109	0.473150	0.000	0.464469	0
80	0.062027	0.010	0.039396	0.007	110	0.486745	0.000	0.482325	0
81	0.068615	0.009	0.043952	0.007	111	0.496356	0.000	0.495110	0
82	0.075532	0.008	0.049153	0.007	112	0.500000	0.000	0.500000	0
83	0.082510	0.008	0.054857	0.007	113	0.500000	0.000	0.500000	0
84	0.089613	0.007	0.060979	0.007	114	0.500000	0.000	0.500000	0
85	0.097240	0.007	0.067738	0.006	115	0.500000	0.000	0.500000	0
86	0.105792	0.007	0.075347	0.005	116	0.500000	0.000	0.500000	0
87	0.115671	0.006	0.084023	0.004	117	0.500000	0.000	0.500000	0
88	0.126980	0.005	0.093820	0.004	118	0.500000	0.000	0.500000	0
89	0.139452	0.005	0.104594	0.003	119	0.500000	0.000	0.500000	0
90	0.152931	0.004	0.116265	0.003	120	1.000000	0.000	1.000000	0

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows: $q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$, where the q_x^{1994} and AA_x are as specified in the 1994 GAR Table

(5) the 2012 Individual Annuity Reserving (2012 IAR) Table which, under §4.2706 of this title (relating to Application of the 2012 IAR Mortality Table), is derived from the following tables:

(A) the 2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table; and

Figure: 28 TAC §4.2701(5)(A)

2012 IAM Period Table
Female, Age Nearest Birthday

AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$
0	**1.621**	30	**0.300**	60	**3.460**	90	**88.377**
1	**0.405**	31	**0.321**	61	**3.916**	91	**97.491**
2	**0.259**	32	**0.338**	62	**4.409**	92	**107.269**
3	**0.179**	33	**0.351**	63	**4.933**	93	**118.201**
4	**0.137**	34	**0.365**	64	**5.507**	94	**130.969**
5	**0.125**	35	**0.381**	65	**6.146**	95	**146.449**
6	**0.117**	36	**0.402**	66	**6.551**	96	**163.908**
7	**0.110**	37	**0.429**	67	**7.039**	97	**179.695**
8	**0.095**	38	**0.463**	68	**7.628**	98	**196.151**
9	**0.088**	39	**0.504**	69	**8.311**	99	**213.150**
10	**0.085**	40	**0.552**	70	**9.074**	100	**230.722**
11	**0.086**	41	**0.600**	71	**9.910**	101	**251.505**
12	**0.094**	42	**0.650**	72	**10.827**	102	**273.007**
13	**0.108**	43	**0.697**	73	**11.839**	103	**295.086**
14	**0.131**	44	**0.740**	74	**12.974**	104	**317.591**
15	**0.156**	45	**0.780**	75	**14.282**	105	**340.362**
16	**0.179**	46	**0.825**	76	**15.799**	106	**362.371**
17	**0.198**	47	**0.885**	77	**17.550**	107	**384.113**
18	**0.211**	48	**0.964**	78	**19.582**	108	**400.000**
19	**0.221**	49	**1.051**	79	**21.970**	109	**400.000**
20	**0.228**	50	**1.161**	80	**24.821**	110	**400.000**
21	**0.234**	51	**1.308**	81	**28.351**	111	**400.000**
22	**0.240**	52	**1.460**	82	**32.509**	112	**400.000**
23	**0.245**	53	**1.613**	83	**37.329**	113	**400.000**
24	**0.247**	54	**1.774**	84	**42.830**	114	**400.000**
25	**0.250**	55	**1.950**	85	**48.997**	115	**400.000**
26	**0.256**	56	**2.154**	86	**55.774**	116	**400.000**
27	**0.261**	57	**2.399**	87	**63.140**	117	**400.000**
28	**0.270**	58	**2.700**	88	**71.066**	118	**400.000**
29	**0.281**	59	**3.054**	89	**79.502**	119	**400.000**
						120	**1000.000**

2012 IAM Period Table
Male, Age Nearest Birthday

AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$
0	**1.605**	30	**0.741**	60	**5.096**	90	**109.993**
1	**0.401**	31	**0.751**	61	**5.614**	91	**123.119**
2	**0.275**	32	**0.754**	62	**6.169**	92	**137.168**
3	**0.229**	33	**0.756**	63	**6.759**	93	**152.171**
4	**0.174**	34	**0.756**	64	**7.398**	94	**168.194**
5	**0.168**	35	**0.756**	65	**8.106**	95	**185.260**
6	**0.165**	36	**0.756**	66	**8.548**	96	**197.322**
7	**0.159**	37	**0.756**	67	**9.076**	97	**214.751**
8	**0.143**	38	**0.756**	68	**9.708**	98	**232.507**
9	**0.129**	39	**0.800**	69	**10.463**	99	**250.397**
10	**0.113**	40	**0.859**	70	**11.357**	100	**268.607**
11	**0.111**	41	**0.926**	71	**12.418**	101	**290.016**
12	**0.132**	42	**0.999**	72	**13.675**	102	**311.849**
13	**0.169**	43	**1.069**	73	**15.150**	103	**333.962**
14	**0.213**	44	**1.142**	74	**16.860**	104	**356.207**
15	**0.254**	45	**1.219**	75	**18.815**	105	**380.000**
16	**0.293**	46	**1.318**	76	**21.031**	106	**400.000**
17	**0.328**	47	**1.454**	77	**23.540**	107	**400.000**
18	**0.359**	48	**1.627**	78	**26.375**	108	**400.000**
19	**0.387**	49	**1.829**	79	**29.572**	109	**400.000**
20	**0.414**	50	**2.057**	80	**33.234**	110	**400.000**
21	**0.443**	51	**2.302**	81	**37.533**	111	**400.000**
22	**0.473**	52	**2.545**	82	**42.261**	112	**400.000**
23	**0.513**	53	**2.779**	83	**47.441**	113	**400.000**
24	**0.554**	54	**3.011**	84	**53.233**	114	**400.000**
25	**0.602**	55	**3.254**	85	**59.855**	115	**400.000**
26	**0.655**	56	**3.529**	86	**67.514**	116	**400.000**
27	**0.688**	57	**3.845**	87	**76.340**	117	**400.000**
28	**0.710**	58	**4.213**	88	**86.388**	118	**400.000**
29	**0.727**	59	**4.631**	89	**97.634**	119	**400.000**
						120	**1000.000**

(B) the Projection Scale G2 (Scale G2) table of annual rates.

Figure: 28 TAC §4.2701(5)(B)

Projection Scale G2
Female, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	**0.010**	30	**0.010**	60	**0.013**	90	**0.006**
1	**0.010**	31	**0.010**	61	**0.013**	91	**0.006**
2	**0.010**	32	**0.010**	62	**0.013**	92	**0.005**
3	**0.010**	33	**0.010**	63	**0.013**	93	**0.005**
4	**0.010**	34	**0.010**	64	**0.013**	94	**0.004**
5	**0.010**	35	**0.010**	65	**0.013**	95	**0.004**
6	**0.010**	36	**0.010**	66	**0.013**	96	**0.004**
7	**0.010**	37	**0.010**	67	**0.013**	97	**0.003**
8	**0.010**	38	**0.010**	68	**0.013**	98	**0.003**
9	**0.010**	39	**0.010**	69	**0.013**	99	**0.002**
10	**0.010**	40	**0.010**	70	**0.013**	100	**0.002**
11	**0.010**	41	**0.010**	71	**0.013**	101	**0.002**
12	**0.010**	42	**0.010**	72	**0.013**	102	**0.001**
13	**0.010**	43	**0.010**	73	**0.013**	103	**0.001**
14	**0.010**	44	**0.010**	74	**0.013**	104	**0.000**
15	**0.010**	45	**0.010**	75	**0.013**	105	**0.000**
16	**0.010**	46	**0.010**	76	**0.013**	106	**0.000**
17	**0.010**	47	**0.010**	77	**0.013**	107	**0.000**
18	**0.010**	48	**0.010**	78	**0.013**	108	**0.000**
19	**0.010**	49	**0.010**	79	**0.013**	109	**0.000**
20	**0.010**	50	**0.010**	80	**0.013**	110	**0.000**
21	**0.010**	51	**0.010**	81	**0.012**	111	**0.000**
22	**0.010**	52	**0.011**	82	**0.012**	112	**0.000**
23	**0.010**	53	**0.011**	83	**0.011**	113	**0.000**
24	**0.010**	54	**0.011**	84	**0.010**	114	**0.000**
25	**0.010**	55	**0.012**	85	**0.010**	115	**0.000**
26	**0.010**	56	**0.012**	86	**0.009**	116	**0.000**
27	**0.010**	57	**0.012**	87	**0.008**	117	**0.000**
28	**0.010**	58	**0.012**	88	**0.007**	118	**0.000**
29	**0.010**	59	**0.013**	89	**0.007**	119	**0.000**
						120	**0.000**

