# TITLE 24. INSURANCE



## Cross References

For disposition of repealed provisions, see Insurance Law Revision reference table (1987) at end of chapter 435.
Service contracts, see chapter 481X.

## CHAPTER 431 [OLD]
## THE HAWAII INSURANCE LAW

**REPEALED.** L 1987, c 347, §1.

## Cross References

For disposition of repealed provisions, see Insurance Law Revision reference table (1987) at end of chapter 435.

## CHAPTER 431
## INSURANCE CODE

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# ARTICLE 1
# DEFINITIONS

## PART I. GENERAL PROVISIONS

**§431:1-100 Short title.** This chapter shall be known and may be cited as the Insurance Code. [L 1987, c 347, pt of §2]

**§431:1-100.5 Purpose.** The legislature hereby declares that the purpose of this chapter is to recodify, without substantive change, the insurance law in effect immediately prior to July 1, 1988. [L 1987, c 347, pt of §2]

**Revision Note**

"July 1, 1988" substituted for "the effective date of this chapter".

**§431:1-101 Compliance required.** No person shall transact a business of insurance in this State without complying with the applicable provisions of this code. Any person transacting a business of insurance under chapter 432 shall be subject to this code only to the extent provided in chapter 432. [L 1987, c 347, pt of §2]

**§431:1-102 Public interest.** The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception and practice honesty and equity in all insurance matters. Upon the insurer, the insured and their representatives rests the duty of preserving inviolate the integrity of insurance. [L 1987, c 347, pt of §2]

**§431:1-103 Headings.** The meaning or scope of any provision is not affected by any heading. [L 1987, c 347, pt of §2]

**§431:1-104 Particular provisions prevail.** Provisions of this code relating to a particular class of insurance or a particular type of insurer or to a particular matter prevail over provisions relating to insurance in general or insurers in general or to such matter in general. [L 1987, c 347, pt of §2]

**Case Notes**

Mentioned: 95 F.3d 791; 795 F. Supp. 1036.

**§431:1-105 Records, statements and reports.** (a) All records, statements and reports required or authorized by this code shall be made in writing in the English language.

(b) All statements, estimates, percentages, payments, and calculations required or authorized by this code shall be made on the basis of the lawful money of the United States. [L 1987, c 347, pt of §2]

## PART II. GENERAL DEFINITIONS

**§431:1-201 Insurance defined.** (a) Insurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies.

(b) The following contracts are not considered to be insurance for the purposes of this code:

(1) A bond with respect to which no premium is charged or paid;

(2) A bond or contract or undertaking in the performance of which the surety has an interest other than that of surety;

(3) A plan or agreement between an employer and any employee or the employee's representative, individually or collectively, by the terms of which the employer or the parties to the plan or agreement agree to contribute to the cost of nonoccupational disability benefits, medical attention, treatment or hospitalization for the employee or members of the employee's family unless such plan is underwritten by an insurer as defined in this article;

(4) A legal service plan as defined in chapter 488 other than plans in which either the person or entity offering the plan or the person administering the plan is otherwise subject to this code;

(5) Any unincorporated interindemnity or reciprocal or interinsurance contract, which qualifies under chapter 435E between members of a cooperative corporation, whose members consist only of physicians and surgeons licensed in Hawaii, which contracts indemnify solely in respect to medical malpractice claims against such members, and which do not collect in advance of loss any moneys other than contributions by each member to a collective reserve trust fund or for necessary expenses of administration. [L 1987, c 347, pt of §2; am L 2012, c 34, §22]

**Case Notes**

Materialman guaranteeing general contractor's performance through surety bond did not have an interest in the performance of the bond other than that of surety. 797 F. Supp. 832.

When the uncontested requirements of the managed care plan request for proposals were read alongside the text of subsection (a) defining the term "insurance", it was clear that the insurers had agreed to assume a

risk based on a relationship with plan members--not the department of human services--and were "undertaking to indemnify another or pay a specified amount upon determinable contingencies"; thus, insurers were not performing their plan contracts under no licensing authority but held licenses pursuant to article 431:10A and were contracted to provide insurance services for plan members. 126 H. 326, 271 P.3d 621 (2012).

Vehicle theft registration system sold by car dealership did not constitute "insurance" where the system warranted against the "defect" that the system would fail to deter a theft and fail to aid in the recovery of the owner's vehicle, and did not warrant against the fortuitous happening of the theft itself. 122 H. 181 (App.), 223 P.3d 246 (2009).

