26-19-101. Scope and applicability of article; short title.

(a) This article applies only to group disability and blanket disability insurance contracts.

(b) This article may be cited as the "Group and Blanket Disability Insurance Law".

(c) This article does not apply to any contract made or issued prior to January 1, 1968, nor to any extensions, renewals, reinstatements or modifications of or amendments to any contract whenever made.

26-19-102. "Group disability insurance" defined; eligible groups.

(a) "Group disability insurance" means that form of disability insurance covering groups of persons as described in this section and W.S. 26-19-110, with or without one (1) or more members of their families or one (1) or more of their dependents, or covering one (1) or more members of the families or one (1) or more dependents of the groups of persons. Except as provided in W.S. 26-19-110, a group disability insurance policy shall not be issued for delivery in this state unless the policy is issued to:

(i) An employer or trustees of a fund established or adopted by an employer, which employer or trustee is deemed the policyholder, insuring the employer's employees for the benefit of persons other than the employer, subject to the following requirements:

(A) All employees or any class of employees are eligible for insurance under the terms of the policy;

(B) The policy may define "employees" to include:

(I) The officers, managers and employees of the employer;

(II) The individual proprietor or partner if the employer is an individual proprietor or partnership;

(III) The officers, managers and employees of subsidiary or affiliated corporations;

(IV) The individual proprietors, partners and employees of individuals and firms, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise;

(V) Retired employees;

(VI) Former employees;

(VII) Directors of a corporate employer;

(VIII) Elected or appointed officials;

(IX) The trustees, their employees, or both, if their duties are principally connected with the trusteeship.

(C) If the insured employee does not pay any part of the premium for his insurance, the policy shall insure all eligible employees, except those who reject the coverage in writing.

(ii) An association, or a trust or the trustee of a fund established or adopted for the benefit of members of one (1) or more associations. This definition does not include "employer association group(s)" including multiple employer welfare arrangements (MEWAs) as defined at .The association shall have at the time the policy is first issued a minimum of fifty (50) ~~persons~~ individuals eligible for insurance, shall have a constitution and bylaws which provide that the association holds regular meetings not less than annually to further the members' purposes, that the association, except for credit unions, collects dues or solicits contributions from members, and that the members have voting privileges and representation on the governing board and committees. Prior to marketing or offering any group disability insurance to an association formed for the sole purpose of obtaining insurance, the producer shall file a written report with the department setting forth the name of the association, the insurer and its address and the offering producer and his address. Failure to file such report with the department may result in administrative action. The department shall keep the name of the association confidential. The provisions of the Small Employer Health Insurance Availability Act, W.S. 26-19-301 et seq., shall apply

~~to~~ to all insurance issued to an association under this subsection. The policy is subject to the following requirements:

(A) The policy may insure one (1) or more of the following or all of any class of the following for the benefit of persons other than the employee's employer:

(I) Members of the association;

(II) Employees of the association; or

(III) Employees of members.

~~(B)~~ If the covered person does not pay any part of the premium for his insurance, the policy shall insure all

eligible persons, except those who reject the coverage in writing.

(iii)Multiple Employer Welfare Arrangement (MEWA) means an employee welfare benefit plan, or any other arrangement which is established or maintained for the purpose of offering or providing any medical, surgical or hospital care or benefits in the event of sickness, accident, disability, or death to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries. MEWA includes employer group association health plans (AHP) as defined at . The provisions of the Small Employer Health Insurance Availability Act, W.S. 26-19-301 et seq., shall apply.

(iv)A trust or the trustees of a fund established or adopted by two (2) or more employers, by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations, which trust or trustees are deemed the policyholder, to insure employees of the employers or members of the union or organization for the benefit of persons other than the employers, unions or organizations, subject to the following requirements:

(A) All employees of the employers, members of the unions or organizations or any class of the employers, union members or organization members are eligible for insurance under the terms of the policy;

(B) The policy may provide that the term "employees" shall include:

(I) The employees of one (1) or more subsidiary corporations and the employees, individual proprietors and partners of one (1) or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

(II) Retired or former employees;

(III) Directors of a corporate employer;

(IV) The trustees, trustees' employees, or both, if their duties are principally connected with the trusteeship.