Projection Scale G2
Male, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	**0.010**	30	**0.010**	60	**0.015**	90	**0.007**
1	**0.010**	31	**0.010**	61	**0.015**	91	**0.007**
2	**0.010**	32	**0.010**	62	**0.015**	92	**0.006**
3	**0.010**	33	**0.010**	63	**0.015**	93	**0.005**
4	**0.010**	34	**0.010**	64	**0.015**	94	**0.005**
5	**0.010**	35	**0.010**	65	**0.015**	95	**0.004**
6	**0.010**	36	**0.010**	66	**0.015**	96	**0.004**
7	**0.010**	37	**0.010**	67	**0.015**	97	**0.003**
8	**0.010**	38	**0.010**	68	**0.015**	98	**0.003**
9	**0.010**	39	**0.010**	69	**0.015**	99	**0.002**
10	**0.010**	40	**0.010**	70	**0.015**	100	**0.002**
11	**0.010**	41	**0.010**	71	**0.015**	101	**0.002**
12	**0.010**	42	**0.010**	72	**0.015**	102	**0.001**
13	**0.010**	43	**0.010**	73	**0.015**	103	**0.001**
14	**0.010**	44	**0.010**	74	**0.015**	104	**0.000**
15	**0.010**	45	**0.010**	75	**0.015**	105	**0.000**
16	**0.010**	46	**0.010**	76	**0.015**	106	**0.000**
17	**0.010**	47	**0.010**	77	**0.015**	107	**0.000**
18	**0.010**	48	**0.010**	78	**0.015**	108	**0.000**
19	**0.010**	49	**0.010**	79	**0.015**	109	**0.000**
20	**0.010**	50	**0.010**	80	**0.015**	110	**0.000**
21	**0.010**	51	**0.011**	81	**0.014**	111	**0.000**
22	**0.010**	52	**0.011**	82	**0.013**	112	**0.000**
23	**0.010**	53	**0.012**	83	**0.013**	113	**0.000**
24	**0.010**	54	**0.012**	84	**0.012**	114	**0.000**
25	**0.010**	55	**0.013**	85	**0.011**	115	**0.000**
26	**0.010**	56	**0.013**	86	**0.010**	116	**0.000**
27	**0.010**	57	**0.014**	87	**0.009**	117	**0.000**
28	**0.010**	58	**0.014**	88	**0.009**	118	**0.000**
29	**0.010**	59	**0.015**	89	**0.008**	119	**0.000**
						120	**0.000**

§4.2702. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) 1983 GAM Table--Mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983, by the National Association of Insurance Commissioners (NAIC).

(2) 1983 Table "a"--Mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982, by the NAIC.

(3) 1994 GAR Table--The 1994 Group Annuity Reserving Table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and adopted as a recognized mortality table for annuities on December 16, 1996, by the NAIC.

(4) Annuity 2000 Mortality Table--Mortality table developed by the Society of Actuaries Committee on Life Insurance Research and adopted as a recognized mortality table for annuities on December 16, 1996, by the NAIC.

(5) Period Table--Table of mortality rates applicable to a given calendar year.

(6) Generational Mortality Table--Mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a Period Table and a projection scale containing rates of mortality improvement.

(7) 2012 IAR Table--Generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, q_x^{2012+n}, derived from a combination of the 2012 IAM Period Table and Projection Scale G2, using the methodology stated in §4.2706 of this title (relating to Application of the 2012 IAR Mortality Table).

(8) 2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table--The Period Table containing loaded mortality rates for calendar year 2012. This table contains rates, q_x^{2012}, developed by the Society of Actuaries Committee on Life Insurance Research.

(9) Projection Scale G2 (Scale G2)--Table of annual rates, $G2_x$, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012. The Society of Actuaries Committee on Life Insurance Research developed this table.

§4.2705. Application of the 1994 GAR Table.

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

Figure: 28 TAC §4.2705

$$q_x^{1994+n} = q_x^{1994}(1 - AA_x)^n$$

where q_x^{1994} and AA_x are as specified in the 1994 GAR Table.

§4.2706. Application of the 2012 IAR Mortality Table.

In using the 2012 IAR Mortality Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows:

Figure: 28 TAC §4.2706

$1000q_x^{2012+n} = 1000q_x^{2012} * (1 - G2_x)^n$

where:

x is the age in year 2012+n;

$1000q_x^{2012}$ is the applicable mortality rate from the 2012 IAM Period Table in Figure: 28 TAC §4.2701(5)(A); and

$G2_x$ is the projection scale rate from Scale G2 in Figure: 28 TAC §4.2701(5)(B).

The resulting $1000q_x^{2012+n}$ must be rounded to three decimal places, e.g., 0.741 deaths per 1,000. The rounding must occur only once according to the formula above which begins with the 2012 period table rate.

For example:

For a male age 30 in 2013 (2012 + 1):
$1000q_{30}^{2013} = 1000q_{30}^{2012} * (1 - G2_{30})^1 = 0.741 * (1 - 0.010)^1 = 0.73359$, which is rounded to 0.734

For a male age 30 in 2014 (2012 + 2):
$1000q_{30}^{2014} = 1000q_{30}^{2012} * (1 - G2_{30})^2 = 0.741 * (1 - 0.010)^2 = 0.7262541$, which is rounded to 0.726

For a male age 30 in 2015 (2012 + 3):
$1000q_{30}^{2015} = 1000q_{30}^{2012} * (1 - G2_{30})^3 = 0.741 * (1 - 0.010)^3 = 0.718991559$, which is rounded to 0.719

For a male age 30 in 2016 (2012 + 4):
$1000q_{30}^{2016} = 1000q_{30}^{2012} * (1 - G2_{30})^4 = 0.741 * (1 - 0.010)^4 = 0.711801643$, which is rounded to 0.712

For a male age 30 in 2037 (2012 + 25):
$1000q_{30}^{2037} = 1000q_{30}^{2012} * (1 - G2_{30})^{25} = 0.741 * (1 - 0.010)^{25} = 0.576365627$, which is rounded to 0.576

A method leading to incorrect rounding would be for the male age 30 in 2014, above, to calculate $1000q_{30}^{2014}$ as $1000q_{30}^{2012} * (1 - 0.010)$ rounded to 0.734 and then multiply again by (1 - 0.010) and round a second time which would produce 0.727. It is incorrect to round more than once in order to calculate $1000q_{30}^{2014}$.

Example for a specific valuation year where future projections involving mortality are needed for that valuation year:

The mortality rate must be calculated per the formula and rounding above for the valuation year and for each projection year needed for that valuation year. For a person age x in the valuation year the mortality rate would be derived for that person age x in the valuation year, then the rate would be derived for that person who would be age x+1 in the first projection year after the valuation year, then the rate would be derived for that person who would be age x+2 in the second projection year after the valuation year, etc.

For example, assume a male age 30 in the valuation year 2015.

The mortality rate for this male age 30 in the valuation year 2015 is calculated as:
$1000q_{30}^{2015} = 1000q_{30}^{2012} * (1 - G2_{30})^3 = 0.741 * (1 - 0.010)^3 = 0.718991559$, which is rounded to 0.719

The mortality rate in the first projection year (2016) past the valuation year for this male (age 31 in 2016) is:
$1000q_{31}^{2016} = 1000q_{31}^{2012} * (1 - G2_{31})^4 = 0.751 * (1 - 0.010)^4 = 0.721407604$, which is rounded to 0.721

The mortality rate in the second projection year (2017) past the valuation year for this male (age 32 in 2017) is:
$1000q_{32}^{2017} = 1000q_{32}^{2012} * (1 - G2_{32})^5 = 0.754 * (1 - 0.010)^5 = 0.717046498$, which is rounded to 0.717

The mortality rate in the twenty-second projection year (2037) past the valuation year for this male (age 52 in 2037) is:
$1000q_{52}^{2037} = 1000q_{52}^{2012} * (1 - G2_{52})^{25} = 2.545 * (1 - 0.011)^{25} = 1.930167846$, which is rounded to 1.930

The mortality rate in the twenty-third projection year (2038) past the valuation year for this male (age 53 in 2038) is:
$1000q_{53}^{2038} = 1000q_{53}^{2012} * (1 - G2_{53})^{26} = 2.779 * (1 - 0.012)^{26} = 2.030341567$, which is rounded to 2.030

Subchapter AA. Mortality Tables
Division 2. Smoker-Nonsmoker Composite Mortality Tables
28 TAC §§4.2712 - 4.2716

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2712 - 4.2716 under Insurance Code §§36.004, 541.057, 541.401, 1105.055(h), and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §541.057 prohibits unfair discrimination in the rates, dividends, or any other contract terms and conditions for individuals of the same class and life expectancy in life insurance and annuity contracts.

