

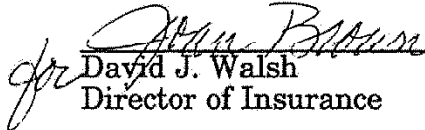
ORDER R94-06 ADOPTING, AMENDING, and REPEALING REGULATIONS OF
THE DIVISION OF INSURANCE

The attached 24 pages of regulations, dealing with medicare supplement insurance and filing requirements of insurer rate and form filing are hereby adopted and certified to be a correct copy of the regulations that the Division of Insurance adopts, amends, and repeals under authority of AS 21.06.090 and after compliance with the Administrative Procedure Act (AS 44.62), specifically including notice under AS 44.62.190 and AS 44.62.200 and opportunity for public comment under AS 44.62.210.

This action is not expected to require an increased appropriation.

This order takes effect on the 30th day after it has been filed by the Lieutenant Governor, as provided in AS 44.62.180.

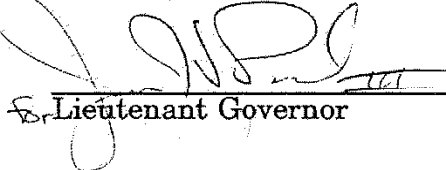
DATE: August 1, 1994
Juneau, Alaska



David J. Walsh
Director of Insurance

FILING CERTIFICATION

James H. Rowd, III for
I, John B. Coghill, Lieutenant Governor for the State of Alaska, certify that on November 4, 1994, at 10:24 a.m., I filed the attached regulations according to the provisions of AS 44.62.040 -- AS 44.62.120.



John B. Coghill
Lieutenant Governor

Effective December 4, 1994

Register 132 January 1995

JB/lvs479.ins
072994a

TITLE 3. COMMERCE AND ECONOMIC DEVELOPMENT.

PART 2. DIVISION OF INSURANCE.

CHAPTER 28. LIFE, DISABILITY, VARIABLE,
AND RELATED INSURANCE.

ARTICLE 2. FILING OF FORMS.

Section

200. (Repealed) [FORM FILING REQUIREMENTS]

211. (Repealed) [FILING ACKNOWLEDGEMENTS AND RETENTION]

3 AAC 28.200 is repealed:

3 AAC 28.200. FORM FILING REQUIREMENTS. Repealed. (Eff. 11/8/73,
Register 48; am 12/14/77, Register 64; am 3/26/82, Register 81; repealed 12/4/94,
Register 132)

3 AAC 28.211 is repealed:

3 AAC 28.211. FILING ACKNOWLEDGMENTS AND RETENTION.
Repealed. (Eff. 12/14/77, Register 64; repealed 12/4/94, Register 132)

ARTICLE 3. FILING OF RATES.

Section

Register 132, January 1995

COMMERCE AND ECON. DEV.

230. (Repealed) [RATE FILINGS BY HOSPITAL OR MEDICAL SERVICE
CORPORATIONS]

3 AAC 28.230 is repealed:

3 AAC 28.230. RATE FILINGS BY HOSPITAL OR MEDICAL SERVICE
CORPORATIONS. Repealed. (Eff. 11/8/73, Register 48; repealed 12/4/94,
Register 132)

ARTICLE 5. DISABILITY INSURANCE MARKETED AS MEDICARE SUPPLEMENTS.

Section

490. Required disclosure provisions

The charts for Plan A - Plan J, Medicare (Part B), at the end of 3 AAC 28.490(m) are
amended to read:

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts *	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	<u>Generally 80%</u>	<u>Generally 20%</u>	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts *	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 <u>Generally 80%</u> \$0	\$0 <u>Generally 20%</u> \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* \$0 Remainder of Medicare Approved Amounts <u>Generally 80%</u> Part B Excess Charges (Above Medicare Approved Amounts) \$0	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$0	\$0 \$0 All Costs
BLOOD First 3 pints \$0 Next \$100 of Medicare Approved Amounts* \$0 Remainder of Medicare Approved Amounts 80%	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	Generally 80% \$0	Generally 20% \$0	\$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts*	\$0 \$0	All Costs 0	\$0 \$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 <u>Generally 80%</u> \$0	\$0 <u>Generally 20%</u> \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible)
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN F

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 80%	\$100 (Part B Deductible) \$0 20%
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN J

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am 7/1/92, Register 122;

am / / , Register)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

CHAPTER 31. MISCELLANEOUS.

Note to Publisher: Please designate existing 3 AAC 31.010 - 3 AAC 31.090 as

ARTICLE 1. FEES.

Section

090. (Repealed) [DEFINITIONS]

3 AAC 31.090 is repealed:

3 AAC 31.090. DEFINITIONS. Repealed. (Eff. 6/2/88, Register 106; am
7/9/92, Register 123; repealed 12/4/94, Register 132)

Editor's notes: After Register 132, January 1995, the substance of 3 AAC 31.090 appears in
3 AAC 31.900.

