DENTAL PLAN ORGANIZATIONS—GROUP STAND-ALONE DENTAL COVERAGE OFFERED THROUGH THE SHOP EXCHANGE OR CERTIFIED TO BE SOLD OUTSIDE THE EXCHANGE with POLICY YEARS THAT BEGIN ON OR AFTER JANUARY 1, 2026

COMPANY:	NAIC Code:
FORM(S):	
DATE:	
SERFF TRACKING NO.:	

The items listed below may paraphrase the law or regulation. **The checklist is not required to be included with a form filing.** It should be used as a guide in determining which laws and regulations apply to the contract. Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland.

A. Filing Incomplete or in Unacceptable Format

	Citation	Description	"X" Means Applicable	Form/ Page
A1.	45 CFR §156.150(b)	Certification of the actuarial value of coverage for the pediatric dental EHBs by a member of the American Academy of Actuaries using generally accepted actuarial principles		
A2.	45 CFR §156.150(a)(1) and (2) 2026 CMS Letter to Issuers dated January 15, 2025	2026 Annual limitation on cost-sharing for essential pediatric dental benefits (such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services) • $450 - one child • $900 - 2 or more children (in aggregate)		
	45 CFR §155.20	Cost-sharing defined as any expenditure required by or on behalf of an enrollee with respect to essential pediatric dental benefits; such term includes deductibles, coinsurance, copayments, or similar charges		
A3.	MIA Bulletin 25-1	Separate schedule of benefit form for each plan design with specific combination of benefits and cost-sharing		
A4.	COMAR 31.04.17.04A(2)	Form contains text in brackets, denoting variability. Only specific items allowed for variability. Submit specific description of how each bracketed item will vary. If other items are desired, include the item		
A5.	COMAR 31.12.04.10A	Premium Rates and Actuarial Memorandum		

	Citation	Description	"X" Means Applicable	Form/ Page
A6.	COMAR 31.04.17.03-I(2)	If the filing is not being made by the DPO, the filer must submit a signed third party authorization letter from the DPO.		
A7.	COMAR 31.04.17.03D	Form Number		
A8.	COMAR 31.04.17.03G	Corporate Name		
A9.	COMAR 31.04.17.03H	Unacceptable Modifications		
A10.	COMAR 31.04.17.03K	Specimen Data		
A11.	COMAR 31.04.17.03M	Signature of Officer		
A12.	COMAR 31.04.17.07	Advertising Prohibited		
A13.	COMAR 31.04.17.03E	Size of Type		
A14.	COMAR 31.12.04.09B(4)	Illegible Form		
A15.	§2-112(a)(10)	Filing Fees Insufficient		
A16.	COMAR 31.04.17.04B	Contracts Comprised of Insert Pages		
A17.	COMAR 31.04.17.04C	Contracts Comprised of Sections		

B. Essential Pediatric Dental Benefits (Benchmark Plan-MCHIP dental benefit)

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	45 CFR § 156.115(a)(6)	Coverage **provided until at least the end of the month** in which the child turns 19 years of age		
B2.	MIA Bulletins 13-01 and 15-33	Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry		
B3.	MIA Bulletins 13-01 and 15-33	Diagnostic services included in the Maryland Children's Health Insurance Plan (MCHIP) dental benefit		
B4.	MIA Bulletins 13-01 and 15-33	Preventive services included in the MCHIP dental benefit		
	§15-135.1	• Annual dental preventive care visit must be covered if provided at any time during the plan year – may not require visit to occur after a specified time period (e.g. 12 months) following prior visit		