**§431:1-202 Insurer defined.** Insurer means every person engaged in the business of making contracts of insurance and includes reciprocal or interinsurance exchanges. [L 1987, c 347, pt of §2]

**Attorney General Opinions**

The State did not meet definition of insurer in this section. Att. Gen. Op. 95-2.

**§431:1-203 Classes of insurance.** For the purposes of this code, the classes of insurance are: life insurance (including industrial and group life insurance) as defined in section 431:1-204; accident and health or sickness insurance, also referred to as disability insurance (including group disability insurance), as defined in section 431:1-205; property insurance as defined in section 431:1-206; marine and transportation insurance as defined in section 431:1-207; vehicle insurance as defined in section 431:1-208; general casualty insurance as defined in section 431:1-209; surety insurance as defined in section 431:1-210; and such other classes as may be authorized by law. [L 1987, c 347, pt of §2; am L 2002, c 155, §4]

**§431:1-204 Life insurance defined.** (a) Life insurance is insurance on human lives and insurance appertaining thereto or connected therewith.

(b) For the purposes of this code, the transacting of life insurance includes contracting to provide additional benefits in the event of death or dismemberment by accident or accidental means, or in the case of total and permanent disability of the insured, further includes effecting optional modes of settlement of proceeds.

(c) For the purposes of this code, the transacting of life insurance includes the granting of annuities and endowment benefits, except for annuities that are provided under a charitable gift annuity agreement with a donor and issued by a nonprofit educational foundation or a nonprofit organization that has met the requirements of paragraphs (1) to (4).

A nonprofit educational foundation or nonprofit organization issuing charitable gift annuities shall:

(1) Meet the following requirements:

(A) The foundation or organization shall have conducted

business in the form of program services or fundraising activities in the State continuously for at least ten years;

(B) The foundation or organization shall maintain a net worth in the State of not less than $200,000 in cash, cash equivalents, or publicly traded securities, exclusive of the assets funding any annuity; and

(C) The foundation or organization shall have filed an annual statement that certifies compliance with this subsection, on forms that may be prescribed by the department of the attorney general. Each foundation or organization shall file its annual statement with the attorney general on or before March 15 of each year;

(2) Maintain segregated assets in a financial institution equal to at least the sum of the reserves on its outstanding charitable gift annuity agreements, calculated in accordance with mortality tables and discount rates to be determined by the commissioner of insurance, and a surplus of ten per cent of the reserves or the amount of $100,000, whichever is higher. The assets shall be segregated as separate and distinct funds independent of all other funds and shall not be applied toward the payment of the debts and obligations of the foundation or organization, other than with respect to the annuity agreements. The segregated assets shall not be considered in determining whether the foundation or organization meets the net worth requirement of paragraph (1)(B). In determining the fund reserves, a deduction shall be made, and no surplus shall be required, for all or any portion of an annuity risk that is lawfully reinsured by an authorized insurer;

(3) Invest and manage assets as would a prudent investor, taking into account the purposes, terms, and distribution requirements expressed in its governing instrument. To satisfy this standard, the fiduciary shall exercise reasonable care, skill, and caution; and

(4) Prominently state on the first page of a charitable gift annuity agreement that the agreement is not insurance under the laws of the State, is not subject to regulation by the insurance division, and is not protected by any state guaranty fund.

Upon the failure of a nonprofit educational foundation or nonprofit organization to comply with any of the requirements of paragraphs (1) to (4), a charitable gift annuity agreement issued by the foundation or organization shall be deemed life insurance and subject to the provisions of this code governing life insurance.

For the purposes of this subsection:

"Charitable gift annuity agreement" means a contract under which an individual transfers property to a charity, conditioned upon the right to receive a specific sum of money for life.

"Nonprofit organization" means an organization that has been granted tax exempt status as a charitable organization by the Internal Revenue Service pursuant to section 501(c)(3) of the Internal Revenue Code of 1986, as amended. [L 1987, c 347, pt of §2; am L 1989, c 91, §1; am L 1994, c 127, §1; am L 2004, c 172, §1; am L 2005, c 136, §1]

**§431:1-205 Accident and health or sickness insurance defined.** Accident and health or sickness insurance, also referred to as disability insurance, is insurance against bodily injury, disablement, or death by accident, or accidental means, or the expense thereof; against disablement or expense resulting from sickness; and every insurance appertaining thereto, including health and medical insurance. [L 1987, c 347, pt of §2; am L 2002, c 155, §5]

**§431:1-206 Property insurance defined.** Property insurance is

insurance against loss of or damage to real or personal property of every kind and any interest therein, from any or all hazard or cause and against loss consequential upon such loss of or damage. An inclusion within other defined classes of insurance of the right to insure against certain designated perils to real or personal property shall not be deemed a diminution of the definition of property insurance. [L 1987, c 347, pt of §2]

**Cross References**

Hawaii hurricane relief fund, see chapter 431P.

