BLANKET ACCIDENT INSURANCE

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.	COMAR 31.10.01.03A	Premium Rates and Actuarial Memorandum (Include in same SERFF tracking number filing)		
A2.	COMAR 31.04.17.03I(2)	If the filing is not being made by the insurer, the filer must submit a signed third party authorization letter from the insurer.		
A3.	COMAR 31.04.17.03C	Listing of Forms		
A4.	COMAR 31.04.17.03J	Description of New Features		
A5.	COMAR 31.04.17.03D	Form Number (Form number must be identical to form number in SERFF Form Schedule)		
A6.	COMAR 31.04.17.03G, COMAR 31.10.01.03B	Corporate Name		
A7.	COMAR 31.04.17.03H	Unacceptable Modifications		
A8.	COMAR 31.04.17.03K	Specimen Data		
A9.	COMAR 31.04.17.03M	Signature of Officer		
A10.	COMAR 31.04.17.04A(2)	Form contains items in brackets, denoting variability. Submit specific description of how each item can vary. If other text is desired, include specific text.		
A11.	COMAR 31.04.17.04B	Contracts Comprised of Insert Pages		
	COMAR 31.04.17.04B(1)(b)(i)	a. Description of How Pages will be Combined		
	COMAR 31.04.17.04B(1)(b)(ii)	b. Listing of Substitute Pages		
	COMAR 31.04.17.04B(3)(a)	c. Form Number and Approval Date for Pages Replaced		

	Citation	Description	"X" Means Applicable	Form/ Page
	COMAR 31.04.17.04B(3)(b)	d. Copy of Currently Approved Contract		
A12.	COMAR 31.04.17.04C	Contracts Comprised of Sections		
	COMAR 31.04.17.04C(1)(b)(i)	a. Description of How Sections will be Combined		
	COMAR 31.04.17.04C(1)(b)(ii)	b. Listing of Substitute Sections		
	COMAR 31.04.17.04C(3)(a)	c. Form Number and Approval Date for Pages Replaced		
	COMAR 31.04.17.04C(3)(b)	d. Copy of Currently Approved Contract		
A13.	COMAR 31.10.01.03E	Signature of Policyholder for Reduction Rider		
A14.	COMAR 31.10.02.02A(4)	Size of Type		
A15.	COMAR 31.10.02	Simplified Language (Readability Certification)		
A16.	§2-112(a)(10)	Filing Fees Insufficient		
A17.	COMAR 31.04.17.03F	Language other than English in Forms		
A18.	§15-305	Contract for Unacceptable Group		

B. Mandated Benefits

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	§15-803	Blood Products		
B2.		Health Care Cost Containment		
	§15-819(b)(1)	a. Outpatient Benefit		
	§15-819(b)(2)	b. Second Opinion		
B3.	§15-808	Home Health Care		
B4.	§15-809; COMAR 31.10.09	Hospice (Required Offering)		
B5.	§15-821	Coverage of Face, Neck or Head		
B6.	§15-828	General Anesthesia for Dental Care		
B7.	§15-833	Extension of Benefits		
B8.	§15-417	Part-time Students with Disabilities		
B9.	§15-838	Hearing Aids Coverage for Children		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-838.1, Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25)	Hearing Aids- Coverage for Adults		
	§ 15-838.1(c)(2), House Bill 1355, Chapter 742, Acts of 2025	• Expanded to include coverage for a hearing aid that is ordered, fitted and dispensed by a licensed hearing aid dispenser		
	§15-838.1(d)(2), Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25)	• Must permit member to select a hearing aid that costs more than the benefit listed in the contract and pay the additional cost of the hearing aid without financial or contractual penalty to the provider of the hearing aid		
B10.	§15-844, Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Prosthetic Devices (including Components and Repairs)		
	§15-844(a), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Definition of “prostheses”		
	§15-844(c), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Benefits must be provided once annually		
	§15-844(d), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Coverage for prosthetic and component replacements		
	§15-844(e), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	May not require copayment or coinsurance higher than other similar services		
	§15-844(g), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Medical necessity to be determined by the treating provider		
	§15-844(g)(1), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Any standard medical necessity exclusion in contract must indicate prostheses or components are considered medically necessary if satisfies medical necessity requirements established under the Medicare Coverage Database		
	§15-844(g)(2), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Benefits will be provided for prostheses health care provider determines are medically necessary when used for activities identified in statute		
B11.	§15-139	Health Care Services through Telehealth		