	Citation	Description	"X" Means Applicable	Form/ Page
		• If the contract provides benefits for dental preventive care more often than once per plan year, the contract may not require that the visits be separated by more than 120 days		
B5.	MIA Bulletins 13-01 and 15-33	Restorative services included in the MCHIP dental benefit		
B6.	MIA Bulletins 13-01 and 15-33	Endodontic services included in the MCHIP dental benefit		
B7.	MIA Bulletins 13-01 and 15-33	Periodontic services included in the MCHIP dental benefit		
B8.	MIA Bulletins 13-01 and 15-33	Removable prosthodontics services included in the MCHIP dental benefit		
B9.	MIA Bulletins 13-01 and 15-33	Maxillofacial prosthetics included in the MCHIP dental benefit (codes D5992 and D 5993)		
B10.	MIA Bulletins 13-01 and 15-33	Fixed prosthodontic services included in the MCHIP dental benefit-(D6930-recement fixed partial denture)		
B11.	MIA Bulletins 13-01 and 15-33	Oral and Maxillofacial Surgery included in the MCHIP dental benefit		
B12.	MIA Bulletins 13-01 and 15-33	Orthodontics included in the MCHIP dental benefit - only for children with severe, dysfunctional, handicapping malocclusion		
	CMS FAQ on Health Insurance Market Reforms and Marketplace Standards, May 26, 2016	• Waiting period may NOT be applied		
B13.	MIA Bulletins 13-01 and 15-33	Adjunctive general dental services included in the MCHIP dental benefit		
B14.	45 CFR §155.1065(a)(2)	No lifetime or annual limits permitted for essential pediatric dental benefits		
B15.	Sec. 1311(d)(2)(B)(ii) of the ACA	Essential pediatric dental benefit must be included in all contracts sold on the Exchange, including contracts issued only to adults		

C. Stand-alone Dental Plan Standards 45 CFR §155.1065(a)(3). Applicable to Qualified Dental Plans sold on the Exchange (§31-101(q)), but not to Exchange Certified Stand-Alone Dental Plans sold outside the Exchange (§31-116(f)(1)(ii))

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	45 CFR §155.706(b)(6) 45 CFR §156.210(a)	Premium rates for the employer must be set for the entire plan year		
C2.	45 CFR §155.20	Plan year defined as a consecutive 12 month period during which the dental plan organization provides coverage for dental benefits		
C3.	45 CFR §155.706(b)(10) §156.286(d);	Minimum employee participation rate may not be applied to the rate of participation in the particular qualified dental plan		
C4.	45 CFR 155.710(b) §31-101(r)	Qualified employer definition		
C5.	§31-101(aa)	Small employer definition		

D. Open Enrollment and Special Enrollment Periods 45 CFR §156.286(b). Applicable to Qualified Dental Plans sold on the Exchange (§31-101(q)), but not to Exchange Certified Stand-Alone Dental Plans sold outside the Exchange (§31-116(f)(1)(ii))

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§15-1208.2(b)	Annual open enrollment period of no less than 30 days for employees of small employer to enroll, discontinue enrollment, or change enrollment		
D2.	§15-1208.2(c)	Enrollment period of at least 30 days for new employees		
	42 USC §300gg-7 45 CFR §147.116 §15-1A-12	• Waiting period for an otherwise eligible employee to enroll may not exceed 90 days		
D3.	§15-1208.1(b)	Special enrollment period of 30 days for employee/dependent who loses other coverage		
D4.	§15-1208.1(c)(1)	Special enrollment period of 31 days for individuals who become dependents of employee through marriage, birth, adoption, placement for adoption, or placement for foster care		
	§15-1208.1(c)(2)	• Permit employee to enroll himself when he or she acquires new dependents		
	§15-1208.1(c)(3)	• For spouse of employee at birth or adoption of child, or placement of a child in foster care, or through a child support order or other court order.		

	Citation	Description	"X" Means Applicable	Form/ Page
D5.	§15-1208.1(c)(4)	At the option of the Exchange, special enrollment period of 31 days for an enrollee who is the eligible employee or spouse if the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the employee, or his or her dependent, dies		
D6.	§15-1208.2(d), Senate Bill 217, Chpt. 118, Acts of 2024, effective 10/1/2024 45 CFR §156.286(b) 45 CFR §155.726(c)(2)(i)	Special enrollment period of 30 days for certain "triggering events"		
	§15-1208.2(d)(4)(i) 45 CFR §155.420(d)(1)(i)	a. Eligible employee or dependent loses minimum essential coverage. The date of the loss of coverage is the last day the consumer would have coverage under his or her previous plan or coverage.		
	§15-1208.2(d)(5) 45 CFR §155.420(e)	• Does not include loss of coverage due to voluntary termination, failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA, or loss due to a rescission authorized under 45 CFR §147.128		
	§15-1208.2(d)(4)(ii) 45 CFR §155.420(d)(1)(iii)	b. Employee or dependent loses pregnancy related coverage under §1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (Medicaid) or loses access to health care services through coverage provided to a pregnant woman's unborn child. The date of the loss of coverage is the last day the qualified individual would have pregnancy-related coverage or access to health care services through the unborn child coverage.		
	§15-1208.2(d)(4)(iii) 45 CFR § 155.420(d)(1)(iv)	c. Eligible employee or dependent loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. The date of the loss of coverage is the last day the consumer would have medically needy coverage.		
	§15-1208.2(d)(6)	• Permitted only once per year per individual		
	§15-1208.2(d)(4)(iv) 45 CFR §155.420(d)(5)	d. Eligible employee or a dependent enrolled in the SHOP Exchange adequately demonstrates to the Exchange that the qualified plan substantially violated a material provision of its contract in relation to the eligible employee or dependent		