(C) If the insured person does not pay any part of the premium for his insurance, the policy shall insure all eligible persons, except those who reject such coverage in writing.

(iv) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under the group life policy;

(v) Repealed by Laws 1990, ch. 5, § 3.

(vi) A creditor, a creditor's parent holding company or a trustee or agent designated by two (2) or more creditors, which creditor, holding company, affiliate, trustee or agent is deemed the policyholder, to insure debtors of the creditor concerning their indebtedness, subject to the following requirements:

(A) All debtors or any class of debtors of the creditor are eligible for insurance under the terms of the policy;

(B) The policy may provide that the term "debtors" shall include:

(I) Borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction;

(II) The debtors of one (1) or more subsidiary corporations; and

(III) The debtors of one (1) or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships or partnerships is under common control.

(C) If the insured debtor does not pay any part of the premium for his insurance, the policy shall insure all eligible debtors;

(D) The total amount of insurance payable for an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor is disabled as defined in the policy;

(E) The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment and any excess of the insurance is payable to the insured or the estate of the insured;

(F) Notwithstanding subparagraphs (A) through (D) of this paragraph, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(vii) A credit union or a trustee or agent designated by two (2) or more credit unions, which credit union, trustee or agent is deemed the policyholder, to insure members of the credit union for the benefit of persons other than the credit union, trustee, agent or any of their officials, subject to the following requirements:

(A) All members or all of any class of members of the credit union are eligible for insurance under the terms of the policy;

(B) Policy premiums shall be paid by the policyholder from the credit union's funds and shall insure all eligible members.

(viii) A labor union or similar employee organization which union or organization is deemed the policyholder, to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

(A) All members or any class of members of the union or organization are eligible for insurance under the terms of the policy;

(B) If the insured member does not pay any part of the premium for his insurance, the policy shall insure all eligible members, except those who reject such coverage in writing.

26-19-103. Repealed by Laws 1990, ch. 5, § 3.

26-19-104. Repealed by Laws 1990, ch. 5, § 3.

26-19-105. Readjustment of premiums; dividends.

Any group disability insurance contract may provide for the readjustment of the rate of premium based upon the experience under the contract. If a policy dividend is declared or a reduction in rate is made or continued for the first or any subsequent year of insurance under any group disability insurance policy issued to any policyholder, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under those policies made from funds contributed by the policyholder, or by an employer of insured persons, or by a union or association to which the insured persons belong, including expenditures made in connection with administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members.

26-19-106. Blanket disability insurance; defined.

(a) Blanket disability insurance is that form of disability insurance covering groups of persons under a policy or contract issued to:

(i) Any common carrier or to any operator, owner or lessee of a means of transportation, who is deemed the policyholder, covering a group of persons who may become passengers as defined by reference to their travel status on the common carrier or the means of transportation;

(ii) An employer, who is deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder;

(iii) A college, school or other institution of learning, a school district or school jurisdictional unit, or to the head, principal or governing board of any educational unit,

who is deemed the policyholder, covering students, teachers or employees;

(iv) Any religious, charitable, recreational, educational or civic organization, or branch thereof, which is deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or operations sponsored or supervised by the policyholder;

(v) A sports team, camp or sponsor thereof, which is deemed the policyholder, covering members, campers, employees, officials or supervisors;

(vi) Any volunteer fire department, first aid, civil defense or other similar volunteer organization, which is deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or operations sponsored or supervised by the policyholder;

(vii) A newspaper or other publisher, which is deemed the policyholder, covering its carriers;

(viii) An association, including a labor union, which has a constitution and bylaws and which is deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or operations sponsored or supervised by the policyholder. Prior to marketing or offering any blanket disability insurance to an association, including a labor union, formed for the sole purpose of obtaining insurance, the producer shall file a written report with the department setting forth the name of the association, the insurer and its address and the offering producer and his address. The department shall keep the name of the association confidential. The provisions of the Small Employer Health Insurance Availability Act, W.S. 26-19-301 et seq., shall apply to all insurance issued to an association under this section;

(ix) Cover any other risk or class of risks which, in the commissioner's discretion, may be properly eligible for blanket disability insurance. The commissioner's discretion may be exercised on an individual risk basis or class of risks, or both.

