# **02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 580: THIRD-PARTY NOTICE OF CANCELLATION**

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**Section 1. Authority**

 This Rule is adopted by the Superintendent pursuant to 24 M.R.S.A. §2370 and 24‑A M.R.S.A. §§ 212, 2707-A, 2847-C, 4212(2), 4222-A, and 5016.

**Section 2. Purpose**

 The purpose of this Rule is to establish conditions and procedures, including disclosure requirements and cancellation restrictions, to reduce the danger that persons suffering from cognitive impairment or functional incapacity will lose their health coverage because their medical condition caused them to neglect their premium payment obligations or made them unaware that their coverage would be terminating. In particular, the third-party notice provisions of this Rule allow an insured person to establish in advance a line of communication that will increase the likelihood that adequate notice is given in the event that the insured person subsequently develops cognitive impairment or functional incapacity.

**Section 3. Scope**

 This Rule applies to all health insurance, health maintenance organization contracts, and nonprofit health service contracts, including Medicare supplement policies, long-term care policies, and disability income policies, executed, delivered, issued for delivery, continued, or renewed in the State of Maine, and subject to 24 M.R.S.A. chapter 19 or 24-A M.R.S.A. chapters 33, 35, 56, 67, 68, or 68-A, including certificates delivered in the State of Maine under out-of-state group policies or contracts. For long-term care insurance subject to Bureau of Insurance Rule 425, compliance with Rule 425, Section 7, shall constitute compliance with this Rule. For group long-term care policies in which the insured pays premium through payroll deduction, insurers may defer the provision of Third Party Notice Request Forms and collection of third-party designation information consistent with Paragraph 5(A)(3) of this Rule.

**Section 4. Definitions**

 For purposes of this Rule the following terms shall have the following meanings:

A. “Contract” means a policy, certificate, or other evidence of coverage issued by an insurer, health maintenance organization, or nonprofit service organization and includes certificates delivered in the State of Maine pursuant to out-of-state group policies. “Contract” includes both group and individual contracts and individual certificates of coverage unless stated otherwise.

B. “Insured” means the named insured, subscriber, member, or enrollee provided coverage by a contract, and includes the individual responsible for making premium payments on behalf of a small employer group or subgroup.

C. “Insurer” means an insurance company, health maintenance organization, or nonprofit service organization.

D. “Nonpayment of Premium” means the failure to remit any payment that the insured is required to make to an insurer, group policyholder, or plan sponsor or administrator.

E. “Subgroup” means an employer covered under a contract issued under a multiple-employer trust, association, or other group plan covering more than one employer.

**Section 5. Notification**

A. The following paragraphs describe alternative ways of providing notice and are applicable to group and individual insurance. At their option insurers may provide more extensive notification to covered persons.

1. **First alternative**. The insurer shall provide to each insured a “Third Party Notice Request Form” giving the insured the option to designate an additional person to receive notice of any intent to cancel a contract or certificate.

a) The Third Party Notice Request Form may be included as part of each initial or renewal application, or may be a supplemental form.

b) If separate, it shall be furnished to the insured before or at the time of delivery of the contract or certificate to the covered person.

c) If the insured does not return the form within 30 days, the insurer may presume that the insured elects not to designate a third party. However, the insured may designate a third party at any subsequent time.

2. **Second Alternative**. It shall be the insurer’s responsibility that a Third Party Notice Request Form is mailed or personally delivered to the insured within 30 days after a request by the insured. The contract and any certificate subject to this Rule shall provide notice of the right:

a) To designate a third party to receive notice of cancellation;

b) To change the designation; and

c) Of reinstatement of the contract if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured’s nonpayment of premium or other lapse or default on the part of the insured.

3. **Third Alternative**. If the insured’s portion of the premium is paid through a payroll deduction plan, the insurer may elect to defer the provision of Third Party Notice Request Forms and the collection of third-party designation information for up to 60 days after the insurer stops receiving the premiums through the payroll deduction plan. Within 60 days after the insurer stops receiving the premiums through the payroll deduction plan, the insurer shall obtain or confirm the insured’s address and notify the insured of the right to designate a third party to receive notice of cancellation.

B. At any time after completion of a Third Party Notice Request Form the designation may be changed upon written request of the insured.

C. At least 10 calendar days before cancellation of the contract or certificate, in addition to giving notice to the insured in a manner consistent with the law applicable to that type of contract, the insurer shall give notice of pending cancellation to the designated third party, if any, at the last address(es) provided.

1. The notice shall state the reason(s) for cancellation and the date that coverage is to terminate.

2. If the contract or certificate is subject to cancellation for nonpayment of premium, the notice shall include the amount of unpaid premium and the date by which premium must be paid. If the reason for cancellation is some other lapse or default on the part of the insured, the notice shall include an explanation of how to cure the default and the time by which the default must be cured. If the reason for cancellation is beyond the insured’s control, the notice shall say so.

3. When applicable, the notice shall include notice of the following rights:

a) For medical coverage, notice of the right to guaranteed issuance of individual health plans, and, if the current contract is an individual or group health plan subject to the *Continuity of Coverage Act*, notice that the new coverage must be issued without preexisting condition exclusions, to the extent that the condition is covered under the current contract, if the new coverage is in place within 90 days.

b) For Medicare supplement coverage, notice of the 90-day period in which the insured may apply to any insurer for any new Medicare supplement policy offered in Maine by that insurer and providing the same or lesser benefits as the insured’s existing coverage, without being subject to medical underwriting or preexisting condition exclusions.

c) Any offer by the insurer of replacement coverage or new payment arrangements, whether made voluntarily or pursuant to legal or contractual requirements. For group coverage, this includes any right the insured might have to convert to individual coverage or to enroll in a different group.