**§431:1-207 Marine and transportation insurance defined.** Marine and transportation insurance is:

(1) Insurance against any and all kinds of loss of or damage to:

(A) Vessels, craft, aircraft, cars, automobiles, and vehicles of every kind, as well as all goods, freights, cargoes, merchandise, effects, disbursement, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests, and all other kinds of property and interests therein, in respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment, or reshipment incident thereto, including marine builder's risks and all personal property floater risks;

(B) Person or to property in connection with or appertaining to a marine, inland marine, transit, or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of such insurance (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles);

(C) Precious stones, jewels, jewelry, gold, silver, and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise; and

(D) Bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, and civil commotion are the only hazards to be covered; piers, wharves, docks, and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, and civil commotion; other aids to navigation and transportation, including drydocks and marine railways, against all risks.

(2) Marine protection and indemnity insurance, meaning insurance against, or against legal liability of the insured for, loss, damage or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person. [L 1987, c 347, pt of §2]

**§431:1-208 Vehicle insurance defined.** (a) Vehicle insurance is insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, and against any loss, expense or liability for loss or damage to persons or property resulting from or incident to ownership, maintenance, or use of any such vehicle or aircraft or animal.

(b) Insurance against accidental death or accidental injury to individuals including the named insured while in, entering, alighting from, adjusting, repairing, cranking, or caused by being struck by a vehicle, aircraft, or draft or riding animal, if such insurance is issued as part of insurance on the vehicle, aircraft, or draft or riding animal, shall be deemed to be vehicle insurance. [L 1987, c 347, pt of §2]

**§431:1-209 General casualty insurance defined.** General casualty insurance includes vehicle insurance as defined in section 431:1-208, and accident and health or sickness insurance as defined in section 431:1-205 when issued as an incidental coverage with or supplemental to liability insurance. In addition, general casualty insurance is insurance:

(1) Against legal liability for the death, injury, or disability of any human being, or from damage to property;

(2) Of medical, hospital, surgical, and funeral benefits to persons injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury, or disability of human beings;

(3) Of the obligation accepted by, imposed upon, or assumed by employers under law for death, disablement, or injury to employees;

(4) Against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, or wrongful conversion, disposal, or concealment, or from any attempt of any of the foregoing; also insurance against loss or damage to moneys, coins, bullion, securities, notes, drafts, acceptances, or any other valuable papers or documents, resulting from any cause, except while in the mail;

(5) Upon personal effects of individuals, by an all-risk type of policy commonly known as the personal property floater;

(6) Against loss or damage to glass and its appurtenances resulting from any cause;

(7) Against any liability and loss or damage to property resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus;

(8) Against loss of or damage to any property of the insured resulting from the ownership, maintenance, or use of elevators, except loss or damage by fire;

(9) Against loss or damage to any property caused by the breakage or leakage of sprinklers, water pipes, or containers, or by water entering through leaks or openings in buildings;

(10) Against loss or damage resulting from failure of debtors to pay their obligations to the insured (credit insurance);

(11) Against loss of or damage to any domesticated or wild animal resulting from any cause (livestock insurance);

(12) Against loss of or damage to any property of the insured resulting from collision of any other object with such property, but not including collision to or by vessels, craft, piers, or other instrumentalities of ocean or inland navigation (collision insurance);

(13) Against legal liability of the insured, and against loss, damage, or expense incident to a claim of such liability, and including any obligation of the insured to pay medical, hospital, surgical, and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death or injury of any person, or arising out of injury to the economic interest of any person as the result of negligence in rendering expert, fiduciary, or professional service (malpractice insurance);

(14) Against any contract of warranty or guaranty which promises service maintenance, parts replacement, repair, money, or any other indemnity in the event of loss of or damage to a motor vehicle or any part thereof from any cause, including loss of or damage to or loss of use of the motor vehicle by reason of depreciation, deterioration, wear and tear, use, obsolescence, or breakage if made by a warrantor or guarantor who or which as such is doing an insurance business; provided that service contracts, as defined and meeting the requirements of chapter 481X, shall not be subject to chapter 431.

