Title 760. Department of Insurance
Article 1. General Provisions
Rule 61. Viatical Settlements

760 IAC 1-61-12 Insurance coverage verification forms

Sec. 12. (a) The form for standardized viatical settlement verification of coverage for individual policies is as follows:

VERIFICATION OF COVERAGE FOR INDIVIDUAL POLICIES

Section One:

(To be Completed by the Viatical Settlement Provider, Broker, or Agent)

Insurance Company: .... Name of Policyowner: ....

Policy Number: .... Owner's Social Security Number: ....

Name of Insured: .... Policyowner's Address: ....

Street

Insured's date of birth: ....

....
....

Please provide the information requested in Section Two (below) with regard to the policy identified above and in accordance with the attached authorization.

In addition, please provide the forms checked below which are available from your company to complete a viatical settlement transaction:

[] Absolute Assignment/Change of Ownership/Viatical Assignment Form
[] Change of Beneficiary
[] Release of Irrevocable Beneficiary (if applicable)
[] Waiver of Premium Claim Form
[] Disability Waiver of Premium Approval Letter

....
Date Signature of a representative of Viatical Settlement Provider, Broker, or Agent

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....
....
Full name and address of Viatical Settlement Provider,
Broker, or Agent

Section Two:

(To be Completed by the Life Insurance Company)

1) Face amount of policy: $ ....

2) Original date of issue: .../.../... (Month/Date/Year)

3) Was face amount increased after original issue date? []no []yes

a) If yes, when: .../.../... (Month/Date/Year)

4) Type of Policy: ... (Term/Whole Life/Universal Life/Variable Life)

5) Is policy participating? []no []yes

a) If yes, what is current dividend election? ....

6) Current net death benefit: .... (Enter full amount payable, including any additional insurance and/or dividends accumulated at interest, minus policy loans, outstanding interest on policy loans, and/or accelerated death benefits paid)

7) a) Current cash value: $ .... (Enter full amount, including cash value of any additional insurance and/or dividends accumulated at interest, minus policy loans and outstanding interest on policy loans)

b) Currently surrender value: $ ....

8) Terms of policy loans:

a) Amount of policy loans: $ ....

b) Amount of outstanding interest on policy loan: $ ....

c) Current interest rate: ....

9) Has policy lapsed? [] no [] yes

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a) If yes, when did policy lapse? .../.../...
If policy has lapsed, is coverage continued under nonforfeiture option? []] no [] yes
If yes, indicate which option, amount of coverage, duration, etc.: ....

10) Is policy in force? [] no [] yes

a) If yes, has policy ever been reinstated?
[] no [] yes
If yes, date of reinstatement: .../.../...

11) Amount of contract/scheduled premiums: $ ....

12) Current premium mode: (Monthly, Semiannually, etc.)

d) When is next premium due? .../.../... (Month/Day/Year)

13) Does the policy include a Disability Premium Waiver provision/rider? []] no [] yes

a) If yes, are premiums currently being waived? [] no [] yes

b) If yes, since when? .../.../...

c) How often is continued eligibility reviewed?

d) When is next review? .../.../...

14) Can payment of all or part of the death benefit be accelerated under this policy?
[] no [] yes

a) If yes, by what method is the benefit calculated, the lien method or the discount method?
....

b) If lien method, what is the interest rate? ....

c) Can any remaining death benefit be assigned? [] no [] yes

15) Has a claim for Accelerated Death Benefit been submitted? [] no [] yes

a) If yes, was payment made under this provision? [] no [] yes
Amount paid: .... Date paid: ....

16) Do current records show any assignments of record? [] no [] yes

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17) Do current records show any outstanding liens or encumbrances of record? []] no [] yes

18) Please identify current primary beneficiaries: ....

e) Are they named irrevocably, or is owner otherwise limited in designation of new beneficiaries? [] no [] yes

19) Have any riders been added to this policy after issue? [] no [] yes

If yes, please identify: ....