	§15-1208.2(d)(4)(x) 45 CFR §155.420(d)(7) 45 CFR §155.420(a)(5)	e. Eligible employee or dependent gains access to new qualified health plans due to a permanent move and had minimum essential coverage for one or more days during the 60 days preceding the move • Employee/dependent may satisfy prior coverage requirement by demonstrating that they: o Had minimum essential coverage; o Had pregnancy related coverage or access to healthcare services through unborn child coverage described in 45 CFR § 155.420(d)(1)(iii) o Had medically needy coverage described in 45 CFR § 155.420(d)(1)(iv) o Are an Indian; o Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or o For 1 or more days during the 60 days preceding the move or during their most recent preceding open enrollment period or special enrollment period, lived in a service area where no qualified dental plan was available through the SHOP Exchange		
	§15-1208.2(d)(4)(vi)4 45 CFR §155.420(d)(9)	f. Eligible employee or dependent enrolled in the SHOP Exchange demonstrates to the Exchange, in accordance with HHS guidelines, that the eligible employee or dependent meets other exceptional circumstances		
	§15-1208.2(d)(4)(vi)1 45 CFR §155.420(d)(4)	g. The eligible employee's or dependent's enrollment or non-enrollment is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities		

	§15-1208.2(d)(4)(vii) and (d)(10) 45 CFR § 155.420(d)(10)	h. Eligible employee is a victim of domestic abuse or spousal abandonment, including a dependent within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, and seeks to enroll in coverage at the same time as the victim		
	§15-1208.2(d)(4)(viii) and (ix) 45 CFR § 155.420(d)(11)	i. Eligible employee or dependent applies for coverage on the Individual Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event OR applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended.		
	§15-1208.2(d)(4)(vi)3 and (d)(11), SB 217, Chpt.118, Acts of 2024, effective 10/1/2024 45 CFR § 155.420(d)(12)	j. The eligible employee's or dependent's enrollment in a qualified dental plan through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing or premium. A material error is one that is likely to have influenced the eligible employee's or dependent's enrollment in a qualified dental plan.		
D7.	§15-1208.2(d)(9) 45 CFR §155.726(c)(3)(ii)	Special enrollment period of 60 days		
	§15-1208.2(d)(4)(v)1 45 CFR §155.726(c)(2)(ii)	Loss of eligibility for coverage under a Medicaid plan or CHIP plan		
	§15-1208.2(d)(4)(v)2. 45 CFR §155.726(c)(2)(iii)	• Becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under such Medicaid or CHIP plan		
D8.	§15-1208.2(d)(4)(vi)2. and (d)(8) 45 CFR §155.420(d)(8) 45 CFR § 155.726(c)(2)(i)	Eligible employees who gain or maintain status as Indians may enroll in or change to any qualified dental plan on the Exchange once per month		