**Section 6. Limitations on Cancellation; Right to Reinstatement**

A. **Individual and group coverage**

1. Within 90 days after cancellation of a contract for nonpayment of premium, the insured, any person authorized to act on behalf of the insured, or any dependent of the insured covered under the contract may request reinstatement of the contract on the basis that the insured suffered from cognitive impairment or functional incapacity at the time of contract cancellation.

2. The insurer may request a medical demonstration that the insured suffered from cognitive impairment or functional incapacity at the time of cancellation of the contract. If the demonstration is waived, or substantiates the existence of cognitive impairment or functional incapacity at the time of cancellation to the satisfaction of the insurer, the contract shall be reinstated. The medical demonstration may be at the expense of the insured.

3. The reinstated contract shall be issued without any evidence of insurability.

4. The reinstated contract shall cover loss occurring from the date of contract cancellation. There shall be no gaps in coverage. Coverage shall be at the level provided immediately before the cancellation.

5. Premium shall be paid from the date of the last premium payment at the rate which would have been in effect had the contract remained in force. Payment shall be made within 15 days after request by the insurer. If the premium is not paid as required, the insurer has no obligation to reinstate the policy. If the policy is not reinstated, the insurer is not responsible for claims incurred after the date of cancellation.

6. The insured also has the right to reinstatement of the prior contract, subject to the conditions and procedures set forth in Paragraphs 1 through 5 of this Subsection, in the event of cancellation for any other lapse or default on the part of the insured, provided that the default is cured promptly and an adequate causal connection is made between the default and the insured’s cognitive impairment or functional incapacity.

7. All policies and certificates subject to this Rule issued on or after January 1, 2013 shall include notice of the right to seek reinstatement after cancellation, if loss of coverage is attributable to the contract holder’s affliction with cognitive impairment or functional incapacity. This requirement may be satisfied through an endorsement to the contract or by including the notice of reinstatement right in an application that is incorporated into the contract.

B. **Additional Requirements for Group Coverage**

1. If coverage was provided through a group policy which was replaced by the group or subgroup, the insured shall become covered under the new policy if at the time of replacement the insured would have qualified for the replacing coverage.

2. If the insured was covered by a group policy which terminated and was not replaced by the group or subgroup, the insured shall be entitled to all continuation and conversion benefits which were provided by the group policy at the time of policy termination.

3. If coverage for a group or subgroup is canceled as a result of a responsible individual’s cognitive impairment or functional incapacity, the group or subgroup has the right to reinstate coverage in the same manner and subject to the same limitations as provided in Subsection A. This provision does not limit an insurer’s right to cancel coverage for an employer group or subgroup prospectively, after giving sufficient notice, on the ground that the employer is no longer in business, even if the cessation of business results from the employer’s cognitive impairment or functional incapacity.

**Section 7. Administrative Rights**

A. If a request for reinstatement of coverage because of cognitive impairment or functional incapacity is denied, notice of denial shall be provided to the insured and to the person making the request, if different. The notice of denial shall include notification of the 30 day period following receipt of the notice during which a hearing before the Superintendent may be requested.

B. Any hearing shall be for the purpose of determining whether a violation of this Rule or the *Maine Insurance Code* has occurred.

**Section 8. Transition**

A. Within 60 days after the effective date of any amendment to this Rule, every insurer shall file with the Superintendent any new forms or contract provisions, and all revisions to existing forms or contracts, which it will be using as a result of the amendment.

B. If the forms will be part of an application or contract, the requirements of 24-A M.R.S.A. §2412 and any other applicable form filing requirements must be satisfied.

C. Every insurer required to file forms with the Superintendent pursuant to Subsection A of this Section shall send all applicable forms and amended contract provisions to existing individual and group contract holders within 60 days after the first billing date after the form or contract provision has been approved by the Superintendent. Sufficient copies of the form or contract provision to permit distribution to covered insureds shall be provided to group contract holders when the contract holder retains information concerning insureds. At the request of the insurer, the Superintendent may waive the 60-day deadline for notice to existing insureds upon a determination that the revised forms are determined to be substantially similar to the forms previously provided to those insureds.

**Section 9. Severability**

If any section, term, or provision of this Rule shall be deemed invalid for any reason, any remaining section, provision, or definition shall remain in full force and effect.

**Section 10. Effective Date**

This Rule shall be effective January 1, 1991. The 1996 Amendments shall be effective December 1, 1996. The 2012 Amendments shall be effective November 3, 2012, except that any required changes to contract forms shall apply to policies, contracts, and certificates executed, delivered or issued for delivery, continued, or renewed in this State on or after January 1, 2013. The 2014 Amendment shall be effective October 27, 2014.

EFFECTIVE DATE:

 January 1, 1991 – filing 90-565 under the title: ORGANIC BRAIN DISEASE.

EFFECTIVE DATE (ELECTRONIC CONVERSION):

 January 14, 1997

AMENDED:

 December 1, 1996 – filing 96-502

 November 3, 2012 (but see Section 10 above) – filing 2012-301

 October 27, 2014 – filing 2014-262

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18, 2025