The doing or proposing to do any business in substance equivalent to the business described in this section in a manner designed to evade the provisions of this section is the doing of an insurance business; and

(15) Against any other kind of loss, damage, or liability properly the subject of insurance and not within any other class or classes or type of insurance as defined in sections 431:1-204 to 431:1-211, if such insurance is not contrary to law or public policy. [L 1987, c 347, pt of §2; am L 2000, c 221, §3; am L 2002, c 155, §6; am L 2003, c 212, §14; am L 2014, c 186, §4]

**§431:1-210 Surety insurance defined.** Surety insurance includes:

(1) Bail bond insurance, which is a guarantee that any person, in or in connection with any proceedings in any court, will:

(A) Attend in court when required, or
(B) Will obey the orders of judgment of the court, as a condition to the release of the person from confinement, and the execution of bail bonds for any such purpose. The making of property or cash bail does not constitute the transacting of bail bond insurance.

(2) Fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust.

(3) Guaranteeing the performance of contracts and guaranteeing and executing bonds, undertakings and contracts of suretyship.

(4) Indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss resulting from any cause of bills of exchange, notes, bonds, securities, evidences of debts, deeds, mortgages, warehouse receipts, or other valuable papers, documents, money, precious metals, and articles made therefrom, jewelry, watches, necklaces, bracelets, gems, precious and semiprecious stones, including any loss while the same are being transported in armored motor vehicles, or by messenger, but not including any other risks of transportation or navigation; also against loss or damage to such insured's premises, or to the insured's furnishings, fixtures, equipment, safes, and vaults therein, caused by burglary, robbery, theft,

vandalism, or malicious mischief, or any attempted burglary, robbery, theft, vandalism, or malicious mischief.

(5) Forgery insurance. [L 1987, c 347, pt of §2]

**§431:1-211 Ocean marine insurance defined.** Ocean marine insurance (although not a class of insurance as named in section 431:1-203), whenever the term is used in this code, means insurance:

(1) Upon vessels, crafts, hulls, and of interests therein, or with relation thereto;

(2) Of marine builders' risks, marine war risks and contracts of marine protection and indemnity insurance;

(3) Of freights and disbursements pertaining to a subject of insurance coming within this definition;

(4) Of personal property and interests therein, in course of movement into or out of this State or among the islands of this State, or in course of exportation from or importation into any country, or in course of transportation coastwise, including transportation by land, water, or air from point of origin to final destination, in respect to, appertaining to, or in connection with, any risk or peril of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, storage, transshipment, or reshipment incident thereto. [L 1987, c 347, pt of §2]

**§431:1-212 Person defined.** Person means any individual, company, insurer, association, organization, group, reciprocal or interinsurance exchanges, partnership, business, trust, or corporation. [L 1987, c 347, pt of §2]

**§431:1-213 State defined.** State means any state of the United States and the governments of Puerto Rico, American Samoa, Guam, the Northern Mariana Islands, the United States Virgin Islands, and the District of Columbia. [L 1987, c 347, pt of §2; am L 1997, c 233, §2; am L 2011, c 68, §2]

**§431:1-214 United States defined.** United States, when used to signify a place, means the states of the United States and the governments of Puerto Rico, American Samoa, Guam, the Northern Mariana Islands, the United States Virgin Islands, and the District of Columbia. [L 1987, c 347, pt of §2; am L 1997, c 233, §3; am L 2011, c 68, §3]

**§431:1-215 Transaction of an insurance business.** Transaction of an insurance business means any of the following acts in this State effected by mail or otherwise by or on behalf of an insurer. The venue of an act committed by mail is at the point where the matter transmitted by mail is delivered and takes effect. Unless otherwise indicated, the term insurer as used in this definition includes all corporations, associations, partnerships, and individuals, engaged as principals in the business of insurance and also includes reciprocal insurers.

(1) The making of or proposing to make, as an insurer, an insurance contract;

(2) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(3) The taking or receiving of any application for insurance;

(4) The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof;

(5) The issuance or delivery of contracts of insurance to residents of this State or to persons authorized to do business in this State;

(6) The transaction of any kind of insurance business specifically recognized as transacting an insurance business under this code; or

(7) The transacting or proposing to transact any insurance business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this code. [L 1987, c 347, pt of §2]

**§431:1-216 General business practice.** General business practice means an established measure or model practiced or used at least three times in one calendar year in the general business community. [L 1987, c 349, §1]

**[§431:1-217] Insurance policies issued to construction professionals.** (a) For purposes of a liability insurance policy that covers occurrences of damage or injury during the policy period and that insures a construction professional for liability arising from construction-related work, the meaning of the term "occurrence" shall be construed in accordance with the law as it existed at the time that the insurance policy was issued.

