2. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at 5 percent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph "1."

3. Divide the result of subparagraph "2" (subparagraph "1" for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph "2" (subparagraph "1" for guaranteed-cost policies) over the respective periods stipulated in subparagraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

4. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5 percent interest compounded annually to the end of the period stipulated in subparagraph "1" and dividing the result by the respective factors stated in subparagraph "3" (this amount is the annual premium payable for a level premium plan).

5. Subtract the result of subparagraph "3" from subparagraph "4."

6. Divide the result of subparagraph "5" by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

"Policy summary," for the purposes of these rules, shall mean a written statement describing the elements of the policy including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION.

2. The name and address of the insurance producer or, if no producer is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

4. The generic name of the basic policy and each rider.

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier:

(a) The annual premium for the basic policy.

(b) The annual premium for each optional rider.

(c) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide and other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

(d) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(e) Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(f) Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate.

7. Life insurance cost indexes for 10 and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor for basic policies or optional riders covering more than one life.

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed.

9. A policy summary which includes dividends shall also include a statement that dividends are based on the company's illustrated scale and are not guaranteed and a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide.

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide.

11. The date on which the policy summary is prepared.

The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph "5" of this definition shall be listed in total, not a per-thousand nor a per-unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

Appendix II

ACKNOWLEDGMENT OF NONDUPLICATION

PLEASE READ CAREFULLY BEFORE SIGNING

I, _____, certify that I have done the following:

(Producer's Name)

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether any duplicate coverage will occur with the issuance of this policy.

2. Reviewed the policies listed below and have found that duplication WILL/WILL NOT occur with the issuance of the following policy.

COMPANY	POLICY NUMBER	TYPE OF POLICY

_____Duplication will not occur because the above-listed policy(ies) will be replaced by the applied-for policy.

_____No health policies in force at this time.

_____Applicant has elected not to have the policy(ies) reviewed.

_____ _____

DATE PRODUCER

I certify that I have been informed of my right to have all of my existing health policies reviewed and:

_____I have been informed that the policy for which I am applying WILL/WILL NOT result in duplicate coverage.

_____I have elected not to have my policies reviewed.

_____ _____

DATE APPLICANT

This rule is intended to implement Iowa Code section 507B.12.

APPENDIX III
HIV Antibody Test
Information Form For Insurance Applicant

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and persons who have had sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next ten years.

The HIV antibody test:

Before consenting to testing, please read the following important information:

1. Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. Positive test results. If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

3. Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:

a. False positives: This test gives a positive result, even though you are not infected. This happens rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

4. Side effects. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results become known to others. A negative result may create a false sense of security.

5. Disclosure of results. A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician or through the alternative testing site.

6. Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

7. Prevention. Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. Information. Further information about HIV testing and AIDS can be obtained by calling the national AIDS hotline at 1-800-342-2437.

INFORMED CONSENT

I hereby authorize the company and its designated medical facilities to draw samples of my blood or other bodily fluid for the purpose of laboratory testing to provide applicable medical information concerning my insurability. These tests may include but are not limited to tests for: cholesterol and related blood lipids; diabetes; liver or kidney disorders; infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law); immune disorders; or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by a medically accepted procedure which is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA blood or other bodily fluid test will be done.

a. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

b. If the initial ELISA blood or other bodily fluid test is negative, a negative finding will be reported to the company.

2. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

a. If the second ELISA blood or other bodily fluid test is also positive, a Western Blot blood or other bodily fluid test will be performed to confirm the positive results of the two ELISA blood or other bodily fluid tests.

b. If the second ELISA blood or other bodily fluid test is negative, a third ELISA blood or other bodily fluid test will be performed. If the third ELISA blood or other bodily fluid test is positive, a Western Blot blood or other bodily fluid test will be performed to confirm the previous positive results. If the third blood or other bodily fluid test is negative, a negative result will be reported to the company.

3. Only if at least two ELISA blood or other bodily fluid tests and a Western Blot blood or other bodily fluid test are all positive will the result be reported as a positive. All other results will be reported as negative to the company.

Without a court order or written authorization from me, these results will be made known only to the company and its reinsurers (if involved in the underwriting process). The company will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Screen will be disclosed only as I direct below. In addition, the company may make a brief report to MIB, Inc., in a manner described in the Pre-notice which I received as a part of the application process. All the company will report to MIB, Inc. is that positive results were obtained from a blood or other bodily fluid test. The company will not report what tests were performed or that the positive result was for HIV antibodies.

These organizations will be the only ones maintaining this information in any type of file except as required by law. Positive HIV Antibody Screen results are to be reported to: (elect one) ☐ the Alternative Testing Site or ☐ my physician; _____

(name and address of attending physician)

This authorization will be valid for 90 days from the date below.

Dated At: _____ Day _____ Month _____, 19____

Witness _____ Proposed Insured: _____

Producer (Signature) (Signature)

This rule is intended to implement Iowa Code section 505.16.