Insurance Code §541.401 provides that the commissioner may adopt and enforce reasonable rules necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §1105.055(h) specifies that the commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2712. Definitions.

The following words and terms, when used in these sections, have the following meanings unless the context clearly indicates otherwise.

(1) 1958 CET Table--That mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the National Association of Insurance Commissioners (NAIC) Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Extended Term Insurance Table.

(2) 1980 CET Table--That mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC amendments to the Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

(3) 1958 CSO Table--That mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Standard Ordinary Mortality Table.

(4) 1980 CSO Table, with or without Ten-Year Select Mortality Factors--That mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors. The same select factors will be used for both smokers and nonsmokers tables.

(5) Composite mortality tables--The mortality tables previously defined in this section as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

(6) Smoker and nonsmoker mortality tables--The mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined elsewhere in this section, which were developed by the Society of Actuaries Task Force on

Smoker/Nonsmoker Mortality and the California Insurance Department staff and recommended by the NAIC Technical Staff Actuarial Group.

§4.2713. Alternate Tables.

(a) For any policy of insurance delivered or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B, concerning Computation of Adjusted Premiums Using Nonforfeiture Net Level Premium Method, for that policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in §4.2714 of this title (relating to Conditions):

(1) the 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and

(2) the 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

(b) The tables specified in subsection (a) of this section must be used as described in subsection (a) of this section to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision. Provided, however, that for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision determined using 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured. Provided further that the substitution of the 1958 CSO or CET Smoker and Nonsmoker Mortality Tables is

available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form and before a date not later than January 1, 1989.

(c) For any policy of insurance delivered or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B), for the policy form, at the option of the company and subject to the conditions stated in §4.2714 of this title:

(1) the 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and

(2) the 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

(d) The tables specified in subsection (c) of this section must be used as provided in subsection (c) of this section to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision.

(e) Values of 1,000 qx for the tables specified in this section can be found in "Proceedings of the NAIC," Volume I, 1984, pages 402 - 413. These tables are adopted by reference for use in an appropriate manner as described in this subchapter. Copies may be obtained by contacting the Life and Health Division, Life and Health Actuarial, MC: LH-ACT, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. These tables are more particularly identified as follows:

(1) 1958 CSO Nonsmokers and Smokers Mortality Tables;

(2) 1958 CET Nonsmokers and Smokers Mortality Tables;

(3) 1980 CSO Female Nonsmokers and Smokers Mortality Tables;

(4) 1980 CSO Male Nonsmokers and Smokers Mortality Tables;

(5) 1980 CET Female Nonsmokers and Smokers Mortality Tables; and

(6) 1980 CET Male Nonsmokers and Smokers Mortality Tables.

§4.2714. Conditions.

For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may:

(1) use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits or benefits under any extended term insurance provision;

(2) use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Insurance Code §425.068, concerning Reserve Computation: Gross Premium Charged Less Than Valuation Net Premium, and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision; or

(3) use smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision.

§4.2715. Severability.

If any provision of these sections or the application of these sections to any person or circumstance is for any reason held to be invalid, the remainder of the sections and the application of such provision to other persons or circumstances will not be affected.

§4.2716. 2001 CSO Mortality Table.

The 2001 CSO Mortality Table must be used for purposes of this subchapter under the requirements of Subchapter AA, Division 3 of this chapter (relating to 2001 CSO Mortality Table).

Subchapter AA. Mortality Tables
Division 3. 2001 CSO Mortality Table
28 TAC §§4.2721 - 4.2726

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2721 - 4.2726 under Insurance Code §§36.004, 425.058(c)(3), 1105.055(h), and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §425.058(c)(3) specifies that for an ordinary life insurance policy issued on the standard basis, to which Insurance Code Chapter 1105, Subchapter B, applies, the applicable table is any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard values under Insurance Code Chapter 425, Subchapter B.

Insurance Code §1105.055(h) specifies that the commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2721. Purpose.

The purpose of this subchapter is to recognize, permit, and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with Insurance Code §425.058(c)(3), concerning Computation of Minimum Standard: General Rule, and §1105.055(h), concerning Use of Mortality Tables and Interest Rates With Nonforfeiture Net Level Premium Method, and §4.2825 of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves). For policies issued on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, provides applicable mortality tables.

§4.2722. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) 2001 CSO Mortality Table--Mortality tables, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries

CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the National Association of Insurance Commissioners in December 2002. Unless the context indicates otherwise, the 2001 CSO Mortality Table includes both the ultimate form of that table, and the select and ultimate form of that table, and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

(2) 2001 CSO Mortality Table (F)--Mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(3) 2001 CSO Mortality Table (M)--Mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(4) Composite mortality tables--Mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(5) Smoker and nonsmoker mortality tables--Mortality tables with separate rates of mortality for smokers and nonsmokers.

§4.2723. 2001 CSO Mortality Table.

(a) At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in this subchapter, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after May 1, 2003, and before the date specified in subsection (b) of this section to which Insurance Code §425.058(c)(3), concerning Computation of Minimum Standard: General Rule, and §1105.055(h), concerning Use of Mortality Tables and Interest Rates With Nonforfeiture Net Level Premium Method, and §4.2825 of this title (relating to General Calculation Requirements

for Basic Reserves and Premium Deficiency Reserves) are applicable. If the company elects to use the 2001 CSO Mortality Table, it must do so for both valuation and nonforfeiture purposes.

(b) Subject to the conditions stated in this subchapter, the 2001 CSO Mortality Table must be used in determining minimum standards for policies issued on and after January 1, 2009, and before January 1, 2017, to which Insurance Code §425.058(c) and §1105.055(h) and §4.2825 of this title are applicable, except as provided in Subchapter BB, Division 4 of this chapter (relating to Preneed Life Insurance Minimum Mortality Standards for Determining Reserve Liabilities and Nonforfeiture Values) for preneed life insurance policies and certificates. For policies issued on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, provides applicable mortality tables.

(c) The minimum basis for computation of values related to extended term benefits will be the 2001 CSO Mortality Table under the requirements of this subchapter.

(d) The commissioner adopts by reference the 2001 CSO Mortality Table. The table is available from the Financial Regulation Division, Actuarial Office, MC: FRD, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030 or on the internet by accessing the department's website at www.tdi.texas.gov/rules/2003/ficso.html.

§4.2724. Conditions.

(a) For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use:

(1) composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(2) smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Insurance Code §425.068, Reserve Computation: Gross Premium Charged Less Than Valuation Net Premium, and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits; or

(3) smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(b) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables must be used.

(c) For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of §4.2725 of this title (relating to Applicability of the 2001 CSO Mortality Table to Chapter 4, Subchapter BB, Division 3 of this Title) relative to use of the select and ultimate form.

§4.2725. Applicability of the 2001 CSO Mortality Table to Chapter 4, Subchapter BB, Division 3 of this Title.

(a) The 2001 CSO Mortality Table may be used in applying Chapter 4, Subchapter BB, Division 3 of this title (relating to Valuation of Life Insurance Policies) in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in §4.2723 of this title (relating to 2001 CSO Mortality Table).

(1) Section 4.2823(1)(B)(ii) of this title (relating to Applicability): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(2) Section 4.2824(2) of this title (relating to Definitions). All calculations are made using the 2001 CSO Mortality Rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in paragraph (4) of this subsection. The value of "qx+k+t-1" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(3) Section 4.2825(a) of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves). The 2001 CSO Mortality Table is the minimum standard for basic reserves.

(4) Section 4.2825(b) of this title. The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in §4.2825(b)(3)(A) to (I) of this title. In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant Actuarial Standards of Practice.

(5) Section 4.2826(c) of this title (relating to Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)). The valuation mortality table used in determining the tabular cost of insurance is the ultimate mortality rates in the 2001 CSO Mortality Table.

(6) Section 4.2826(e)(4) of this title. The calculations specified in §4.2826(e) of this title use the ultimate mortality rates in the 2001 CSO Mortality Table.

(7) Section 4.2826(f)(4) of this title. The calculations specified in §4.2826(f) of this title use the ultimate mortality rates in the 2001 CSO Mortality Table.

(8) Section 4.2826(g)(2) of this title. The calculations specified in §4.2826(g) of this title use the ultimate mortality rates in the 2001 CSO Mortality Table.

(9) Section 4.2827(a)(1)(B) of this title (relating to Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Second Guarantee Period). The one-year valuation premium is calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

(b) Nothing in this section may be construed to expand the applicability of Chapter 4, Subchapter BB, Division 3 of this title to include life insurance policies exempted under §4.2823(1) of this title.

§4.2726. Gender-Blended Tables.