(b) Notwithstanding any other provision to the contrary, this section shall apply to surplus lines insurance as defined by section 431:8-102.

(c) Any provision of an insurance policy issued in violation of this section shall be void and unenforceable as against public policy.

(d) This section shall apply to all liability insurance policies issued and in effect as of [June 3, 2011].

(e) For purposes of this section:

"Construction professional" means a person, sole proprietorship, partnership, corporation, limited liability corporation, or other entity that engages in an activity intended to assist in the development, construction, or repair of an improvement to real property, including a contractor licensed pursuant to chapter 444, a building owner, or a developer of a project regardless of whether the person or entity maintains a professional license.

"Liability insurance policy" means a contract of insurance including an owner-controlled, contractor-controlled, or other similar pooled insurance program that covers occurrences of damage or injury during the policy period and that insures a construction professional for liability arising from construction-related work. [L 2011, c 83, §2]

**Case Notes**

Subsection (a) required that commercial general liability umbrella policies in question, issued by plaintiff insurers in 2007, be interpreted under the law as it existed in 2007; even if this statute

ostensibly nullified the Hawaii intermediate court of appeals' decision in Group Builders by "restoring" pre-Group Builders law, the statute did not purport to nullify any decision preceding Group Builders; thus, the policies in issue continued to fall under the Ninth Circuit's 2004 analysis in Burlington. 870 F. Supp. 2d 1015 (2012).

Pursuant to subsection (a), the court could not construe the meaning of the term "occurrence" based on the holding in Group Builders because the case was decided on May 19, 2010, and was not in existence when plaintiff issued the general liability insurance policies, the most recent of which took effect on January 18, 2010. The operative case law was that which existed at the time plaintiff issued the first policy, which took effect on November 11, 2002. 891 F. Supp. 2d 1179 (2012).

Cited: 955 F. Supp. 2d 1121 (2013).

Mentioned: 829 F. Supp. 2d 914 (2011).

## ARTICLE 2
## ADMINISTRATION OF INSURANCE LAWS

### PART I. INSURANCE DIVISION

**§431:2-101 Insurance division.** The insurance division is established within the department of commerce and consumer affairs. [L 1987, c 347, pt of §2]

**§431:2-102 Insurance commissioner.** (a) The insurance division shall be under the supervision and control of an administrator who shall be known as the insurance commissioner. The director of commerce and consumer affairs shall, with the approval of the governor, appoint the insurance commissioner who shall not be subject to chapter 76. The insurance commissioner shall hold the insurance commissioner's office at the pleasure of the director of commerce and consumer affairs and shall be responsible for the performance of the duties imposed upon the division.

(b) Commissioner, where used in this code, means the insurance commissioner of this State. [L 1987, c 347, pt of §2; am L 2000, c 253, §150]

**§431:2-103 Salary.** The salary of the commissioner shall be set by the director of commerce and consumer affairs but shall not be more than the maximum salary of first deputies to department heads. [L 1987 c 347, pt of §2]

**Cross References**

Salary of deputies or assistants, see §26-53.

**§431:2-104 Seal.** The official seal of the commissioner shall be a vignette of King Kamehameha I, with the words "Insurance Commissioner, State of Hawaii" surrounding the vignette. Any certificate or license issued by the commissioner shall bear the commissioner's official seal. [L 1987, c 347, pt of §2]

**§431:2-105 Deputies, employees.** (a) There shall be a chief deputy commissioner, who shall be subject to chapter 76. The chief deputy commissioner shall have the power to perform any act or duty assigned by the commissioner. If a commissioner has not been appointed, the chief deputy commissioner shall have the power to perform any act that the commissioner is authorized to perform until an appointment becomes effective. The certificate of the chief deputy commissioner's appointment shall be filed in the office of the lieutenant governor.

(b) There may be additional deputy commissioners and examiners and actuarial, technical, and administrative assistants and clerks for such purposes as the commissioner may designate. All of the positions shall be subject to chapter 76.

(c) The commissioner may appoint a senior rate and policy analyst who shall not be subject to chapter 76.