	§15-139(a), House Bill 869, Chapter 482, Acts of 2025 (effective June 1, 2025)	a. Revised to include a Definition of "telehealth:" • Audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service. • Amended to NOT include, except as provided above, audio-only telephone conversation between a health care provider and a patient.		
	§15-139(c)(1), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	b. Coverage shall: • Be provided regardless of the location of the patient at the time the telehealth services are provided. • Not be excluded or denied for a behavioral health care service that is a covered benefit under a health insurance policy or contract when provided in person solely because the behavioral Health Care Service may also be provided through a covered telehealth benefit.		
	§15-139(c)(2), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	c. Telehealth care services include counseling and treatment for substance use disorders and mental health conditions.		
	§15-139(e), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	d. May not require that covered health care services delivered through telehealth be provided by a third-party vendor designated by the carrier.		
B12.	§15-840	Residential Crisis Services		
B13.	§15-848	Ostomy Equipment and Supplies		

C. Open Enrollment

	Citation	Description	"X" Means Applicable	Form/ Page
C1.		Open Enrollment		
	§15-404	• Dependent Children Death of Spouse		

D. Prescription Coverage Benefits (applicable only if contract provides prescription drugs)

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§15-805	Coverage of drugs from local pharmacies same as mail order		
D2.	§15-824	90 Day Supply for Maintenance Drugs		
D3.	§15-804	Off Label Use of Drugs		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-804(a)(4)	• Include "Standard reference compendia" definition		
D4.	§15-831	For Formulary Benefits – Right to Receive Non-Formulary Drugs		
D5.	§15-842	Copayment or coinsurance may not exceed the retail price of drug.		
D6.	§15-845(b)(1), §15-845(b)(2)(i)	Coverage for certain prescription eye drop refills (if contract provides coverage for prescription eye drops).		
D7.	§15-142(c)	A contract may not impose a step therapy or fail–first protocol on an insured or an enrollee if: 1) the step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated; or 2) a prescriber provides supporting medical information to the entity that a prescription drug covered by the entity: i. was ordered by a prescriber for the insured or enrollee within the past 180 days; and ii. based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition.	i.	
	§15-142(e), House Bill 970, Chpt 688, Acts of 2025 (effective January 1, 2026)	As of January 1, 2026, step therapy may also not be required when: a. The prescription drug is used to treat the insured's or enrollee's stage four advanced metastatic cancer; and b. The prescription drug is approved by the U.S. Food and Drug Administration and is insulin or an insulin analog used to treat Type 1, Type 2 or gestational diabetes**.** c. The prescription drug is approved by the U.S. Food and Drug Administration and is prescribed by a treating physician to treat a symptom or side effect from treatment of stage four advanced metastatic cancer if the use of the drug is:		

	Citation	Description	"X" Means Applicable	Form/ Page
		i. Consistent with best practices for the treatment of stage four advanced metastatic cancer, a condition associated with stage four advanced metastatic cancer, or a side effect associated with treatment of stage four advanced metastatic cancer; ii. Supported by peer-reviewed medical literature; and iii. Covered under the terms of the contract.		
D8.	§15-850	Preauthorization cannot be required for certain drug products used to treat opioid use disorder		
D9.	§15-851	Preauthorization cannot be required for drugs used for treatment of opioid addiction.		
D10.	§15-854	Limits on prior authorization requirements for certain drugs		
	§15-854(g), House Bill 785, Chpt 365, Acts of 2023 (effective 01/01/24)	• More than one prior authorization prohibited if two or more tablets of different dosage strengths of the same prescription drug are prescribed at the same time and are made by the same manufacturer. This does not apply to opioids that are not opioid partial agonists.		
D11.	§15-849	Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy		
	§15-849(c)(1)	• If contract lists specific drugs that are covered, must list at least two brand name and two generic abuse-deterrent opioid analgesic drugs on the lowest cost tier		
	§15-849(c)(2)	• No fail first protocol applied to opioid analgesic drugs before being allowed abuse-deterrent opioid analgesic drugs		
D12.	§15-852	Prorated daily copayment/coinsurance for partial supply of prescription drug dispensed by in-network pharmacy.		
D13.	§15-858, House Bill 970, Chpt. 684, Acts of 2022 (effective 01/01/23)	Prohibition on prior authorization for prescription drugs used as Postexposure Prophylaxis for the prevention of HIV if the drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines		