(a) For any ordinary life insurance policy delivered or issued for delivery in this state on and after May 1, 2003, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subsection. For

any ordinary life insurance policy delivered or issued for delivery in Texas on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, provides the applicable mortality tables.

(b) The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the National Association of Insurance Commissioners in December 2002. These blended tables are available from the Financial Regulation Division, Actuarial Office, MC: FRD, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030 or on the internet by accessing the department's website at www.tdi.texas.gov/rules/2003/ficso.html.

(c) It is not, in and of itself, a violation of Insurance Code Chapter 541, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices, for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

Subchapter AA. Mortality Tables
Division 4. Preferred Mortality Tables
28 TAC §§4.2731 - 4.2734

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2731 - 4.2734 under Insurance Code §§36.004, 425.058(c)(3), 1105.055(h), and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §425.058(c)(3) specifies that for an ordinary life insurance policy issued on the standard basis, to which Insurance Code Chapter 1105, Subchapter B, applies, the applicable table is any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard values under Insurance Code Chapter 425, Subchapter B.

Insurance Code §1105.055(h) specifies that the commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2731. Purpose.

The purpose of this subchapter is to recognize and permit the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities in accordance with Insurance Code §425.058(c)(3), concerning Computation of Minimum Standards: General Rule, and §4.2825 of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves). Policies issued on or after January 1, 2017, must follow the applicable mortality table requirements provided by the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law.

§4.2732. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) 2001 CSO Mortality Table--Mortality tables, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the National Association of Insurance Commissioners (NAIC) in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002) and supplemented by the 2001 CSO Preferred Class Structure Mortality Table defined below. Unless the context indicates otherwise, the 2001 CSO Mortality Table includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Mortality tables in the 2001 CSO Mortality Table include the following.

(A) 2001 CSO Mortality Table (F)--Mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(B) 2001 CSO Mortality Table (M)--Mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(C) Composite mortality tables--Mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(D) Smoker and nonsmoker mortality tables--Mortality tables with separate rates of mortality for smokers and nonsmokers.

(2) 2001 CSO Preferred Class Structure Mortality Table--Mortality tables with separate rates of mortality for super preferred nonsmokers, preferred nonsmokers, residual standard nonsmokers, preferred smokers, and residual standard smoker splits of the 2001 CSO Nonsmoker and Smoker tables as adopted by the NAIC at the September 2006 national meeting and published in the Proceedings of the NAIC (3rd Quarter 2006). Unless the context indicates otherwise, the 2001 CSO Preferred Class Structure Mortality Table includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

(3) Statistical agent--An entity with proven systems for protecting the confidentiality of individual insured and insurer information, demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers, which are its members or subscribers, and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

§4.2733. 2001 CSO Preferred Class Structure Table.

(a) Policies issued on or after January 1, 2007, and before January 1, 2017. At the election of the insurer, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this subchapter, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. Policies issued on or after January 1, 2017,

must follow the mortality table requirements provided by the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law.

(b) Policies issued on or after May 1, 2003, and before January 1, 2007. At the election of the insurer and with the consent of the commissioner, for policies issued on or after May 1, 2003, and before January 1, 2007, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard subject to the conditions of §4.2734 of this title (relating to Conditions). In determining such consent, the commissioner may rely on the consent of the commissioner of the insurer's state of domicile.

(c) Requirement to make election. No election in subsection (a) or (b) of this section may be made until the insurer demonstrates that at least 20% of the business to be valued on this table is in one or more of the preferred classes.

(d) 2001 CSO Preferred Class Structure Mortality Table Treatment. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, under the requirements of this subchapter, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation under the requirements of Subchapter AA, Division 3 of this title (relating to 2001 CSO Mortality Table).

(e) Adoption by reference. The commissioner adopts by reference the 2001 CSO Preferred Class Structure Mortality Table. The table is available from the Financial Regulation Division, Actuarial Office, MC: FRD, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030 or on the internet by accessing the department's website at www.tdi.texas.gov/rules/2003/ficso.html.

§4.2734. Conditions.

(a) For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary must certify that:

(1) the present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class; and

(2) the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary must certify that:

(1) the present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality

improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table; and

(2) the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

(c) Unless exempted by the commissioner, every insurer using the 2001 CSO Preferred Class Structure Table must annually file with the commissioner, with the National Association of Insurance Commissioners (NAIC), or with a statistical agent designated by the NAIC and acceptable to the commissioner, statistical reports showing mortality and such other information as the commissioner may deem necessary or expedient for the administration of the provisions of this regulation. The form of the reports will be established by the commissioner, or the commissioner may require the use of a form established by the NAIC or by a statistical agent designated by the NAIC and acceptable to the commissioner. The form of the statistical reports will be promulgated by rule. Insurers are not required to file such statistical reports until such rule has been adopted by the commissioner. At the commissioner's discretion, the commissioner may request mortality experience and other information at any time.

(d) The use of the 2001 CSO Preferred Class Structure Table for the valuation of policies issued before January 1, 2007, will not be permitted in any statutory financial statement in which a company reports, with respect to any policy or portion of a policy coinsured, either of the following.

(1) In cases where the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds,

by more than the amount specified in this paragraph as Y, the gross reserve calculated before reinsurance. Y is the amount of the gross reinsurance premium that:

(A) provides coverage for the period from the next policy period premium due date to the earlier of the end of the policy year and the next reinsurance premium due date; and

(B) would be refunded to the ceding entity upon the termination of the policy.

(2) In cases where the mode of payment of the reinsurance premium is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve, calculated before reinsurance, by an amount that is less than the amount specified in this paragraph as Z. Z is the amount of gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

(3) For purposes of the conditions stated in paragraphs (1) and (2) of this subsection, the reserve for the mean reserve method will be defined as the mean reserve minus the deferred premium asset, and for the mid-terminal reserve method must include the unearned premium reserve. A company may estimate and adjust its accounting on an aggregate basis in order to meet the conditions to use the 2001 CSO Preferred Class Structure Table.

Subchapter BB. Life and Annuity Reserves
Division 1. Actuarial Opinion and Memorandum Regulation
28 TAC §§4.2801 - 4.2808

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2801 - 4.2808 under Insurance Code §§36.004, 425.054, and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §425.054 provides that the commissioner specify by rule the requirements of an actuarial opinion under §425.064(b), including any matters considered necessary to the opinion's scope.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2801. Purpose.

The purpose of this subchapter is to prescribe guidelines and standards for the following activities:

(1) the submission of a statement of actuarial opinion in accordance with Insurance Code §425.054, concerning Annual Valuation of Reserves for Policies and Contracts Issued on or After Operative Date of Valuation Manual, and for memoranda in support of such opinion;

(2) the appointment of an appointed actuary; and

(3) guidance as to the meaning of "adequacy of reserves."

§4.2802. Scope and Applicability.

(a) This subchapter applies to all life insurance companies doing business in this state and to all life insurance companies that are authorized to reinsure life insurance, annuities, or accident and health insurance business in this state.

(b) This subchapter must be applied in a manner that allows the appointed actuary to utilize their professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice; however, the commissioner has the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

(c) This subchapter applies to the actuarial opinion for the 2005 valuation through the 2016 valuation. The requirements of the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, apply to actuarial opinions for valuations on or after January 1, 2017.

(d) A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §4.2806 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis), and a memorandum in support of the statement of opinion in accordance with §4.2807 of this title (relating to Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary), is required each year, unless exempt under §4.2808 of this title (relating to Asset Adequacy Analysis Exemption).

§4.2803. Commissioner Discretion.

The commissioner may require any company, otherwise exempt from asset adequacy analysis requirements in this subchapter, to provide an actuarial opinion and actuarial memorandum that complies with the asset adequacy analysis requirements in this subchapter including requirements in §4.2806 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis) and in §4.2807 of this title (relating to Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary) if, in the opinion of the commissioner, an asset adequacy analysis is necessary with respect to the company.

§4.2804. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) AVR--Asset valuation reserve.

(2) Actuarial opinion--The opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §4.2806 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis) and with applicable Actuarial Standards of Practice.

(3) Actuarial Standards Board--The board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(4) Annual statement--That financial statement as of December 31st of the preceding year required to be filed annually by the company with the Texas Department of Insurance.

(5) Appointed actuary--A qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by this subchapter, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary.

(6) Asset adequacy analysis--An analysis that meets the standards and other requirements referred to in §4.2805(c) of this title (relating to General Requirements).

(7) Company--A life insurance company or reinsurer subject to the provisions of this subchapter including a stipulated premium insurance company insuring or assuming risk for coverages under Insurance Code §884.307, concerning Issuance of Annuity Contract, or §884.402, concerning Additional Coverage.

(8) IMR--Interest maintenance reserve.