20) If an ownership or beneficiary change or assignment were to be made on this policy, to whom would the completed forms be sent?

Name: .... Title: .... Signature: .... Name (Printed): ...
Company Name: .... Department: ...... Title: ....
Address (No P.O. Box, please): ...... Company: ....
City: .. ST: .. ZIP: .... Direct Telephone Number: ....
Telephone Number: Fax Number: ..... Direct Fax Number: ....
....
The answers provided reflect
information contained in the company's
records as of: .... (date)

(b) The form for standardized viatical settlement verification of coverage for group policies is as follows:

VERIFICATION OF GROUP LIFE INSURANCE BENEFITS

Section One:

(To be Completed by the Viatical Settlement Provider, Broker, or Agent)

....

Insurance Company Name of Employee/Member

....

Employer/Policyholder Name Insured's Date of Birth

....

Policy Number Insured's Social Security Number

....

Certificate Number Employee/Membership Number

....

....

Please provide the
information

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requested in Section Two or Section Three, as appropriate, with regard to the individual and coverage described, in accordance with the attached authorization.

In addition, please provide the forms checked below which are available from your company to complete a viatical settlement transaction:

[]	Absolute Assignment
[]	Change of Beneficiary (irrevocable if applicable)
[]	Disability Waiver of premium claim or
[]	Disability Waiver of premium award letter
....	....
Date	Signature of a representative of Viatical Settlement Provider, Broker, or Agent
	....
	Full name and address of Viatical Settlement Provider, Broker, or Agent

Section Two:

(To be Completed by the Employer/Group Policyholder)

1) BASIC COVERAGE

a) Is the plan self-insured or is coverage provided under a group policy issued by a life

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insurance company? ....
If by a group policy, please provide the name of the insurance company for BASIC life insurance coverage: ....

b) Effective date of BASIC life insurance coverage: ....

c) Face amount of BASIC life insurance: ....

d) Does BASIC life insurance coverage plan have contestable provisions? []] no [] yes

e) Is BASIC life insurance coverage subject to a suicide provision? [] no []] yes

f) Monthly premium paid by employer/group policyholder for BASIC life insurance coverage: $ ....

g) Monthly premium paid by employee/insured for BASIC life insurance coverage: $ ....

h) Is BASIC life insurance coverage
[] Term [] Universal Life?

I) If Universal Life, please indicate cash value, if any: ...
Is this amount payable in addition to the face amount? [] no [] yes

i) Is coverage in force? [] no [] yes

j) When is next premium due? ....

k) Has employee's coverage under this plan ever been reinstated? [] no []] yes

l) If yes, date of reinstatement: ....

2) SUPPLEMENTAL (OPTIONAL) COVERAGE

a) Insurance Company for SUPPLEMENTAL life insurance coverage: ....

b) Effective date of SUPPLEMENTAL life insurance coverage: ....

c) Face amount of SUPPLEMENTAL life insurance: ....

d) Does SUPPLEMENTAL life insurance coverage plan have contestable provisions? [] no [] yes

e) Is SUPPLEMENTAL life insurance coverage subject to a suicide provision?
[] no [] yes

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f) Monthly premium paid by employer/group policyholder for SUPPLEMENTAL life insurance: $ ....

g) Monthly premium paid by employee/insured for SUPPLEMENTAL life insurance: $ ....

h) Is SUPPLEMENTAL life insurance coverage [] Term [] Universal Life?

I) If Universal Life, please indicate cash value, if any: ...
Is this amount payable in addition to the face amount? [] no [] yes

i) Is coverage in force? [] no [] yes

j) When is next premium due? ....

I) Has employee's coverage under this policy ever been reinstated? []] no [] yes

k) If yes, date of reinstatement: ....

3) DISABILITY WAIVER OF PREMIUM

a) Does plan provide for waiver of premium in the event of employee/insured's disability?