E. Practitioners

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	§15-701	Health Care Providers		
	§15-701, Senate Bill 216, Chpt. 330, Acts of 2023 (effective 7/01/23)	• May not exclude medically necessary treatment services otherwise covered under the contract when those services are provided by a massage therapist		
E2.	§15-703	Certified Nurse Practitioner		
E3.	§15-708	Nurse Anesthetist		
E4.	§15-705	Chiropractor		
E5.	§15-713	Podiatrists		
E6.	§15-704	Clinical Professional Counselors		
E7.	§15-707	Social Workers		

F. Disability

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	COMAR 31.10.01.03L	Definition of Total Disability		
F2.	COMAR 31.10.01.03M	Definition of Partial Disability		
F3.	§15-501	Social Security "Freeze"		
F4.	§ 27-909.1, House Bill 1007, Chapter 394, Acts of 2025 (effective October 1, 2025)	Discrimination based on genetic information in life and disability coverage		
	§ 27-909.1(c), House Bill 1007, Chapter 394, Acts of 2025 (effective October 1, 2025)	An insurance carrier offering life insurance or disability insurance policies or contracts in Maryland may not: a. access sensitive medical information, including the genetic data of an individual, without first obtaining the individual's signed, written consent b. mandate existing or new genetic testing or full genome sequencing as a prerequisite for life insurance or disability insurance eligibility or coverage		

G. Other

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-604	Payment of Maryland Hospitals Based on Rate Set by Health Services Cost Review Commission		
G2.	§15-603	Reimbursement for Services Paid for or Provided by the Maryland Department of Health		
G3.	Title 15, Subtitle 10D; COMAR 31.10.29	Complaint process for coverage decisions		
		• Revised Member Definition		
	§15-10D-01(f)(3)	• Coverage decision definition excludes Pharmacy Inquiries		
	§15-919	Medicare Supplement Disclaimers for individual eligible for Medicare due to age (non-employer and non-labor organization contracts only)		
G4.	COMAR 31.10.01.02C	Standard of Time		
G5.	COMAR 31.10.01.03G	Right to Elect Alternative Benefits		
G6.	§12-209(1), §12-209(2), §12-209(4)	Contract governed by Maryland law and Maryland courts		
G7.	COMAR 31.10.01.03F	If contract indicates that one of several benefits will be payable for one accident or sickness, it must state the largest of the benefits will be payable (fixed indemnity basis only allowed for blanket sickness)		
G8.	§15-110(d)	Required exclusion for Prohibited Practitioner Referral		
G9.	§15-309	Direct Payment of Hospital or Medical Services		
G10.	§15-1005(g)	Payment of Interest on Unpaid Claims		
	COMAR 31.15.10	Payment of Claims, Unfair Trade Practices		
G11.	COMAR 31.10.01.03R	Notice of Premium Increase at Renewal		
G12.	§27-216; MIA Bulletin17-10	Requirements for acceptance of credit cards for premium payment and charging of fees for use of credit cards.		

G13.	MIA Bulletin 21-24; Consolidated Appropriations Act of 2021 and interim final regulations issued by the Department of HHS, under 45 CFR Parts 144, 147, 149, and 156	• Coverage of emergency services • Cost-sharing, payment and balance billing protections for emergency services, and air ambulance services		
G14.	§ 15-862, House Bill 1086, Chapter 683, Acts of 2025 (effective January 1, 2026)	Time Limitations on Anesthesia Prohibited		
G15.	§ 27-209, Senate Bill 725, Chapter 38, Acts of 2023	Value Added Services/ Non Insurance Benefits		
G16.	§ 12-211, House Bill 1069, Chapter 396, Acts of 2025 (effective October 1, 2025).	Discretionary Clauses Prohibited		
G17.	§ 12-201	Insurable Interest Required		