(9) Qualified actuary--An individual who:

(A) is a member in good standing of the American Academy of Actuaries;

(B) is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(C) is familiar with the valuation requirements applicable to life and health insurance companies;

(D) has not been found by the commissioner (or, if so found, has subsequently been reinstated as a qualified actuary), following appropriate notice and opportunity for hearing, to have:

(i) violated any provision of, or any obligation imposed by, the Insurance Code or other law in the course of their dealings as a qualified actuary;

(ii) been found guilty of fraudulent or dishonest practices;

(iii) demonstrated their incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(iv) submitted to the commissioner during the past five years, under this subchapter, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this subchapter including standards set by the Actuarial Standards Board; or

(v) resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(E) has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under subparagraph (D) of this paragraph.

§4.2805. General Requirements.

(a) Submission of statement of actuarial opinion. Any statement of actuarial opinion required by this subchapter must be submitted in accordance with paragraphs (1) and (2) of this subsection.

(1) There is to be included on or attached to page one of the annual statement for each year beginning with the year in which this subchapter becomes effective the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with §4.2806 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis).

(2) Upon written request by the company, the commissioner may grant an extension of the date for submission of the statement of actuarial opinion.

(b) Appointment of actuary. The company must give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm), and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and must state in the notice that the person is a qualified actuary. Once notice is furnished, no further notice is required with respect to this person, provided that the company gives the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements for a qualified actuary. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice must so state and give the reasons for replacement.

(c) Standards for asset adequacy analysis. The asset adequacy analysis required by this subchapter must:

(1) conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and any additional standards set forth in this subchapter, which standards are to form the basis of the statement of actuarial opinion in accordance with this subchapter; and

(2) be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

(d) Liabilities to be covered. The liabilities to be covered will be in accordance with paragraphs (1) - (3) of this subsection.

(1) Under authority of Insurance Code §425.054, concerning Actuarial Opinion of Reserves Issued Before Operative Date of Valuation Manual, the statement of

actuarial opinion applies to all in-force business on the statement date, whether directly issued or assumed, regardless of when or where issued; for example, annual statement reserves in Exhibits 5, 6, and 7, and claim liabilities in Exhibit 8, Part 1 and equivalent items in the separate account statement or statements.

(2) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in Insurance Code §§425.064, concerning Commissioners Reserve Valuation Method For Life Insurance and Endowment Benefits; 425.065, concerning Commissioners Annuity Reserve Valuation Method For Annuity and Pure Endowment Benefits; 425.068, concerning Reserve Computation: Gross Premium Charged Less Than Valuation Net Premium; and 425.069, concerning Reserve Computation: Indeterminate Premium Plans and Certain Other Plans; and other applicable Insurance Code provisions, the company must establish the additional reserve.

(3) Additional reserves established under paragraph (2) of this subsection and deemed not necessary in subsequent years may be released. Any amounts released must be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

§4.2806. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis.

(a) General description. The statement of actuarial opinion required by this section must consist of the following paragraphs:

(1) a paragraph identifying the appointed actuary and their qualifications, recommended language is provided in subsection (b)(1) of this section;

(2) a scope paragraph (recommended language is provided in subsection (b)(2) of this section) identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) a reliance paragraph (recommended language is provided in subsection (b)(3) of this section) describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures, or assumptions (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios), supported by a statement of each such expert with the information prescribed by subsection (e) of this section; and

(4) an opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (recommended language is provided in subsection (b)(6) of this section).

(5) One or more additional paragraphs will be needed in individual company cases as follows:

(A) if the appointed actuary considers it necessary to state a qualification of their opinion;

(B) if the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

(C) if the appointed actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release; or

(D) if the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

(b) Recommended language. The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. The language is what should be included in typical circumstances in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses their professional judgment. Regardless of the language used, the opinion must retain all pertinent aspects of the language provided in this section.

(1) The opening paragraph should generally indicate the appointed actuary's relationship to the company and the appointed actuary's qualifications to sign the opinion.

(A) For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

Figure: 28 TAC §4.2806(b)(1)(A)

"I, (name), am (title) of (insurance company name) and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of said insurer to render this opinion as stated in the letter to the commissioner dated (insert date). I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(B) For a consulting actuary, the opening paragraph should include a statement such as:

Figure: 28 TAC §4.2806(b)(1)(B)

"I, (name), a member of the American Academy of Actuaries, am associated with the firm of (name of consulting firm). I have been appointed by, or by the authority of, the Board of Directors of (name of company) to render this opinion as stated in the letter to the commissioner dated (insert date). I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as:

Figure: 28 TAC §4.2806(b)(2)

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20( ). Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis.

Asset Adequacy Tested Amounts--Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (*) (2)	Analysis Method (**)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
Exhibit 5 Life Insurance					
Annuities					
Supplementary Contracts With Life Contingencies					
Accidental Death Benefits					
Disability - Active Lives					
Disability - Disabled Lives					
Miscellaneous Reserves					
Total Exhibit 5 (Page 3, Line 1)					
Exhibit 6 Active Life Reserve					
Claim Reserve					
Total Exhibit 6 (Page 3, Line 2)					
Exhibit 7 Guaranteed Interest Contracts Column 2, Line 14					
Annuities Certain Column 3, Line 14					
Supplemental Contracts Column 4, Line 14					
Dividend Accumulations or Refunds Column 5, Line 14					
Premium and Other Deposit Funds Column 6, Line 14					
Total Exhibit 7 Column 1, Line 14 (Page 3, Line 3)					
Exhibit 8, Part 1 Life (Page 3, Line 4.1)					
Health (Page 3, Line 4.2)					
Total Exhibit 8, Part 1 Column 1, Line 4.4					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)					
TOTAL RESERVES					

IMR (General Account, Page ___ Line ___)	
(Separate Accounts, Page ___ Line ___)	
AVR (Page ___ Line ___)	(***)
Net Deferred and Uncollected Premium	

Notes:

(*) The additional actuarial reserves are the reserves established under §4.2805(d)(2) of this title (relating to General Requirements).

(**) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in §4.2805(c) of this title, by means of symbols that should be defined in footnotes to the table.

(***) Allocated amount of AVR.

(3) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

Figure: 28 TAC §4.2806(b)(3)

"I have relied on (name), (title) for (e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios" or "certain critical aspects of the analysis performed in conjunction with forming my opinion"), as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts should be accompanied by a statement by each of the experts with the information prescribed by subsection (e) of this section.

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

Figure: 28 TAC §4.2806(b)(4)

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to (exhibits and schedules listed as applicable) of the company's current annual statement."

(5) If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

Figure: 28 TAC §4.2806(b)(5)

"In forming my opinion on (specify types of reserves) I relied upon data prepared by (name and title of company officer certifying in force records or other data) as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to (exhibits and schedules to be listed as applicable) of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."

The reliance paragraph shall be accompanied by a statement by each person relied upon with the information prescribed by subsection (e) of this section.

(6) The opinion paragraph should include a statement such as:

Figure: 28 TAC §4.2806(b)(6)

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

{a} are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

{b} are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

{c} meet the requirements of the insurance law and regulation of the state of (state of domicile); and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

{d} are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and

{e} include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion.

or

The following material changes which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

Choose whichever of the two immediately preceding paragraphs is appropriate.

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

_____
Signature of Appointed Actuary

_____
Address of Appointed Actuary

_____
Telephone Number of Appointed Actuary

_____
Date"

(c) Assumptions for new issues. The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption

used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this section.

(d) Adverse opinions. If the appointed actuary is unable to form an opinion, then the appointed actuary must refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then the appointed actuary must issue an adverse or qualified actuarial opinion explicitly stating the reasons for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

(e) Reliance on information furnished by other persons. If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies must provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness, or reasonableness, as applicable, of the items. This certification must include the signature, title, company, address, email address, and telephone number of the person rendering the certification, as well as the date on which it is signed.

(f) Alternate option.

(1) Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, gives the commissioner broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of

subsection (b)(6) of this section, the commissioner may make one or more of the following additional approaches available to the opining actuary.

(A) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of (state of domicile) and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile." If the commissioner chooses to allow this alternative, a formal written list of standards and conditions must be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year apply to statements for that calendar year and remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

(B) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of (state of domicile) and I have verified that the company's request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the commissioner for approval of that request have been met." If the commissioner chooses to allow this alternative, a formal written statement of such allowance must be issued no later than March 31 of the year it is first effective. It will remain valid until rescinded or modified by the commissioner. The rescission or modifications must be issued no later than March 31 of the year they are first effective. Before that statement may be issued, if a company chooses to use this alternative, the company must file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request will be deemed approved on October 1 of that year if the commissioner has not denied the request by that date.

(C) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of (state of domicile) and I have submitted the required comparison as specified by this state."