3 AAC 31 is amended by adding new sections to read:

ARTICLE 2. FILING PROCEDURE FOR FORMS, RATES, MANUALS, RATING
PLANS, AND RULES.

Section

200. Applicability and scope

210. Filing

220. Cover letter

230. Rate filing

240. Loss cost filing

3 AAC 31.200. APPLICABILITY AND SCOPE. 3 AAC 31.200 -

3 AAC 31.240 apply to all persons who are required to file forms, rates, manuals, rating plans, rules, policies, certificates, or other documents under AS 21.39.040; AS 21.42.120; AS 21.57.080; AS 21.66.370, 21.66.450; AS 21.84.270, 21.84.300; AS 21.86.070; AS 21.87.180, or 21.87.190. (Eff. 12/4/94, Register 132)

Authority: AS 21.06.090

AS 21.39.040

AS 21.42.120

AS 21.57.080

AS 21.66.370

AS 21.66.450

AS 21.84.270

AS 21.84.300

AS 21.86.070

AS 21.87.180

AS 21.87.190

3 AAC 31.210. FILING. (a) A filing made under 3 AAC 31.200 -

3 AAC 31.240 must be mailed to the director. Responses to questions from the division regarding a specific filing must be addressed to the division employee requesting the information.

(b) Rates and rules may be filed together in a single filing; forms must be filed separately. To facilitate cross-referencing, if related filings are made at the same time, that fact must be noted on the cover letter of each related filing.

(c) A separate filing must be made for each line of business for which a change is requested. For property and casualty lines of business, the filer may combine the sublines of lines 19 and 21 on page 14 of the insurer's annual statement.

(d) Upon receipt of a filing, the director will assign an identification number to the filing that must be used on all subsequent communications regarding the filing.

(e) A filing must include three copies of the cover letter required under 3 AAC 31.220, one copy of the filing materials and supporting documentation, and two self-addressed, stamped envelopes.

(f) The division will stamp each copy of the cover letter with the date of receipt by the division and with the identification number assigned under (d) of this section. One copy of the cover letter will be returned to the filer as confirmation that the filing was received by the division. The appropriate deemer provision under AS 21.39.040(d), AS 21.42.120(b), AS 21.66.370(c), 21.66.450(a), AS 21.84.300(c), AS 21.86.070(b), or AS 21.87.180(b) may be applied based upon the receipt date stamped on the cover letter by the division.

(g) After reviewing the filing, if the division finds the filing acceptable, the division will mark a copy of the cover letter "approved" and return it to the filer. The filer shall retain the approved copy of the cover letter for three years after the date the filing is replaced by a new filing.

(h) If the division finds the filing unacceptable, the division will notify the filer of that finding. The filer shall retain the disapproval letter for three years after the date of disapproval.

(i) The division will keep a third copy of the cover letter, the filing materials, and supporting documentation on file according to the division's retention schedule.

(j) Affiliated property and casualty insurers submitting at the same time a substantially similar rate or rule filing or an identical form filing are encouraged to submit a

single filing and include on the cover letter the name of each affiliated company included in the filing. If affiliated companies choose to make a separate filing for each company, this fact must be clearly explained in each company's cover letter. Except for form filings, a filing made by a group of affiliated companies does not need to be identical for each company in the group, but any differences must be clearly explained in the cover letter.

(k) A group letterhead may be used for a cover letter of a filing or subsequent correspondence if the company to which the correspondence applies is clearly identified in the subject line.

(l) Responses to questions asked by the division regarding a specific filing must meet the applicable requirements under this section.

(Eff. / / , Register 132)

Authority: AS 21.06.090

AS 21.39.040

AS 21.42.120

AS 21.66.370

AS 21.66.450

AS 21.84.270

AS 21.84.300

AS 21.86.070

AS 21.87.180

AS 21.87.190

Editor's notes: The address for mailing a filing to the director is: Director of Insurance; Rate and Form Filings; Alaska Division of Insurance; P.O. Box 110805; Juneau, Alaska 99811-0805.

3 AAC 31.220. COVER LETTER. (a) A filing made under 3 AAC 31.200 - 3 AAC 31.240 must include a cover letter that is addressed to the director. The cover letter will be considered part of the filing.

(b) The cover letter must include a subject line that specifies

(1) the three-digit National Association of Insurance Commissioners' group number, the five-digit National Association of Insurance Commissioners' company number, and the name of the company making the filing, if the filing is not made by a rating organization;

(2) if the filing is made by a rating organization, the name of the rating organization;

(3) whether the filing is a rate, rule, or form filing;

(4) the line of business to which the filing applies;

(5) the specific product to which the filing applies, if any;

(6) the company's name for the product, if any;

(7) if the filing is a form filing, the form number, edition date, and name of the form; and

(8) the filer's code number for the filing, if any.