BASIC: [] no [] yes What is the waiting period? ....

SUPPLEMENTAL: [] no [] yes What is the waiting period? ....

b) Are premiums currently being waived under disability premium waiver?

BASIC: [] no [] yes

SUPPLEMENTAL: [] no [] yes

c) Who pays premiums under disability premium waiver?

BASIC: [] Insurance carrier [] Employer

SUPPLEMENTAL: [] Insurance carrier [] Employer

d) What was the date of approval? ....

e) Next review date? ....

f) If the insured is no longer eligible for waiver, what amount of coverage can be converted to an individual policy? $ ....

I) Will a new suicide/contestability clause be in effect for the converted policy? [] no [] yes

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II) Will assignee be notified if insured is no longer eligible for waiver? [] no [] yes

4) BENEFICIARIES, ASSIGNMENTS, AND LIMITATIONS

a) Who are the primary beneficiaries of the coverage(s)?

BASIC: ....

SUPPLEMENTAL: ....

b) Is any beneficiary under this policy designated irrevocably, or is insured otherwise limited in designation of new beneficiaries? [] no []] yes

c) Can this coverage be assigned?

BASIC: [] no [] yes
If yes, to a corporation? [] no [] yes

To someone not related to insured?
[] no [] yes
SUPPLEMENTAL: [] no [] yes
If yes, to a corporation? [] no [] yes
To someone not related to insured?
[] no [] yes

d) Do records show any assignments of record? [] no [] yes

e) Do records show any outstanding liens or encumbrances of record? [] no []] yes

f) Will an Assignee be notified if the master policy is canceled? [] no []] yes

g) Can Assignee convert the coverage without the permission of insured? []] no [] yes

5) ACCELERATED DEATH BENEFITS

a) Is there an Accelerated Death Benefit available under the coverage?

BASIC: [] no [] yes

SUPPLEMENTAL: [] no [] yes

b) Has request for Accelerated Death Benefit been made? [] no [] yes

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c) Has payment been made to insured under this provision? [] no [] yes

I) Amount paid: .... Date paid: ....

II) Is this amount a lien against death proceeds? [] no [] yes
Interest rate ...

III) Can the remaining death benefit be assigned? [] no [] yes

6) MISCELLANEOUS

a) Is coverage portable?

BASIC: [] no [] yes

SUPPLEMENTAL: [] no [] yes

b) If insured is no longer eligible for coverage under the group, will Assignee be notified? [] no [] yes

c) If master policy discontinues, what amount can be converted to an individual policy? ...

d) Is this plan administered by a third party? [] no [] yes
If yes, please provide the name, address, and telephone number of administrator:
Name: .... Title: ....
Company Name: .... Department: ....
Street Address (No P.O. Box, please): ....
City: ...... State: .... Zip: ....
Telephone Number: .... Fax: ....

If a change of beneficiary form or assignment were to be made for this coverage, to whom should the completed forms be sent?
Name: .... Title: ....
Company Name: .... Department: ....
Street Address (No P.O. Box, please): ....
City: ...... State: .... Zip: ....
Telephone Number: .... Fax: ....

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The answers provided reflect information in our files as of .... (date).

Signature: .... Name: ....

Date: .... Title: ....

Company: ....

Direct Telephone Number: ....

Direct Fax Number: ....

Information not provided by the employer may be obtained from the insurance company if different from administrator identified above:

Name: .... Title: ....

Company Name: .... Department: ....

Address (No P.O. Box, please): ....

City: ...... State: .... Zip: ....

Telephone Number: .... Fax: ....

Section Three:

The insurance company or the third party administrator named above is requested to complete the information not provided by the employer in Section Two, above, Items number: .....

The answers provided to the identified questions reflect information in the files of the insurance company as of .... (date).

Signature: .... Name: ....

Date: .... Title: ....

Company: ....

Telephone Number: ....

Fax Number: ....

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