(i) If the commissioner chooses to allow this alternative, a formal written list of products (to be added to the table in Figure: 28 TAC §4.2806(f)(1)(C)(ii)) for which the required comparison must be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year applies to statements for that calendar year and remains in effect until it is revised or revoked. If no list is available, this alternative is not available.

(ii) If a company desires to use this alternative, the appointed actuary must provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under §7.18 of this title (relating to National Association of Insurance Commissioners Accounting Practices and Procedures Manual). Gross nationwide reserves are the total reserves calculated for the total company in force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided must include the following:

Figure: 28 TAC §4.2806(f)(1)(C)(ii)

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

(iii) The information listed must include all products identified by either the state of filing or any other states subscribing to this alternative.

(iv) If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary must provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

(2) The commissioner may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within 60 days of the request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract with an independent actuary at the company's expense to prepare and file the opinion.

§4.2807. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary.

(a) General. Any actuarial memorandum required by the provisions of this subchapter must be prepared in accordance with and subject to the provisions and qualifications of paragraphs (1) - (5) of this subsection.

(1) In accordance with Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, the appointed actuary must prepare a memorandum to the company describing the analysis done in support of the appointed actuary's opinion regarding the reserves under the opinion. The memorandum must be made available for examination by the commissioner upon the commissioner's request.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of the appointed actuary's own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of §4.2804 of this title

(relating to Definitions), with respect to the areas covered in such memoranda, and so state in the other actuaries' memoranda.

(3) If the commissioner requests a memorandum and no such memorandum exists or if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board as required by §4.2805 of this title (relating to General Requirements), or the standards and requirements of this subchapter, the commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review must be paid by the company but will be directed and controlled by the commissioner.

(4) The reviewing actuary will have the same status as an examiner for purposes of obtaining data from the company, and the work papers and documentation of the reviewing actuary will be retained by the commissioner. The reviewing actuary may not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer required by this subchapter for any one of the current year or the preceding three years.

(5) In accordance with Insurance Code Chapter 425, Subchapter B, the appointed actuary must prepare a regulatory asset adequacy issues summary, the contents of which are specified in subsection (c) of this section. Texas domestic companies must submit the regulatory asset adequacy issues summary by email to ActuarialDivision@tdi.texas.gov or by paper copy to the Financial Regulation Division, MC: FRD, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030 no later than March 15 of the year following the year for which a statement of actuarial opinion

based on asset adequacy is required. Nondomestic companies must submit the regulatory asset adequacy issues summary when requested by the commissioner.

(b) Details of the memorandum section documenting asset adequacy analysis. When an actuarial opinion under §4.2806 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis) is provided, the memorandum must demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in §4.2805(c) of this title and any additional standards under this subchapter. The documentation of the assumptions used in paragraphs (1) and (2) of this subsection must be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions. The memorandum must specify:

(1) for reserves:

(A) product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

(B) source of liability in force;

(C) reserve method and basis;

(D) investment reserves;

(E) reinsurance arrangements;

(F) identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

(G) documentation of assumptions to test reserves for the following:

(i) lapse rates (both base and excess);

(ii) interest crediting rate strategy;

(iii) mortality;

(iv) policyholder dividend strategy;

(v) competitor or market interest rate;

(vi) annuitization rates;

(vii) commissions and expenses; and

(viii) morbidity.

(2) For assets:

(A) portfolio descriptions, including a risk profile disclosing the quality, distribution, and types of assets;

(B) investment and disinvestment assumptions;

(C) source of asset data;

(D) asset valuation bases; and

(E) documentation of assumptions made for:

(i) default costs;

(ii) bond call function;

(iii) mortgage prepayment function;

(iv) determining market value for assets sold due to disinvestment strategy; and

(v) determining yield on assets acquired through the investment strategy.

(3) For the analysis basis:

(A) methodology;

(B) rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(C) rationale for degree of rigor in analyzing different blocks of business (including the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

(D) criteria for determining asset adequacy (including the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

(E) whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis;

(4) summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

(5) summary of results; and

(6) conclusions.

(c) Details of the regulatory asset adequacy issues summary.

(1) The regulatory asset adequacy issues summary must include the following.

(A) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date that, if held, would eliminate the negative aggregate surplus values. Ending surplus values must be determined by either extending the projection period until the in

force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(B) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis.

(C) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion.

(D) Comments on any interim results that may be of significant concern to the appointed actuary. For example, the comments must describe the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods.

(E) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.

(F) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including, but not limited to, those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

(2) The regulatory asset adequacy issues summary must contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and be signed and dated by the appointed actuary rendering the actuarial opinion.

(3) The regulatory asset adequacy issues summary will be used to examine the company's financial condition and ability to meet its liabilities. It will be considered information obtained during the course of an examination under Insurance Code Chapter 401, concerning Audits and Examinations, and treated as confidential.

(d) Conformity to standards of practice. The memorandum must include a statement with wording substantially similar to that of this subsection as follows: "Actuarial methods, considerations, and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

(e) Use of assets supporting the IMR and the AVR. An appropriate allocation of assets in the amount of the IMR, whether positive or negative, must be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the AVR; these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support. The amount of the assets used for the AVR must be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets must be disclosed in the memorandum.

(f) Documentation retention. The appointed actuary must retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions, and the results obtained.

§4.2808. Asset Adequacy Analysis Exemption.

(a) Companies that do business only in Texas and no other state are not required to perform the asset adequacy analysis required by §4.2805 of this title (relating to General Requirements) unless required by the commissioner under §4.2803 of this title (relating to Commissioner Discretion).

(b) Companies exempted under subsection (a) of this section must submit with the annual statement an actuarial opinion under this subchapter but not based on an asset adequacy analysis.

Subchapter BB. Life and Annuity Reserves
Division 2. Strengthened Reserves Under Insurance Code §425.067
28 TAC §4.2811

STATUTORY AUTHORITY. The commissioner adopts amendments to §4.2811 under Insurance Code §425.067 and §36.001.

Insurance Code §425.067 authorizes the commissioner to establish categories of necessary reserves for certain policies, benefits, or contracts issued by life insurance companies.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2811. Strengthened Reserves Under Insurance Code §425.067.

A life insurance company may increase the amount of its reserve liabilities by changing the basis of computation as provided in Insurance Code §425.067, concerning Optional Reserve Computations. The insurer may establish a higher reserving basis by reporting an increase in reserve in Exhibit 5A of its annual statement. Thereafter the insurer must continue to report on the higher basis. An insurer may, with the approval of the Texas Department of Insurance, as provided in Insurance Code §425.067, adopt a lower standard of valuation, but not lower than the minimum standard provided in Insurance Code §425.053, concerning Annual Valuation of Reserves for Policies and Contracts Issued Before Operative Date of Valuation Manual.

Subchapter BB. Life and Annuity Reserves
Division 3. Valuation of Life Insurance Policies
28 TAC §§4.2821 - 4.2827 and 4.2829

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2821 - 4.2827 and 4.2829 under Insurance Code §§36.004, 425.058(c)(3), and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §425.058(c)(3) specifies that for an ordinary life insurance policy issued on the standard basis, to which Insurance Code Chapter 1105, Subchapter B, applies, the applicable table is any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard values under Insurance Code Chapter 425, Subchapter B.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2821. Purpose.

(a) The purpose of this subchapter is to provide:

(1) tables of select mortality factors and rules for their use;

(2) rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

(3) rules concerning a minimum standard for the valuation of plans with secondary guarantees.

(b) The method for calculating basic reserves defined in this subchapter will constitute the Commissioners' Reserve Valuation Method for policies to which this subchapter is applicable.

§4.2822. Adoption of Tables of Select Mortality Factors.

The six tables of select mortality factors adopted in this section are from the NAIC model regulation titled "Valuation of Life Insurance Policies Model Regulation" that was adopted by the NAIC on March 8, 1999. The six tables of base select mortality factors include: male aggregate, male nonsmokers, male smoker, female aggregate, female nonsmoker, and female smoker. These tables apply to both age-last-birthday and age-nearest-birthday mortality tables.

Figure: 28 TAC §4.2822

SELECT MORTALITY FACTORS

Male, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100

Male, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100

Male, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100

Male, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100

Female, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100

Female, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100

Female, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

§4.2823. Applicability.

This subchapter applies to all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2000, and before January 1, 2017, subject to the following exceptions in paragraph (1) of this section and conditions in paragraph (2) of this section. For all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2017, the requirements of the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law, apply.

(1) Exceptions.

(A) This subchapter does not apply to any individual life insurance policy issued on or after the effective date of this subchapter if the policy is issued in accordance with, and as a result of, the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this subchapter, that guarantees the premium rates of the new policy. This subchapter also does not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

(B) This subchapter does not apply to any universal life policy that meets all the following requirements:

(i) secondary guarantee period, if any, is five years or less;

(ii) specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the 1980 CSO valuation tables and the applicable valuation interest rate; and

(iii) the initial surrender charge is not less than 100% of the first year annualized specified premium for the secondary guarantee period.