26-19-107. Group disability and blanket insurance standard provisions; exceptions.

(a) A policy of group disability or blanket disability insurance shall not be delivered in this state unless it contains in substance the following provisions or provisions which in the commissioner's opinion are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(i) The policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured constitutes the entire contract between the parties;

(ii) Written notice of a claim shall be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within the time provided by this paragraph shall not invalidate nor reduce any claim if it is shown it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible;

(iii) The insurer shall furnish either to the person making a claim or to the policyholder for delivery to the person making a claim the forms it usually furnishes for filing proof of loss. If the forms are not furnished before the expiration of fifteen (15) days after giving of the notice specified in paragraph (ii) of this subsection, the person making the claim is deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made;

(iv) In the case of claim for loss of time for disability, written proof of the loss shall be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable. Subsequent written proofs of the continuance of the disability shall be furnished to the insurer at any intervals the insurer reasonably requires. In the case of claim for any other loss, written proof of the loss shall be furnished to the insurer within ninety (90) days after the date of the loss. Failure to furnish proof within the time provided by this paragraph shall not invalidate nor reduce any claim if it is shown it was not reasonably possible to furnish proof and that proof was furnished as soon as was reasonably possible;

(v) Any benefits payable under the policy are payable as follows:

(A) Benefits other than benefits for loss of time are payable not more than forty-five (45) days after receipt of written proof of the loss and supporting evidence;

(B) Subject to proof of loss and supporting evidence, all accrued benefits payable under a policy for loss of time are payable not less frequently than monthly during the continuance of the disability period for which the insurer is liable, and any balance remaining unpaid at the termination of

the disability period is payable immediately upon receipt of proof and supporting evidence.

(vi) The insurer, at its own expense, may:

(A) Examine the person of the insured when and as often as it reasonably requires during the pendency of claim under the policy; and

(B) Make an autopsy if it is not prohibited by law.

(vii) No action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss is furnished in accordance with the requirements of the policy and no action shall be brought upon the expiration of three (3) years after the time written proof of loss is required to be furnished;

(viii) The policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, and during the grace period the policy shall continue in force unless the policyholder gave the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period provided by this paragraph;

(ix) The validity of the policy shall not be contested except for nonpayment of premiums after it has been in force for two (2) years from the date of issue, and no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement;

(x) A copy of the application, if any, of the policyholder shall be attached to the policy when issued. All statements made by the policyholder or by the persons insured are deemed representations and not warranties. No statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative;

(xi) The additional exclusions or limitations, if any, applicable under the policy concerning a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the

effective date of the person's coverage under the policy shall be specified. The exclusion or limitation shall not exclude coverage for a period beyond twelve (12) months following the individual's effective date of coverage and shall only relate to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. In determining whether a preexisting condition provision applies to an insured or dependent, all private or public health benefit plans shall credit the time the person was previously covered by a private or public health benefit plan if the previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage exclusive of any applicable waiting period. In the case of a preexisting conditions limitation allowable in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan during the period of time this limitation applies under the new plan shall be the lesser of:

(A) The benefits of the new plan determined without application of the preexisting conditions limitation; or

(B) The benefits of the prior plan.

(xii) If the premiums or benefits vary by age, a provision shall specify an equitable adjustment of premiums, benefits, or both, to be made if the age of a covered person has been misstated and containing a clear statement of the method of adjustment to be used;

(xiii) The insurer shall issue to the policyholder for delivery to each person insured a certificate containing a statement of the insurance protection to which that person is entitled, to whom the insurance benefits are payable and of any family member's or dependent's coverage;

(xiv) Benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured or if the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms. Payment of benefits for loss of life of the person insured is subject to the provisions of the policy in the event no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five thousand dollars ($5,000.00), to any relative by blood, marriage or adoption of the person deemed by the insurer to be equitably entitled to the benefits;

(xv) For a policy insuring debtors, the insurer shall furnish the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness;

(xvi) Repealed By Laws 1997, ch. 120, § 2.