	45 CFR §155.420(d)(8)(ii)	• Individual who is or becomes a dependent of an Indian, and is enrolled or is enrolling in a plan on the same application as the Indian, may change plans one time per month at the same time as the Indian		
D9.	§15-1208.1(f) §15-1208.2(e) 45 CFR §155.420(b)	Effective dates of coverage for individuals who enroll during a special enrollment period		
	45 CFR §155.420(b)(2)(iv) 88 FR 25827	a. In the case of loss of: 1. Loss of minimum essential coverage; 2. Loss of pregnancy related coverage; 3. Loss of unborn child coverage; 4. Loss of medically needy coverage; or 5. Gaining access to new plans due to a permanent move The effective date is as follows: • If plan selection is made on or before the date of the triggering event, the Exchange must ensure coverage is effective on the first day of the month following the date of the triggering event. • If plan selection is made after the date of the triggering event, coverage is effective on the first day of the month following plan selection. • For losses of coverage [45 CFR §§155.420(d)(1)], at the option of the Exchange, if plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure the coverage effective date is the first day of the month in which the triggering event occurs		
	§15-1208.1(f)(1)(ii)-(iv) 45 CFR §155.420(b)(2)(i) §15-401(b)(2)	b. In the case of birth, adoption, placement for adoption, or placement for foster care, the date of birth, adoption, or placement for adoption or foster care		
	§15-1208.1(f)(1)(v) 45 CFR §155.420(b)(2)(i)	c. In the case of a child support order or other court order, the effective date of the court order • If permitted by the Exchange, the individual may instead elect a coverage effective date of the first day of the month following plan selection.		

	§15-1208.1(f)(1)(i) 45 CFR §155.420(b)(2)(ii)	d. In the case of marriage, the first day of the month following plan selection		
	45 CFR §155.420(b)(2)(iii)	e. In the case of an individual eligible for special enrollment when: 1. Enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of an error misrepresentation, misconduct, or inaction of an officer, employee, or agent of by the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; 2. The qualified plan substantially violated a material provision of its contract with the individual; 3. The individual meets other exceptional circumstances; 4. The individual applies for coverage on the Individual Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event OR applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended; or 5. The individual's enrollment in a qualified dental plan through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing or premium. The effective date is an appropriate date based on the specific circumstances and is determined by the Exchange		
	§15-1208.1(g)(1) 45 CFR §155.420(b)(2)(v)	f. In the case of an individual or dependent who dies, the first day of the month following the plan selection.		

	§15-1208.1(g)(2) 45 CFR §155.420(b)(1)	g. In the case of an eligible employee who loses a dependent or is no longer considered a dependent through divorce or legal separation, the first day of the month after the individual selects a plan.		
	§15-1208.2(e) 45 CFR §155.420(b)(1)	h. For all other triggering events the first day of month after the individual selects a plan.		

E. Dental Benefit Contract Required Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	COMAR 31.12.04.04A	Effective Date		
E2.	COMAR 31.12.04.04D	Eligibility and effective date for members of the group		
E3.	COMAR 31.12.04.04B	Payment of Premium		
E4.	COMAR 31.12.04.04C COMAR 31.12.04.05	Grace Period		
E5.	COMAR 31.12.04.04E	Benefit Description		
E6.	COMAR 31.12.04.04F	Copayment Description		
E7.	COMAR 31.12.04.04G	Service Area Description		
E8.	COMAR 31.12.04.04H	Out-of-Area Emergency		
E9.	COMAR 31.12.04.04I(1)	Referral to Specialist (closed panel plans only)		
E10.	§15-830(b)	Right to Standing Referral to Network Specialist (gatekeeper plans only)		
E11.	§15-830(d)	Right to Request Referral to Specialist Not on Dental Plan's Provider Panel • Referral must be granted if the dental plan cannot provide reasonable access to a specialist without unreasonable travel or delay		
E12.	COMAR 31.12.04.04I(2)	Inability to Provide Services - Circumstances Beyond the Plan's Control (*closed panel plans only*)		
E13.	§15-140(d)	Receiving carrier requirements for members transitioning to dental plan		
E14.	COMAR 31.12.04.04J	Termination		
E15.	COMAR 31.12.04.04K Title 15, Subtitle 10A, Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025	Grievance Procedure		

	Citation	Description	"X" Means Applicable	Form/ Page
E16.	COMAR 31.12.04.04K Title 15, Subtitle 10D	Complaint Process for Coverage Decisions		
E17.	§15-112(q)	Office to file complaints		
E18.	COMAR 31.12.04.04L §15-833	Extension of Benefits		
E19.	§15-110(d)	Required Exclusion for Prohibited Health Care Practitioner Referrals		

F. Optional Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	COMAR 31.12.04.07B(1)	Missed Appointment Fee		
F2.	COMAR 31.12.04.07B(2)	Premium Increase • Contract holder must be given at least 45 days written notice before the effective date of the increase		
F3.	COMAR 31.12.04.07B(3)	Penalty for voluntary withdrawal during first year of coverage		
F4.	COMAR 31.12.04.07B(4)	Patient Charge Schedule Increase • Contract holder must be given at least 30 days written notice before the effective date of the increase and present schedule must have been in effect for at least 12 months		
F5.	COMAR 31.12.04.07B(5)	Refusal to Follow Treatment		