(C) This subchapter does not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(D) This subchapter does not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(E) This subchapter does not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross

premiums required in order to continue coverage in force for a period in excess of one year.

(2) Conditions.

(A) Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, must be in accordance with the provisions of §4.2826 of this title (relating to Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)).

(B) Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period, must be in accordance with the provisions of §4.2827 of this title (relating to Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period).

§4.2824. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Basic reserves--Reserves calculated in accordance with the principles of Insurance Code §425.064, concerning Commissioners Reserve Valuation Method for Life Insurance and Endowment Benefits.

(2) Contract segmentation method--The method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO valuation tables, as defined in this section, (or any other valuation mortality table adopted by the NAIC after the effective date of this subchapter and promulgated by regulation by the commissioner for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in §4.2825(b) of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves).

Figure: 28 TAC §4.2824(2)

The length of a particular contract segment must be set equal to the minimum of the value t for which G_t is greater than R_t (if G_t never exceeds R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows.

$G_t = GP_{x+k+t} / GP_{x+k+t-1}$

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, ...; t is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ = Guaranteed gross premium per thousand of face amount, for year t of the segment ignoring policy fees only if such policy fees are level for the premium paying period of the policy.

$R_t = q_{x+k+t} / q_{x+k+t-1}$. However, R_t may be increased or decreased by 1% in any policy year, at the company's option, but R_t must not be less than one;

where:

x, k and t are as defined above, and $q_{x+k+t-1}$= valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of §4.2825(b)(2) of this title if §4.2825(b)(3) of this title is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t must be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t must be deemed to be 0.

(3) Deficiency reserves--The excess, if greater than zero, of the minimum reserves calculated in accordance with the principles of Insurance Code §425.068, concerning Reserve Computation: Gross Premium Charged Less Than Valuation Net Premium, over the basic reserves.

(4) Guaranteed gross premiums--The premiums under a policy of life insurance that are guaranteed and determined at issue.

(5) Maximum valuation interest rates--The interest rates defined in Insurance Code §425.061, concerning Computation of Calendar Year Statutory Valuation

Interest Rate: General Rule, that are to be used in determining the minimum standard for the valuation of life insurance policies.

(6) NAIC--National Association of Insurance Commissioners.

(7) 1980 CSO valuation tables--The Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

(8) Scheduled gross premium--The smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in §4.2827(a)(3) of this title (relating to Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period) if any, or else the minimum premium described in §4.2827(a)(4) of this title.

(9) Segmented reserves--Reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The length of each segment is determined by the "contract segmentation method," as defined in this section. The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum

of the lengths of all segments of the policy. For both basic reserves and deficiency reserves computed by the segmented method, present values must include future benefits and net premiums in the current segment and in all subsequent segments. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

(A) the present value of the death benefits and endowment benefits within the segment, plus

(B) the present value of any unusual guaranteed cash value (see §4.2826(d) of this title (relating to Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies))) occurring at the end of the segment, less

(C) any unusual guaranteed cash value occurring at the start of the segment, plus

(D) for the first segment only, the excess of clause (i) of this paragraph over clause (ii) of this paragraph, as follows.

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium may not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one year term premium for the benefits provided for in the first policy year.

(10) Tabular cost of insurance--The net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

(11) Ten-year select factors--The select factors in Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law.

(12) Unitary reserves--The present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

(A) guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

(B) modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of clause (i) of this subparagraph over clause (ii) of this subparagraph, as follows.

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium may not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one-year term premium for the benefits provided for in the first policy year.

(C) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

(13) Universal life insurance policy--Any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

§4.2825. General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves.

(a) At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this subchapter and promulgated by regulation by the commissioner for this purpose). If select mortality factors are elected, they may be:

(1) the ten-year select mortality factors incorporated in Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law;

(2) the select mortality factors adopted in §4.2822 of this title (relating to Adoption of Tables of Select Mortality Factors); or

(3) any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating basic reserves.

(b) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner). If select mortality factors are elected, they may be:

(1) the ten-year select mortality factors in Insurance Code Chapter 425, Subchapter B;

(2) the select mortality factors adopted in §4.2822 of this title;

(3) for durations in the first segment, X percent of the select mortality factors adopted in §4.2822 of this title, subject to the following:

(A) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(B) X is such that, when using the valuation interest rate used for basic reserves, clause (i) of this subparagraph is greater than or equal to clause (ii) of this subparagraph:

(i) the actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(ii) the actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

(C) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five years after the valuation date;

(D) the appointed actuary must increase X at any valuation date where it is necessary to continue to meet all the requirements of paragraph (3) of this subsection;

(E) the appointed actuary may decrease X at any valuation date as long as X continues to meet all the requirements of paragraph (3) of this subsection; and

(F) the appointed actuary must specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(G) If X is less than 100% at any duration for any policy, the following requirements must be met:

(i) the appointed actuary must annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of §4.2807 of this title (relating to Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary);

(ii) in the regulatory asset adequacy issues summary prescribed under §4.2807 of this title, the appointed actuary must disclose the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods; and

(iii) the appointed actuary must annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of paragraph (3) of this subsection. This opinion must be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors must reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience; or

(4) any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating deficiency reserves.

(c) This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten years, the appropriate ten-year select mortality factors may be used thereafter through the tenth policy year from the date of issue.

(d) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums even if not included in the actual calculation of basic reserves.

(e) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change must be the greatest of the following:

(1) reserves calculated ignoring the guarantee;

(2) reserves assuming the guarantee was made at issue; and

(3) reserves assuming that the policy was issued on the date of the guarantee.

(f) The commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued before the effective date of this subchapter. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of §4.2807 of this title.

§4.2826. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies).

(a) Basic reserves. Basic reserves must be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy must use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either one of the two adjustments described in paragraphs (1) or (2) of this subsection may be made.

(1) An insurer may use the adjustments described in this paragraph.

(A) Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment; and

(B) subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(2) An insurer may use the adjustments described in this paragraph.

(A) Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and

(B) subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(b) Deficiency reserves.

(1) The deficiency reserve at any duration must be calculated:

(A) on a unitary basis if the corresponding basic reserve determined by subsection (a) of this section is unitary;

(B) on a segmented basis if the corresponding basic reserve determined by subsection (a) of this section is segmented; or

(C) on the segmented basis if the corresponding basic reserve determined by subsection (a) of this section is equal to both the segmented reserve and the unitary reserve.

(2) This subsection applies to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation

standards of mortality specified in §4.2825(b) of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves) and rate of interest.

(3) Deficiency reserves, if any, must be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in §4.2825(b) of this title.

(4) For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

(c) Minimum value. Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance must use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if the select mortality factors are used, they must be the ten-year select factors incorporated into Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

(d) Unusual pattern of guaranteed cash surrender values.

(1) For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held before the first unusual guaranteed cash surrender value

must not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an n year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where n is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

(2) The reserves actually held after any unusual guaranteed cash surrender value must not be less than the reserves calculated by treating the policy as an n year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

(A) n is the number of years from the date of the last unusual guaranteed cash surrender value before the valuation date to the earlier of:

(i) the date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(ii) the mandatory expiration date of the policy; and

(B) the net premium for a given year during the n year period is equal to the product of the net to gross ratio and the respective gross premium; and

(C) the net to gross ratio is equal to clause (i) of this subparagraph divided by clause (ii) of this subparagraph as follows:

(i) the present value, at the beginning of the n year period, of death benefits payable during the n year period plus the present value, at the beginning of the n year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the n year period;

(ii) the present value, at the beginning of the n year period, of the scheduled gross premiums payable during the n year period.

(3) For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(A) 110% of the scheduled gross premium for that year;

(B) 110% of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(C) 5% of the first policy year surrender charge, if any.

(e) Optional exemption for yearly renewable term (YRT) reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used.

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves must never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (c) of this section.

(3) Deficiency reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency reserves must never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subparagraph (A) of this paragraph.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(5) A reinsurance agreement will be considered YRT reinsurance for purposes of this subsection if only the mortality risk is reinsured.

(6) If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit will be limited to the amount of reserve held by the assuming company for the affected policies.

(f) Optional exemption for attained-age-based yearly renewable term life insurance policies. At the option of the company, the approach described in this subsection for reserves for attained-age-based YRT life insurance policies may be used.

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves may never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (c) of this section.

(3) Deficiency reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency reserves may never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subparagraph (A) of this paragraph.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select

mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(5) A policy will be considered an attained-age-based YRT life insurance policy for purposes of this subsection if:

(A) the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(B) the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance, and attained age.