(d) The commissioner shall be responsible for the official acts of the commissioner's deputies and employees.

(e) The commissioner may require any employee to be bonded as the commissioner deems proper. The cost of the bond shall be borne by the State. [L 1987, c 347, pt of §2; am L 1988, c 363, §2(1); am L 1999, c 246, §1; am L 2000, c 253, §150; am L 2006, c 48, §7; am L 2011, c 81, §1]

**§431:2-105.5 Staff.** There are established within the insurance division of the department of commerce and consumer affairs six positions for technical staff, and three positions for clerical staff, necessary to enable the State to meet and maintain National Association of Insurance Commissioners accreditation standards. These positions shall not be subject to chapter 76. [L 1993, c 321, §1; am L 1999, c 163, §10; am L 2000, c 253, §150]

**§431:2-106 Ethical requirements for insurance division staff.** The commissioner, deputies and employees of the insurance division shall not represent, be employed by, own any securities of, be a creditor of, or be financially interested in any other manner in, any insurer authorized to do business in this State, or in any insurance agency in this State, except that the commissioner, or any deputy or employee, may be a policyholder or obligee of any such insurer. [L 1987, c 347, pt of §2]

**§431:2-107 Workers' compensation rate analysis.** There shall be established within the insurance division a unit to assist the commissioner in workers' compensation insurance rate-filing and rate-making proceedings under article 14. The commissioner may employ or contract actuaries, accountants, investigators, clerks, stenographers, and other assistants who shall not be subject to chapter 76. [L 1987, c 347, pt of §2; am L 2000, c 253, §150]

**Cross References**

Limitation on charges, see §431:10C-308.5.

**§431:2-108 Commissioner may delegate.** Any power, duty, or function vested in the commissioner by this code may be exercised, discharged, or performed by any employee of the department of commerce and consumer

affairs acting in the name and by the delegated authority of the commissioner, with the approval of the director of the department of commerce and consumer affairs. [L 1987, c 347, pt of §2]

**§431:2-109 Supplies, convention blanks.** The commissioner shall purchase at the expense of this State and in the manner provided by law:

(1) Printing, books, reports, furniture, equipment, and supplies as the commissioner deems necessary to the proper discharge of the commissioner's duties under this code.

(2) Convention form insurers' annual statement blanks, which the commissioner may purchase from any printer manufacturing the forms for the various states. [L 1987, c 347, pt of §2]

**§431:2-110 Offices.** The commissioner shall have an office at Honolulu, and may maintain such offices elsewhere in this State as the commissioner may deem necessary. [L 1987, c 347, pt of §2]

## PART II. POWERS AND DUTIES OF COMMISSIONER

### Note

Annual study and report to 2017-2021 legislature by insurance commissioner on impact of L 2016, c 236 (regarding transportation network companies) on personal motor vehicle insurance policy rates in the State (repealed September 1, 2021). L 2016, c 236, §§3, 6.

State innovation waiver task force; health care reform plan; reports to 2015-2017 legislature (dissolved June 30, 2017). L 2014, c 158; L 2015, c 184.

**§431:2-201 General powers and duties.** (a) The commissioner shall have the authority expressly conferred upon the commissioner by or reasonably implied from the provisions of this code.

(b) The commissioner shall execute the commissioner's duties and shall enforce this code.

(c) The commissioner may:

(1) Make reasonable rules for effectuating any provision of this code, except those relating to the commissioner's appointment, qualifications, or compensation. The commissioner shall adopt rules to effectuate article 10C of chapter 431, subject to the approval of the governor's office and the requirements of chapter 91;

(2) Conduct examinations and investigations to determine whether any person has violated any provision of this code or to secure information useful in the lawful administration of any provision;

(3) Require applicants to provide fingerprints and pay a fee to allow the commissioner to make a determination of license eligibility after obtaining state and national criminal history record checks from the Hawaii criminal justice data center and the Federal Bureau of Investigation; and

(4) Require, upon reasonable notice, that insurers report any claims information the commissioner may deem necessary to protect the public interest. [L 1987, c 347, pt of §2; am L 1998, c 275, §12; am L 2003, c 212, §15; am L 2009, c 77, §13]

## Attorney General Opinions

The division will be responsible for enforcement of health insurance provisions of the reciprocal beneficiaries act [L 1997, c 383], because those provisions are placed within the insurance code and, therefore, are within the commissioner's enforcement responsibility under subsection (b); those provisions can only be enforced against insurers, not employers. Att. Gen. Op. 97-10.