G. Other

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	COMAR 31.12.04.07D	Incapacitated Child		
G2.	§15-401 §15-403 §15-403.1	Newborn/Adopted Children/ Grandchildren/ Guardianship (*expense-incurred contracts only*)		
G3.	§15-405	Court Ordered Coverage of Children		
G4.	§12-209(3)	Legal Actions		
G5.	§12-209(1), (2)	Subject to Maryland Law		
G6.	§14-415(b)	Use of “Insurance” Prohibited		

G7.	§15-135.1	Benefits for Adult Dental Preventive Care • Annual dental preventive care visit must be covered if provided at any time during the plan year – may not require visit to occur after a specified time period (e.g. 12 months) following prior visit • If the contract provides benefits for dental preventive care more often than once per plan year, the contract may not require that the visits be separated by more than 120 days		
G8.		Preferred Provider Contracts with Expense-Incurred Benefits		
	§14-205(b)(2)	a. Coinsurance Differential – Difference between coinsurance percentage for non-preferred and preferred providers may not exceed 20 percentage points		
	§15-118(c)	b. Coinsurance amounts for preferred provider must be based on negotiated fees with insurer		
	§14-205(b)(4)	c. Allowed Amounts – The allowed amount paid to non-preferred providers for a health care service covered under a PPO contract may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same service in the same region		
G9.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
G10.	§15-1005(e)	Provider must be permitted minimum of 180 days to file a claim for reimbursement		
G11.	§15-1005(g)	Payment of Interest on Unpaid Claims		
G12.		Coordination of Benefits		
	§15-104(c)	• May not coordinate against guaranteed renewable individual intensive care or specified disease policies		
	§15-104(d)	• May not provide benefits that are secondary to benefits payable under Personal Injury Protection (PIP)		

H. Evidence of Coverage

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	COMAR 31.12.04.06B	Name of Group		

	Citation	Description	"X" Means Applicable	Form/ Page
H2.	COMAR 31.12.04.06A COMAR 31.12.04.07A	Corrections required in master policy also required in evidence of coverage		

I. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
I1.		Initial authorization of course of treatment made:		
	§15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025	a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		
	§15-10B-06(a)(1)(ii)	b. For additional health care services, within 1 working day of receipt of necessary information		
	§15-10B-06(a)(1)(iii), Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025	c. For additional visits or days of care submitted as part of an existing course of treatment, within 1 working day after receipt of the necessary information		
	§15-10B-06(a)(2) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	d. After receipt of initial request, if more information is necessary to make decision, inform the provider no more than 3 calendar days following initial request of the need for more information		
I2.	§15-10A-02(f)(1)(ii), Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/25	Notice of adverse decision must be provided within 5 working days after adverse decision is made to member, member's representative and a health care provider acting on behalf of the member		
I3.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
I4.	§15-1001 Title 15, Subtitle 10B COMAR 31.10.18, Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025 COMAR 31.10.18	Company not certified as Private Review Agent in Maryland		
I5.	§15-140(c)	When dental plan organization is the receiving carrier, the dental plan organization must, upon request, accept a preauthorization from the relinquishing carrier for the lesser of the course of treatment or 90 days		

J. Applications for Use with Plans Offered Outside of the Exchange

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	§27-805	Insurance Fraud-Required Disclosure Statement		
J2.	§15-1210(a)(2)	Employer application must allow employer to elect to cover part-time employees		
J3.	COMAR 31.04.17.06A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		
J4.	COMAR 31.04.17.06I(3)	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant.		
J5.	45 CFR §147.102(a)(iv)	Employee application may ask question about the use of any tobacco product, except religious or ceremonial use, on average four or more times per week within the period no longer than the past 6 months. • If yes, then must ask when tobacco product was last used		
J6.	COMAR 31.04.17.06I(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
J7.	COMAR 31.04.17.06J	If application is to be completed by more than one individual, application signature box must clearly indicate that signature applies only to portion of application completed by that individual		
J8.	§27-216 MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
J9.	COMAR 31.04.17.06B	Certain States		
J10.	COMAR 31.04.17.08	Proxy not permitted		