H. Prohibited Provisions, Limitations and Exclusions

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
H1.	COMAR 31.10.01.03N	Damage to Conveyance		
H2.	COMAR 31.10.01.03O	Chronic or Organic Disease		
H3.	COMAR 31.10.01.03I	Frequency of Physician Visits		
H4.	COMAR 31.10.01.03P	Reimbursement Language		
H5.	COMAR 31.10.01.03Q	Strict Compliance Language		
H6.	COMAR 31.11.10.06A	May not limit or exclude loss due to insured's commission of or attempt to commit a crime.		
H7.	COMAR 31.11.10.06B	May not limit or exclude loss to which a contributing cause was the insured's being engaged in an illegal occupation.		
H8.	COMAR 31.11.10.06C	May not limit or exclude loss due to use of intoxicants or narcotics		
	COMAR 31.11.10.06C(1)(a)	a. Sustained or contracted in consequence of the insured being intoxicated or under the influence of any drug.		
	COMAR 31.11.10.06C(1)(b)	b. Due to the use of alcohol		

	COMAR 31.11.10.06C(1)(c)	c. Due to the use of drugs or narcotics		
	COMAR 31.11.10.06C(1)(d)	d. Due to alcoholism or drug addiction		
H9.	COMAR 31.11.10.07C	Arbitration provision may not require insured or policyholder to use arbitration to settle disputes with insurer.		
H10.	COMAR 31.11.10.06D	Pre-existing Conditions, limitations or exclusions		
H11.	COMAR 31.04.17.10B	Good Health Warranty not permitted		
H12.	§15-711(b)	Physical Therapist Time Limitations		
H13.	§15-104(c)	May not coordinate against guaranteed renewable individual intensive care or specified disease policies.		
H14.	§15-104(d)	May not provide benefits that are secondary to benefits under an automobile policy, including PIP		
H15.	§15-126	May not discourage or prohibit access to the 911 emergency system		
H16.	§15-1009	Denial of Reimbursement for Pre-authorized care prohibited except for limited reasons.		
H17.	§27-303; MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges Prohibited		
H18.	§27-504; 26 CFR §54.98021(b)(2)(iii)	Prohibited Discrimination on Domestic Violence Victims		
H19.	COMAR 31.04.17.11B	Self-Destruction		
H20.	§15-602	State Hospitals, etc. Charitable or Otherwise		
H21.	§15-505	House Confinement, Medical Treatment Permitted Elsewhere		
H22.	§15-502	No Reduction for Medical Assistance Program		
H23.	§15-503	May not deny, cancel, or refuse to renew coverage because insured has been exposed to diethylstilbestrol		
H24.	COMAR 31.04.17.07	Advertising Prohibited		
H25.	§15-716, House Bill 1151, Chpt. 301, Acts of 2023 (amended effective 01/01/24); §15-701	May not exclude coverage for licensed pharmacists providing patient assessment regarding and in administering self-administered medications or maintenance injectable medications when acting within lawful scope of practice		

	§15-716, House Bill 1151,Chpt. 301, Acts of 2023 (amended effective 01/01/24)	• May not condition on whether pharmacist is employed by a physician, pharmacy, or facility or acting under physician's order		

I. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	COMAR 31.11.10.03	Required Standard Provisions		
I2.	COMAR 31.11.10.04A	Entire Contract		
I3.	COMAR 31.11.10.04C	Notice of Claim		
I4.	COMAR 31.11.10.04D	Claim Forms		
I5.	COMAR 31.11.10.05C	Proofs of Loss		
	§15-1005(e)	a. For contracts that provide direct reimbursement to a provider, must include a statement that providers have 180 days from date of service to submit claim for payment.		
	§15-1011	b. Methods for Claim Submission		
I6.	COMAR 31.11.10.05D	Time of Payment of Claims		
I7.	COMAR 31.11.10.04G	Payment of Claims		
I8.	COMAR 31.11.10.04H	Legal Action		
I9.	COMAR 31.11.10.04I	Grace Period		
I10.	COMAR 31.11.10.04L	Misstatement of Age		
I11.	COMAR 31.11.10.05B; §15-207	Statements in Policyholder Application		

J. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	COMAR 31.11.10.07A	Physical Examination		
J2.	COMAR 31.11.10.07B	Autopsy		
J3.	COMAR 31.11.10.07C	Arbitration		

K. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	§15-10A-02(k)	Grievance Procedure Not Included. Please advise where grievance information is provided		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-1001; Title 15, Subtitle 10B COMAR 31.10.18	• Company not certified as Private Review Agent (PRA) in Maryland		
	§15-1001; Title 15, Subtitle 10B; COMAR 31.10.18; §15-10A-02	• Identify Company' PRA for making utilization review determinations of what health care service is medically necessary, experimental or investigative, or cosmetic.		
K2.	§15-10B-05(a)(4)	Utilization review agent must be reasonably available 7 days a week, 24 hours a day		
K3.	§15-142(e)	May not require prior authorization on certain cancer drugs		
K4.	§15-850	May not require prior authorization for a covered opioid antagonist unless at least one formulation of the opioid antagonist is covered without a prior authorization requirement.		
K5.	§15-851	May not require prior authorization for a prescription drug containing methadone, buprenorphine, or naltrexone when the drug is used for treatment of an opioid use disorder.		
K6.	§ 15-861, House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026)	Transfers to Special Pediatric Hospitals - Prior Authorizations		
	§ 15-861 (c), House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026).	• For contracts that require prior authorization for hospital admissions, must include an exception for the transfer of a patient to a special pediatric hospital.		
	§ 15-861 (a), House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026).	• Definition for "special pediatric hospital" required if prior authorization is required.		
K7.	§12-205(b)	May not require preauthorization for emergency care on non-network emergency services that are not imposed in-network		
K8.		Initial authorization of course of treatment made:		

	§15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		
	§15-10B-06(a)(1)(ii)	b. For extended stays or 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 1/1/25)	c. For additional visits or days of care as part of existing treatment, within 1 working day of receipt of necessary information		
	§15-10B-06(a)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	d. After receipt of initial request, if more information is necessary to make decision, inform provider no more than 3 calendar days following initial request of the need for more information		
	§15-10B-06(b), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	e. For emergency inpatient or residential crisis services admissions for the treatment of a mental, emotional, or substance abuse disorder, within 2 hours of receipt of the necessary information		
	§ 15-10B-06(c), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	f. For step therapy exception request submitted electronically, make determination in real time if no additional information is needed and request meets the PRA's criteria for approval		
K9.		For emergency course of treatment or healthcare service:		
	§ 15-10B-06(d)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	a. Make initial determination within 24 hours after initial request for necessary information		
	§ 15-10B-06(d)(1)(ii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	b. If additional information is needed, PRA must promptly request information and no later than 2 hours after receipt of information notify provider of determination		
	§ 15-10B-06(d)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	c. Circumstances PRA shall initiate expedited procedure for emergency case		
K10.	§15-10B-06(e), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	PRA fails to make determination, course of treatment is deemed approved		

K11.	§15-10A-02(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	For non-emergency, 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.		
	§15-10A-02(f)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• A carrier may, but is not required, to use an alternative method of communication, with the consent of the member, member's representative, or provider.		
K12.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services.		
K13.	§ 15-10B-06(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	If provider requests immediate reconsideration of denial, must give decision by telephone within 24 hours of request.		
	§ 15-10B-06(f)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• Must provide additional contact information if physician is unable to immediately speak with provider		
K14.	§ 15-10B-06(g), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	May not deny authorization for inpatient emergency care on basis of late notification from the hospital, if patient's condition prevented the hospital from knowing insurance status or emergency notice process.		
K15.	§ 15-10B-06(h), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	Involuntary or voluntary psychiatric admission of patient in danger – may not deny care during the first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission		

L. Applications

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
L1.	§15-308(a)	May not require individual covered under blanket health insurance policy to complete an individual application.		
		Master Application		
L2.	COMAR 31.04.17.06I(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier.		
L3.	COMAR 31.04.17.06A	Policyholder's application shall stipulate the plan and amount of insurance and any added optional benefits applied for.		
L4.	§27-805; MIA Bulletin 12-07	Insurance Fraud-required Disclosure Statement		

L5.	§12-207	Statements in Policyholder's Application		
L6.	COMAR 31.04.17.08	Proxy		
L7.	COMAR 31.04.17.10B	Good health warranty not permitted		
L8.	COMAR 31.04.17.06B	Certain States		