(xvii) If issued or delivered on or after January 1, 1999, the policy shall provide a notice on the face of the policy of not less than fourteen (14) point bold type, as to the extent to which the policy includes comprehensive adult wellness benefits as defined in subsection (h) of this section. To insure that the disclosure has been made, the notice shall include space for the signature of the policyholder and the sales representative on the disclosure statement. The disclosure statement must be signed by the applicant and sales representative at the time of the policy application. No policy shall be represented as containing comprehensive adult wellness benefits unless the policy meets the criteria specified under subsection (h) of this section. If coverage is included, the notice shall make reference to the exact location within the policy where the level and extent of coverage is described in detail. If coverage is not included, the notice shall state that the policy does not contain comprehensive adult wellness benefits as defined by law. This statement shall also be placed in a prominent location on any materials used in representing the policy, including sales materials. The department of insurance shall prescribe the form and content of the notice required under this paragraph. This paragraph does not apply to any policy with a deductible of five thousand dollars ($5,000.00) or more.

(b) W.S. 26-19-107(a)(xi), (xiii) and (xiv) shall not apply to policies insuring debtors.

(c) The standard provisions for individual disability insurance policies shall not apply to group disability insurance policies.

(d) If any provision of this section is entirely or partially inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer with the approval of the commissioner shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of the provision to conform the policy provision with the coverage provided by the policy.

(e) Repealed By Laws 1997, ch. 120, § 2.

(f) No policy of group or blanket disability insurance shall treat the following as a preexisting condition:

coverage;

(i) Pregnancy existing on the effective date of

(ii) Genetic information, in the absence of a

diagnosis of a condition related to the genetic information.

(g) A policy of group or blanket disability insurance shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the policy based on any of the following health status related factors in relation to the employee or an eligible dependent:

(i) Health status;

(ii) Medical condition, including both physical and mental illness;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability, including conditions arising out of acts of domestic violence;

(viii) Disability.

(h) As used in paragraph (a)(xvii) of this section, "comprehensive adult wellness benefits" means benefits not subject to policy deductibles, which provide a minimum benefit equal to eighty percent (80%) of the reimbursement allowance under the private health benefit plan with a maximum of twenty percent (20%) coinsurance by the insured and which provide a benefit structure to the insured equal to a minimum of one hundred fifty dollars ($150.00) per insured adult per calendar year, or a benefit structure of similar actuarial value to the insured. In addition, the benefits shall at minimum provide for testing procedures and for the examination of adult policyholders and their spouses for breast cancer, prostate cancer, cervical cancer and diabetes.

(j) All group and blanket disability insurance policies providing coverage on an expense incurred basis, group service or indemnity type contracts issued by a nonprofit corporation, group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after July 1, 2001, and providing coverage to any resident of this state shall provide benefits or coverage for:

(i) A pelvic examination and pap smear for any nonsymptomatic women covered under the policy or contract;

(ii) A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person covered under the policy or contract;

(iii) A prostate examination and laboratory tests for cancer for any nonsymptomatic man covered under the policy or contract; and

(iv) A breast cancer examination including a screening mammogram and clinical breast examination for any nonsymptomatic person covered under the policy or contract.

(k) To encourage public health and diagnostic health screenings, the services covered under subsection (j) of this section shall be provided with no deductible due and payable. A health plan shall, at a minimum, be liable for eighty percent (80%) of the reimbursement allowance of the health plan up to a maximum of two hundred fifty dollars ($250.00) per adult insured per year. A patient shall be liable for coinsurance up to twenty percent (20%) if such coinsurance is required pursuant to the patient's health care coverage. Coverage may be in addition to any other preventive care services. This subsection shall apply to private health benefit plans as defined by W.S. 26-1-102(a)(xxxiii) except that it shall not apply to high deductible policies where the deductible equals or exceeds one thousand dollars ($1,000.00) per person or per family per year or policies qualifying as federal medical savings accounts.