## Case Notes

Commissioner's rulemaking authority enabled commissioner to adopt procedural mechanism, i.e., peer review process, through which guidelines for service provider fees and frequency of treatment may be exceeded. 927 F. Supp. 1330.

**[§431:2-201.2] Standards for commissioner.** When reviewing a uniform standard, the commissioner shall consider the following standards in determining whether to opt out of a uniform standard:

(1) Whether the public interest is being served or protected;

(2) Whether the reasonable expectations of the consumer will be met;

(3) Whether the uniform standard is or will require a reasonably clear, plain English communication to the consumer;

(4) Whether the consumer will be protected in a typical transaction where the consumer may have less power, information, or understanding of the meaning or consequences of the transaction, or any part thereof, than the insurer or producer;

(5) The long-term effects of the uniform standard;

(6) The possible effects of the uniform standard on the financial condition of insurers;

(7) Confidentiality requirements in state or federal law;

(8) State and federal constitutional issues;

(9) The impact of the uniform standard on any provision of the insurance code or any state or federal law;

(10) The uniform standard's particular impact in the State and any conditions unique to the State; and

(11) The integration of the uniform standard with state or federal law and any possible conflicts with such laws. [L 2004, c 104, §3]

**[§431:2-201.3 Criminal convictions; consent to engage in business.]** (a) Any person who is engaged in the business of insurance or who is about to engage in the business of insurance in this State and who has been convicted of any felony shall request the commissioner's written consent to engage in the business of insurance.

(b) After receipt of the request, the commissioner, in writing, may:

(1) Consent to the person engaging in the business of insurance;

(2) Provide a limited consent; or

(3) Deny the individual the privilege of engaging in the business of insurance.

(c) Any person who fails to submit the request as required by this section and who engages in the business of insurance without the written consent of the commissioner shall be in violation of this chapter and subject to the fines and penalties provided under this chapter.

(d) The commissioner may prescribe the format and content of the form used to request the commissioner's written consent to engage in the business of insurance. [L 2000, c 73, §1]

**§431:2-201.5 Conformity to federal law.** (a) The provisions of title 42 United States Code section 300gg, et seq., as they relate to group and individual health insurance shall apply to title 24, except:

(1) Where state law provides greater health benefits or coverage than title 42 United States Code section 300gg, et seq., state law shall be applicable; and

(2) This section shall not apply to or affect life insurance, endowment, or annuity contracts, or any supplemental contract thereto, described in section 431:10A-101(4).

(b) The following definitions shall be used when applying title 42 United States Code section 300gg, et seq.:

"Employee" means an employee who works on a full-time basis with a normal workweek of twenty hours or more.

"Group health issuer" means all persons offering health insurance coverage to any group or association, but shall not include those persons offering benefits exempted from title I of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, under sections 732(c) and 733(c) of title I of the Employee Retirement Income Security Act of 1974 and sections 2747 and 2791(c) of the Public Health Service Act.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but no more than fifty employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

(c) All group health issuers shall offer all small group health plans to all small employers whose employees live, work, or reside in the group health issuer's service areas; provided that the commissioner may exempt a group health issuer if the commissioner determines that the group health issuer does not have the capacity to deliver services adequately to enrollees of additional groups given its obligation to existing employer groups; and provided further that the commissioner shall exempt from this subsection group health plans offered to small employers that employ only one employee, if the group health issuer offers the small employer groups at least one small group health plan that meets the requirements of chapter 393, and upon the determination by the commissioner that the group health issuer has the capacity to adequately deliver services to enrollees of the additional groups, subject to its obligations to existing employer groups.

(d) A group health issuer shall be prohibited from imposing any preexisting condition exclusion.

(e) The commissioner may adopt rules to implement, clarify, or

conform title 24 to title 42 United States Code section 300gg, et seq.

(f) The adoption of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, for the purposes of title 24 is not an adoption for any purposes for income taxes under chapter 235.

(g) The State shall have jurisdiction over any matter that title 42 United States Code section 300gg, et seq., permits, including jurisdiction over enforcement.