(6) For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

(A) the initial period is constant for all insureds of the same sex, risk class, and plan of insurance; or

(B) the initial period runs to a common attained age for all insureds of the same sex, risk class, and plan of insurance; and

(C) after the initial period of coverage, the policy meets the conditions of paragraph (5) of this subsection.

(7) If this election is made, this approach must be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this subchapter.

(g) Exemption from unitary reserves for certain n-year renewable term life insurance policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the conditions described in paragraphs (1) - (3) of this subsection are met.

(1) The policy consists of a series of n-year periods, including the first period and all renewal periods, where n is the same for each period, except for the final renewal period, n may be truncated or extended to reach the expiry age, provided that this final renewal period is less than ten years and less than twice the size of the earlier n-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

(2) the guaranteed gross premiums in all n-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten-year select mortality factors; and

(3) there are no cash surrender values in any policy year.

(h) Exemption from unitary reserves for certain juvenile policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the conditions described in paragraphs (1) - (3) of this subsection are met, based upon the initial current premium scale at issue.

(1) At issue, the insured is age 24 or younger;

(2) until the insured reaches the end of the juvenile period, which must occur at or before age 25, the gross premiums and death benefits are level, and there are no cash surrender values; and

(3) after the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

§4.2827. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period.

(a) General.

(1) Policies with a secondary guarantee include:

(A) a policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

(B) a policy in which the minimum premium at any duration is less than the corresponding one-year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose; or

(C) a policy with any combination of subparagraphs (A) and (B) of this paragraph.

(2) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve must be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are

unilaterally changed by the insurer after issue must be considered to have been made at issue. Reserves described in subsections (b) and (c) of this section must be recalculated from issue to reflect these changes.

(3) Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but that otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

(4) For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation must use the policy cost factors (including mortality charges, loads, and expense charges) and the interest crediting rate, which are all guaranteed at issue.

(5) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in §4.2825(b)(2) - (4) of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves) may not be used to calculate the one-year valuation premiums.

(6) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

(b) Basic Reserves for the Secondary Guarantees. Basic reserves for the secondary guarantees must be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums must be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in §4.2824 of this title (relating to Definitions).

(c) Deficiency Reserves for the Secondary Guarantees. Deficiency reserves, if any, for the secondary guarantees must be calculated for the secondary guarantee period in the same manner as described in §4.2826(b) of this title (Relating to Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other Than Universal Life Policies)) with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

(d) Minimum Reserves. The minimum reserves during the secondary guarantee period are the greater of:

(1) the basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(2) the minimum reserves required by other rules or subchapters governing universal life plans.

§4.2829. 2001 CSO Mortality Table.

The 2001 CSO Mortality Table must be used for purposes of this subchapter under the requirements of Subchapter AA, Division 3 of this chapter (relating to 2001 CSO Mortality Table).

Subchapter BB. Life and Annuity Reserves
Division 4. Preneed Life Insurance Minimum Mortality Standards for Determining Reserve Liabilities and Nonforfeiture Values
28 TAC §§4.2831 - 4.2836

STATUTORY AUTHORITY. The commissioner adopts amendments to §§4.2831 - 4.2836 under Insurance Code §§36.004, 425.058(c)(3), 1105.055(h), and 36.001.

Insurance Code §36.004 provides that the commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if certain statutory requirements are met.

Insurance Code §425.058(c)(3) specifies that for an ordinary life insurance policy issued on the standard basis, to which Insurance Code Chapter 1105, Subchapter B, applies, the applicable table is any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard values under Insurance Code Chapter 425, Subchapter B.

Insurance Code §1105.055(h) specifies that the commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§4.2831. Purpose and Applicability.

(a) The purpose of this subchapter is to establish the minimum mortality standards for reserves and nonforfeiture values for preneed life insurance policies or certificates, and to recognize, permit, and prescribe the use of the Ultimate 1980 CSO in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed life insurance policies or certificates in accordance with Insurance Code §425.058(c), concerning Computation of Minimum Standard: General Rule, and §1105.055, concerning Use of Mortality Tables and Interest Rates with Nonforfeiture Net Level Premium Method, and §4.2825(a) of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves).

(b) This subchapter applies to all preneed life insurance policies and certificates issued on or after January 1, 2009.

§4.2832. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) 2001 CSO Mortality Table--Mortality tables, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the 2nd Quarter 2002 *Proceedings of the NAIC*. Unless the context indicates otherwise, the 2001 CSO Mortality Table includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the

composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

(2) Department--The Texas Department of Insurance.

(3) NAIC--National Association of Insurance Commissioners.

(4) Prepaid funeral benefits--As defined in Finance Code §154.002(9), concerning Definitions.

(5) Prepaid funeral benefits contract--A contract or agreement for prepaid funeral benefits subject to the requirements of Finance Code Chapter 154, concerning Prepaid Funeral Services.

(6) Preneed life insurance--A life insurance policy or certificate that is approved by the department, issued by an insurance company licensed by the department, issued in conjunction with an insurance-funded prepaid funeral benefits contract, and that, whether by assignment or otherwise, has the purpose of funding prepaid funeral benefits to be provided at the time of, or immediately following, the death of the insured. For purposes of this subchapter, the definition of preneed life insurance does not include an annuity contract or policy.

(7) Ultimate 1980 CSO--The Commissioners 1980 Standard Ordinary Mortality Table without 10-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

§4.2833. Minimum Valuation Mortality Standards.

Except as provided by §4.2836 of this title (relating to Transitional Use of the 2001 CSO Mortality Table), the Ultimate 1980 CSO is the minimum mortality standard for

determining reserve liabilities and nonforfeiture values for both male and female insureds for preneed life insurance policies issued on or after January 1, 2009.

§4.2834. Minimum Valuation Interest Rate Standards.

(a) The interest rates used in determining the minimum standard for valuation of preneed life insurance are the calendar year statutory valuation rates as defined in Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law.

(b) The interest rates used in determining the minimum standard for nonforfeiture values for preneed life insurance are the calendar year statutory nonforfeiture interest rates as defined in Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance.

§4.2835. Minimum Valuation Method Standards.

(a) The method used in determining the standard for the minimum valuation of reserves for preneed life insurance is the method defined in Insurance Code Chapter 425, Subchapter B, concerning Standard Valuation Law.

(b) The method used in determining the standard for the minimum nonforfeiture values for preneed life insurance is the method defined in Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance.

§4.2836. Transitional Use of the 2001 CSO Mortality Table.

(a) For preneed life insurance policies or certificates issued on or after January 1, 2009, and before January 1, 2012, the 2001 CSO Mortality Table may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both

male and female insureds in accordance with the requirements of Subchapter AA, Division 3, of this chapter (relating to 2001 CSO Mortality Table).

(b) If a company elects to use the 2001 CSO Mortality Table as a minimum standard for any preneed life insurance policy or certificate issued on or after the effective date of this subsection and before January 1, 2012, the company must provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy analysis, an annual written notification to the domiciliary commissioner. The notification must include:

(1) a complete list of all preneed life insurance policy and certificate forms that use the 2001 CSO Mortality Table as a minimum standard;

(2) a certification signed by the appointed actuary stating that the reserve methodology, employed by the company in determining reserves for the preneed life insurance policies or certificates issued after the effective date of this subchapter and using the 2001 CSO Mortality Table as a minimum standard, develops adequate reserves (for the purposes of this certification, the preneed life insurance policies or certificates using the 2001 CSO Mortality Table as a minimum standard cannot be aggregated with any other policies); and

(3) supporting information regarding the adequacy of reserves for preneed life insurance policies or certificates issued after the effective date of this subchapter and using the 2001 CSO Mortality Table as a minimum standard for reserves.

(c) Preneed life insurance policies or certificates issued on or after January 1, 2012, must use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 4, 2024.

DocuSigned by:
Jessica Barta
5DAC5618BBC74D4...

Jessica Barta, General Counsel
Texas Department of Insurance

The repeal of 28 TAC §4.1117 and amendments to 28 TAC §§4.201 - 4.206, 4.601 - 4.608, 4.611, 4.613 - 4.628, 4.1001, 4.1002, 4.1004, 4.1005, 4.1008, 4.1010, 4.1011, 4.1101 - 4.1104, 4.1106 - 4.1116, 4.1201, 4.1502 - 4.1510, 4.1602 - 4.1606, 4.1609 - 4.1613, 4.1702 - 4.1707, 4.2102 - 4.2106, 4.2302, 4.2304, 4.2306 - 4.2312, 4.2322, 4.2701, 4.2702, 4.2705, 4.2706, 4.2712 - 4.2716, 4.2721 - 4.2726, 4.2731 - 4.2734, 4.2801 - 4.2808, 4.2811, 4.2821 - 4.2827, 4.2829, and 4.2831 - 4.2836 are adopted.

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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2024-8463