(m) In addition to the prohibitions on the use of genetic information provided in paragraph (g)(vi) of this section, an insurer offering a policy of group or blanket disability insurance shall not, based on the genetic testing information of an individual or a family member of an individual:

(i) Deny eligibility;

(ii) Adjust premium rates;

(iii) Adjust contribution rates;

(iv) Request or require predictive genetic testing information concerning an individual or a family member of the individual, except the insurer may request, but not require, predictive genetic testing information if needed for diagnosis, treatment or payment. As part of a request under this paragraph, the plan or issuer shall provide a description of the procedures in place to safeguard confidentiality of the information.

26-19-108. Group disability and blanket insurance standard provisions; application and certificate need not be furnished.

An individual application need not be required from a person covered under a blanket disability policy or contract, nor is it necessary for the insurer to furnish each person a certificate.

26-19-109. To whom benefits are payable.

(a) Any benefits under any group or blanket disability policy or contract are payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured is a minor or otherwise not competent to give a valid release, the benefits may be made

payable to his parent, guardian or other person actually supporting him. The policy may provide that any indemnities provided by the policy because of hospital, nursing, medical or surgical services, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of loss, may be paid directly to the hospital or person rendering the services. The policy may not require that the service be rendered by a particular hospital or person. Any payment made under the policy discharges the insurer's obligation with respect to the amount of insurance so paid.

(b) Any group disability policy which contains provisions for the insurer to pay benefits for expenses incurred for hospital, nursing, medical or surgical services for members of the family or dependents of a person insured may provide for the continuation of the benefit provisions entirely or partially after the death of the person insured.

26-19-110. Additional disability insurance groups; requirements.

(a) Group disability insurance offered to a resident under a group disability insurance policy issued to a group other than one described in W.S. 26-19-102 is subject to the following requirements:

(i) A group disability insurance policy shall not be delivered in this state unless the commissioner finds that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration;

(C) The benefits are reasonable in relation to the premiums charged;

(D) The insurer possesses and maintains capital and surplus requirements provided by W.S. 26-3-108 and reserve requirements provided by W.S. 26-6-107.

(ii) Group disability insurance coverage shall not be offered in this state by an insurer under a policy issued in another state unless the commissioner determines the requirements of paragraph (i) of this subsection are met and the insurer files with the commissioner:

(A) A copy of the group master contract;

(B) A copy of the statute of the state where the group policy is issued that authorizes the issuance of the group policy;

(C) Evidence of approval of the group policy in the state where the group policy is issued; and

(D) Copies of all supportive material used by the insurer to secure approval of the group in the state where the group policy is issued.

(iii) If the commissioner fails to make the determination provided by paragraph (ii) of this subsection within forty-five (45) days of filing by the insurer of the documents required by paragraph (ii) of this subsection, the requirements of paragraph (i) of this subsection are deemed to be met.

26-19-111. Notice of compensation.

(a) The insurer shall distribute to prospective insureds a written notice that compensation shall or may be paid for a program of group insurance which would qualify under W.S. 26-19-102(a)(ii) or 26-19-110, if compensation of any kind shall or may be paid to:

(i) A policyholder or sponsoring or endorsing entity in the case of group policy; or

(ii) A sponsoring or endorsing entity in the case of individual, blanket or franchise policies marketed by means of direct response solicitation.

(b) Notice required by this section shall be distributed:

(i) Whether compensation is direct or indirect; and

(ii) Whether compensation is:

(A) Paid to or retained by the policyholder or sponsoring or endorsing entity; or

(B) Paid to or retained by a third party at the direction of the policyholder, sponsoring or endorsing entity or an entity affiliated by way of ownership, contract or employment.

(c) The notice required by this section shall be placed on or accompany any application or enrollment form provided to prospective insureds.

(d) As used in this section:

(i) "Direct response solicitation" means a solicitation through a sponsoring or endorsing entity by the mails, telephone or other mass communications media; and

(ii) "Sponsoring or endorsing entity" means an organization which has arranged for the offering of a program of insurance in a manner which communicates that eligibility for participation in the program is dependent upon affiliation with the organization or that it encourages participation in the program.