Appendix IV
COMPLAINT RECORD

Column A	Column B		Column C	Column D	Column E	Column F	Column G	Column H
Company Identification Number	Function Code	Reason Code	Line Type	Company Disposition after Complaint Received	Date Received	Date Closed	Insurance Division Complaint	State of Origin
(Producer's Number)								

Explanation

A. Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number, name, or other means of identifying any licensee of the Insurance Division, such as a producer that may have been involved in the complaint.

B. Function Code. Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.

Reason Code. Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

1) Underwriting
   a) Premium and rating
   b) Refusal to insure
   c) Cancellation/renewal
   d) Delays
   e) Unfair discrimination
   f) Endorsement/rider
   g) Group conversion
   h) Medicare supplement violation
   i) Miscellaneous (not covered by above)

2) Marketing and Sales
   a) General advertising
   b) Misrepresentation
   c) Producer handling
   d) Replacement
   e) Delays
   f) Miscellaneous (not covered by above)

3) Claims
   a) Post claim underwriting
   b) Delays
   c) Unsatisfactory settlement/offer
   d) Coordination of benefits
   e) Cost containment
   f) Denial of claim
   g) Miscellaneous (not covered by above)

(4) Policyholder service
   a) Premium notice/billing
   b) Cash value

c) Delays/no response
d) Premium refund
e) Coverage question
f) Miscellaneous (not covered by above)

5) Miscellaneous

C. Line Type. Complaints are to be classified according to the line of insurance involved as follows:

1) Automobile
2) Fire
3) Homeowners-Farmowners
4) Crop
5) Life and Annuity
6) Accident and Health
7) Miscellaneous (not covered by above)

D. Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.

The following examples illustrate the type of information called for, but are not intended to be required language nor to exhaust the possibilities:

1. Policy issued/restored.
2. Refund.
3. Claim settled.
4. Delay resolved.
5. Question of fact.
6. Contract provision/legal issue.
7. No jurisdiction.

E. Date Received. This refers to the date the complaint was received.

F. Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

G. Insurance Department Complaint. Complaints are to be classified so as to indicate if the complaint was from an insurance department.

H. State of Origin. The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

[Filed 8/1/63, amended 11/21/63, 11/16/65, 1/13/71, 10/11/72, 7/3/75]
[Filed 12/1/75, Notice 10/6/75—published 12/15/75, effective 1/20/76]
[Filed 2/17/76, Notice 12/15/75—published 3/8/76, effective 4/13/76]
[Filed 4/26/76, Notice 3/22/76—published 5/3/76, effective 6/9/76]
[Filed 9/14/76, Notice 6/14/76—published 10/6/76, effective 7/1/77]
[Filed 1/7/77, Notice 10/20/76—published 1/26/77, effective 3/2/77]
[Filed emergency 12/12/77—published 12/28/77, effective 1/1/78]
[Filed 12/21/78, Notice 10/4/78—published 1/10/79, effective 2/15/79*]
[Filed 2/1/80, Notice 12/12/79—published 2/20/80, effective 3/26/80]
[Filed 11/5/81, Notice 9/2/81—published 11/25/81, effective 12/31/81**]
[Filed emergency 2/26/82—published 3/17/82, effective 3/11/82]
[Filed 5/7/82, Notice 3/17/82—published 5/26/82, effective 7/1/82]
[Filed 4/3/85, Notice 2/27/85—published 4/24/85, effective 5/29/85]
[Filed emergency 8/7/86—published 8/27/86, effective 8/15/86]
[Editorially transferred from [510] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]

*The Administrative Rules Review Committee at their February 13, 1979, meeting delayed the effective date of rules 15.90 to 15.93 seventy days.
**Effective date (12/31/81) of rules 15.9 and 15.31 delayed 70 days by the Administrative Rules Review Committee.
History for Chapter 15 continued on next page.

[Filed 1/23/87, Notice 11/5/86—published 2/11/87, effective 3/18/87]
[Filed 10/2/87, Notice 8/26/87—published 10/21/87, effective 11/25/87]
[Filed emergency 6/24/88—published 7/13/88, effective 7/1/88]
[Filed 7/8/88, Notice 3/9/88—published 7/27/88, effective 9/1/88]
[Filed 7/8/88, Notice 5/18/88—published 7/27/88, effective 11/1/88]◊◊
[Filed 12/9/88, Notice 9/21/88—published 12/28/88, effective 2/1/89]
[Filed 8/16/90, Notice 5/16/90—published 9/5/90, effective 10/10/90]
[Filed 11/6/92, Notice 8/5/92—published 11/25/92, effective 2/1/93]
[Filed 4/23/93, Notice 3/3/93—published 5/12/93, effective 6/16/93]
[Filed 12/26/96, Notice 11/6/96—published 1/15/97, effective 2/19/97]
[Filed 3/5/99, Notice 11/4/98—published 3/24/99, effective 4/28/99]
[Filed 11/24/99, Notice 6/16/99—published 12/15/99, effective 7/1/00]

◊◊ Two ARCs