(c) The cover letter must contain

(1) a requested effective date for the filing that is set far enough in advance to allow sufficient time for receipt of the filing by the division and for the full review period as provided in the statute under which the filing is made; if the requested effective date is before the date the filing is approved or is deemed approved by statute, the date of approval or deemer will become the effective date of the filing;

(2) a statement of whether or not the filing is a replacement of a previous filing and, if so, the prior filing must be explicitly identified with the division's identification number, if available; if the replacement filing is a form or rule filing, a marked copy of the form or rule with new material underlined and deleted material shown with a line stricken through it, or a similar method of identifying changes that has been approved by the director, must be attached;

(3) the name of the person to contact regarding the filing;

(4) a brief description of the purpose of the filing and any changes that the filing will introduce;

(5) if the filing is a rate filing, the overall effect of the rate level change requested in the filing;

(6) if the filing is a form filing and if the state of domicile requires a filing, a statement of whether a filing has been made in the insurer's state of domicile and whether the filing has been approved; and

(7) if the filing is for a medicare supplement policy or medicare supplement subscriber contract, a statement and certification

(A) of compliance with 3 AAC 28.410 - 3 AAC 28.510;
(B) of the expected loss ratio for the entire period for which rates are computed and the expected loss ratio for each year of the period for which rates have been computed. (Eff. 12/4/94, Register 132)

Authority: AS 21.06.090

AS 21.39.040

AS 21.42.120

AS 21.57.080

AS 21.66.370

AS 21.66.450

AS 21.84.270

AS 21.84.300

AS 21.86.070

AS 21.87.180

AS 21.87.190

3 AAC 31.230. RATE FILING. In addition to the requirements under 3 AAC 31.200 - 3 AAC 31.220, a rate filing must include

(1) premium and loss experience, both nationwide and specifically for Alaska, shown separately by each year in the experience period used or with a full explanation if that information is not available; in the case of a filing for more than one company, the premium

and loss experience of the different companies may be combined if an explanation is provided.

(2) expense information, both nationwide and specifically for Alaska, if available,

(A) for property and casualty insurers, the expense information must be broken out in detail at least as specific as the expense groups shown on Part II of the insurance expense exhibit of the annual statement required by AS 21.09.200; if loss adjustment expenses are included in the loss experience, that fact must be clearly explained; or

(B) for life and health insurers and hospital medical service corporations, the expense information must include first year and renewal commission percentages and any other expenses included in the pricing methodology;

(3) an explanation of how investment income was considered in the proposed rate;

(4) an explanation of the actuarial methodology used in developing an indicated rate change, including a description of any trending or credibility procedures used, as well as the role of judgment in the formulation of a final rate proposal;

(5) support for any deviation included in a filing, whether the deviation is between companies or from a rating organization filing;

(6) any other information that the company considers relevant, including reference to rating organization experience or published industry statistics, if appropriate; and

(7) any other information requested by the division in support of the filing.

(Eff. 12/4/94, Register 132)

Register 132, January 1995

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Authority: AS 21.06.090
AS 21.09.200
AS 21.39.040
AS 21.39.060
AS 21.39.070
AS 21.39.130
AS 21.57.080
AS 21.66.370
AS 21.86.070
AS 21.87.190

3 AAC 31.240. LOSS COST FILING. In addition to the requirements under 3 AAC 31.200 - 3 AAC 31.230, a filing by a participating insurer of a rating organization that aims to modify the rating organization's filed and approved loss costs for a line of business by applying a loss cost multiplier must include copies of the reference filing adoption forms provided by the division. An explanation must be included regarding any deviation contained in the filing. (Eff. 12/4/94 , Register 132)

Authority: AS 21.06.090
AS 21.39.040
AS 21.39.060
AS 21.39.070
AS 21.39.130

ARTICLE 3. GENERAL PROVISIONS.

Section

900. Definitions

3 AAC 31.900. DEFINITIONS. In this chapter,

- (1) "all lines" means both life lines and property and casualty lines;
- (2) "director" means the director of the division of insurance;
- (3) "division" means the division of insurance, Department of Commerce and

Economic Development;

- (4) "life lines" means life, disability, annuities, credit life and disability, and, if qualified, variable life and variable annuities;

- (5) "line of business" means, for property and casualty insurers, the lines of business used to report experience on page 14 of the annual statement required by AS 21.09.200; for life and health insurers or hospital medical service corporations, a description of whether the policy is individual or group and whether it is categorized as life insurance, disability insurance, an annuity, or long term care insurance; and for title insurers, title insurance itself;

- (6) "property and casualty lines" means property, casualty, surety, marine, mortgage guaranty, and, if qualified, disability insurance as defined in AS 21.12.050.

(Eff. 12/4/94, Register 132)

Register 132, January 1995

COMMERCE AND ECON. DEV.

Authority: AS 21.06.090

AS 21.09.200

Editor's notes: -- Before Register 132 (January, 1995) the substance of 3 AAC 31.900 appeared in 3 AAC 31.090.