

death benefit will be paid when the first of the two insureds dies.

(i) Section 1.7702-2(d) provides that if a life insurance contract insures the lives of more than one individual on a first-to-die basis, the attained age of the insured is determined by applying §1.7702-2(b) as if the oldest individual were the only insured under the contract. Because X is older than Z, the attained age of X must be used for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

(f) *Effective dates*—(1) *In general.* Except as provided in paragraph (f)(2) of this section, these regulations apply to all life insurance contracts that are either—

(i) Issued after December 31, 2008; or
(ii) Issued on or after October 1, 2007 and based upon the 2001 CSO tables.

(2) *Contracts issued before the general effective date.* Pursuant to section 7805(b)(7), a taxpayer may apply these regulations retroactively for contracts issued before October 1, 2007, provided that the taxpayer does not later determine qualification of those contracts in a manner that is inconsistent with these regulations.

[T.D. 9287, 71 FR 53970, Sept. 13, 2006]

§ 1.7702B-1 Consumer protection provisions.

(a) *In general.* Under sections 7702B(b)(1)(F), 7702B(g), and 4980C, qualified long-term care insurance contracts and issuers of those contracts are required to satisfy certain provisions of the Long-Term Care Insurance Model Act (Model Act) and Long-Term Care Insurance Model Regulation (Model Regulation) promulgated by the National Association of Insurance Commissioners (NAIC), as adopted as of January 1993. The requirements for qualified long-term care insurance contracts under section 7702B(b)(1)(F) and (g) relate to guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, disclosure, prohibitions against post-claims underwriting, minimum standards, inflation protection, prohibitions against pre-existing conditions exclusions and probationary periods, and prior hospitalization. The requirements for qualified long-term care insurance

contracts under section 4980C relate to application forms and replacement coverage, reporting requirements, filing requirements for marketing, standards for marketing, appropriateness of recommended purchase, standard format outline of coverage, delivery of a shopper's guide, right to return, outline of coverage, certificates under group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period.

(b) *Coordination with State requirements*—(1) *Contracts issued in a State that imposes more stringent requirements.* If a State imposes a requirement that is more stringent than the analogous requirement imposed by section 7702B(g) or 4980C, then, under section 4980C(f), compliance with the more stringent requirement of State law is considered compliance with the parallel requirement of section 7702B(g) or 4980C. The principles of paragraph (b)(3) of this section apply to any case in which a State imposes a requirement that is more stringent than the analogous requirement imposed by section 7702B(g) or 4980C (as described in this paragraph (b)(1)), but in which there has been a failure to comply with that State requirement.

(2) *Contracts issued in a State that has adopted the model provisions.* If a State imposes a requirement that is the same as the parallel requirement imposed by section 7702B(g) or 4980C, compliance with that requirement of State law is considered compliance with the parallel requirement of section 7702B(g) or 4980C, and failure to comply with that requirement of State law is considered failure to comply with the parallel requirement of section 7702B(g) or 4980C.

(3) *Contracts issued in a State that has not adopted the model provisions or more stringent requirements.* If a State has not adopted the Model Act, the Model Regulation, or a requirement that is the same as or more stringent than the analogous requirement imposed by section 7702B(g) or 4980C, then the language, caption, format, and content requirements imposed by sections 7702B(g) and 4980C with respect to contracts, applications, outlines of coverage, policy summaries, and notices will be considered satisfied for a contract subject to the law of that State if

the language, caption, format, and content are substantially similar to those required under the parallel provision of the Model Act or Model Regulation. Only nonsubstantive deviations are permitted in order for language, caption, format, and content to be considered substantially similar to the requirements of the Model Act or Model Regulation.

(c) *Effective date.* This section applies with respect to contracts issued after December 10, 1999.

[T.D. 8792, 63 FR 68186, Dec. 10, 1998]

§ 1.7702B-2 Special rules for pre-1997 long-term care insurance contracts.

(a) *Scope.* The definitions and special provisions of this section apply solely for purposes of determining whether an insurance contract (other than a qualified long-term care insurance contract described in section 7702B(b) and any regulations issued thereunder) is treated as a qualified long-term care insurance contract for purposes of the Internal Revenue Code under section 321(f)(2) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(b) *Pre-1997 long-term care insurance contracts—(1) In general.* A pre-1997 long-term care insurance contract is treated as a qualified long-term care insurance contract, regardless of whether the contract satisfies section 7702B(b) and any regulations issued thereunder.

(2) *Pre-1997 long-term care insurance contract defined.* A pre-1997 long-term care insurance contract is any insurance contract with an issue date before January 1, 1997, that met the long-term care insurance requirements of the State in which the contract was situated on the issue date. For this purpose, the long-term care insurance requirements of the State are the State laws (including statutory and administrative law) that are intended to regulate insurance coverage that constitutes “long-term care insurance” (as defined in section 4 of the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act, as in effect on August 21, 1996), regardless of the terminology used by the State in describing the insurance coverage.

(3) *Issue date of a contract—(i) In general.* Except as otherwise provided in this paragraph (b)(3), the issue date of a contract is the issue date assigned to the contract by the insurance company. In no event is the issue date earlier than the date the policyholder submitted a signed application for coverage to the insurance company. If the period between the date the signed application is submitted to the insurance company and the date coverage under which the contract actually becomes effective is substantially longer than under the insurance company’s usual business practice, then the issue date is the later of the date coverage under which the contract becomes effective or the issue date assigned to the contract by the insurance company. A policyholder’s right to return a contract within a free-look period following delivery for a full refund of any premiums paid is not taken into account in determining the contract’s issue date.

(ii) *Special rule for group contracts.* The issue date of a group contract (including any certificate issued thereunder) is the date on which coverage under the group contract becomes effective.

(iii) *Exchange of contract or certain changes in a contract treated as a new issuance.* For purposes of this paragraph (b)(3)—

(A) A contract issued in exchange for an existing contract after December 31, 1996, is considered a contract issued after that date;

(B) Any change described in paragraph (b)(4) of this section is treated as the issuance of a new contract with an issue date no earlier than the date the change goes into effect; and

(C) If a change described in paragraph (b)(4) of this section occurs with regard to one or more, but fewer than all, of the certificates evidencing coverage under a group contract, then the insurance coverage under the changed certificates is treated as coverage under a newly issued group contract (and the insurance coverage provided by any unchanged certificate continues to be treated as coverage under the original group contract).