26-19-112. Dependent group disability insurance.

Except for a policy issued under W.S. 26-19-102(a)(vi), a group disability insurance policy may be extended to insure the employees' or members' or any class of employees' or members' family members or dependents. If the employee or member does not pay any part of the premium for the family members or dependents coverage, the policy shall insure all eligible employees, members or any class of employees or members.

26-19-113. Continuation of group coverage after termination of employment or membership.

(a) A non-COBRA group policy or certificate of insurance on a master policy of a group delivered or issued for delivery in this state on or after July 1, 1995, issued by any insurance company, nonprofit health service corporation, health maintenance organization or any other insurer that provides hospital, surgical or major medical expense insurance or any accommodation of these coverages on an expense incurred basis, but not a policy that provides benefits for specific diseases or for accidental injuries only, shall provide that employees, members or their covered eligible dependents whose insurance under the group policy would otherwise terminate because of termination of employment or membership or eligibility for coverage are entitled to continue their hospital, surgical and major medical insurance under that group policy, for themselves, their eligible dependents or both, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

(i) Continuation is only available to an employee or member who has been continuously insured under the group policy and for similar benefits under any group policy which it replaced, during the entire three (3) month period ending with the termination of eligibility;

(ii) Continuation is not available for any person who is:

(A) Covered by medicare, excluding his spouse or dependent children who shall be entitled to continuation; or

(B) Covered by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group.

(iii) Continuation need not include dental or vision care benefits or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits unless the insurer previously included such benefits and the insured requests such benefits;

(iv) An employee or member who wishes continuation of coverage shall request the continuation in writing within the thirty-one (31) day period following the date of termination of coverage;

(v) An employee or member electing continuation shall pay to the insurer, third party administrator, group policyholder or the employer, as designated by the employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than one hundred two percent (102%) of the group rate for the insurance being continued under the group policy on the due date of each payment. The employer's designation with regard to whom the electing employee or member shall pay his contribution shall be made in writing prior to the date the first contribution by the employee or member is due. The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, shall be given to the insurer, third party administrator, policyholder or employer within thirty-one (31) days of the date the employee's or member's insurance would otherwise terminate;

(vi) Continuation of insurance under the group policy for any person terminates when the person fails to satisfy paragraph (ii) of this subsection or, if earlier, at the first to occur of the following:

(A) The date twelve (12) months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership;

(B) If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made;

(C) The date on which the group policy is terminated or, in the case of an employee, the date the employer terminates participation under the group policy. However, if this subparagraph applies and the coverage ceasing by reason of the termination is replaced by similar coverage under another group policy, the following apply:

(I) The employee or member may become covered under that other group policy for the balance of the period that the employee or member would have remained covered under the prior group policy in accordance with this paragraph had a termination described in this subparagraph not occurred;

(II) The minimum level of benefits to be provided by the other group policy is the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy;

(III) The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

(vii) A notification of the continuation privilege shall be included in each certificate of coverage;

(viii) Upon termination of the continuation period, the member, surviving spouse or dependent is entitled to exercise any option which is provided in the group plan to elect a conversion policy. The member electing a conversion policy shall notify the carrier of the election and pay the required premium within thirty-one (31) days of the termination of the continued coverage under the group contract.

(b) As used in subsection (a) of this section, "non-COBRA" means any group policy or certificate of insurance on a master policy of a group policy which is not subject to continuation of rights as provided under the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

26-19-114. Failure to pay premiums; notification.

When an employer or trustee of a fund established or adopted by an employer, which employer or trustee is deemed the policyholder of the group disability insurance policy insuring the employer's employees for the benefit of persons other than the employer and where the employer or trustee routinely pays any part of the premium for the policy, if the employer or trustee fails to pay the routinely paid portion of the premium when required under the policy for any reason, the employer or trustee shall notify the employee or beneficiary, electronically or in writing, within thirty (30) days of the failure to pay.