(h) As used in this section, "small group health plans" means the medical plans currently offered, advertised, or marketed by a group health issuer for small employers. [L 1997, c 291, §2; am L 1999, c 93, §5; am L 2000, c 151, §1; am L 2001, c 55, §19; am L 2004, c 122, §2; am L 2007, c 247, §1; am L 2008, c 120, §§1, 3; am L 2009, c 11, §14; am L 2013, c 192, §4]

**[§431:2-201.8] Sales to members of the armed forces.** Pursuant to the Military Personnel Financial Services Protection Act, Pub. L. No. 109-290, the commissioner shall have the authority to adopt rules to protect service members of the United States armed forces from dishonest and predatory life insurance sales practices by declaring certain life insurance practices, identified in the rules, to be false, misleading, deceptive, or unfair. [L 2007, c 233, §2]

**§431:2-202 Orders and notices.** (a) Orders and notices of the commissioner shall not be effective unless in writing and signed by the commissioner or by a person acting under authority delegated by the commissioner pursuant to section 431:2-108.

(b) Every such order or notice shall:

(1) Contain a concise statement of the grounds upon which it is based.

(2) Designate the provisions of this code pursuant to which action is so taken or proposed to be taken.

(3) State the effective date of the order or notice.

(4) Contain other matters as may be required by section 91-12.

(c) An order or a notice may be given by delivery to the person to be ordered or notified or by mailing it, postage prepaid, and registered with return receipt requested addressed to the person at the person's residence or principal place of business as last of record in the department of commerce and consumer affairs. [L 1987, c 347, pt of §2; am L 2004, c 122, §3]

**§431:2-202.5 Approval; when deemed effective.** Except as provided otherwise, any approval required by law shall be deemed granted on the sixtieth calendar day following the filing of the request for approval if the commissioner does not take any affirmative action to grant or deny the approval within sixty calendar days of the request. [L 2000, c 264, §1; am L 2001, c 121, §1; am L 2011, c 81, §2]

**§431:2-203 Enforcement.** (a) The commissioner may prosecute an action in any court of competent jurisdiction to enforce any order or

fine made by the commissioner pursuant to any provision of this code.

(b)(1) A person who intentionally or knowingly violates, intentionally or knowingly permits any person over whom the person has authority to violate, or intentionally or knowingly aids any person in violating any insurance rule or statute of this State or any effective order issued by the commissioner, shall be subject to any penalty or fine as provided by this code or by the Penal Code of the Hawaii Revised Statutes.

(2) If the commissioner has cause to believe that any person has violated any penal provision of this code or of other laws relating to insurance, the commissioner shall proceed against that person or certify the facts of the violation to the public prosecutor of the jurisdiction in which the offense was committed.

(3) Violation of any provision of this code is punishable by a fine of not less than $100 nor more than $10,000 per violation, or by imprisonment for not more than one year, or both, in addition to any other penalty or forfeiture provided herein or otherwise by law.

(4) The terms "intentionally" and "knowingly" shall have the same meanings as defined in section 702-206(1) and (2).

(c) If any licensee doing business in this State, persistently or substantially violates this code or an order of the commissioner, and there are grounds for delinquency proceedings against such licensee, or the licensee's methods and practices in the conduct of the licensee's business endanger, or the licensee's financial resources are inadequate to safeguard, the legitimate interest of the licensee's customers or the public, the commissioner may, after a hearing, in whole or in part, suspend, place on probation, limit, or refuse to renew the license or certificate of authority pursuant to section 431:3-217 to section 431:3-221.

(d) If the commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any order of the commissioner, the commissioner may issue a cease and desist order to enforce compliance with this code or any order of the commissioner, or bring an action in any court of competent jurisdiction to enjoin the person from continuing the violation or doing any act in furtherance thereof. The commissioner shall have the discretion to include in a cease and desist order or request in an action brought in any court an assessment of a monetary penalty and restitution against any person who violates this code or who has violated an order of the commissioner.

(e) If, upon examination or at any other time, the commissioner has reasonable cause to believe that any domestic insurer requires supervision because it is in such condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if the domestic insurer gave its consent, then the commissioner may summarily proceed pursuant to section 431:15-201.

(f) The attorney general, corporation counsels, and county prosecuting attorneys, on behalf of the commissioner, shall bring an action in forfeiture against an insurer who violates any order or notice of such order issued by the commissioner. The notice shall be given to the insurer of the commissioner's intention to proceed under such order against the person who does not comply with the order issued. The order may contain this notice of intention to seek a forfeiture if the order is disobeyed. The forfeiture shall be in an amount that the court considers just, but may not exceed an amount of $10,000 for each day that the violation continues after the commencement of the action until judgment is rendered. No forfeiture may be imposed under this subsection if at the time the forfeiture action is commenced, the insurer was in compliance with the order, or if the violation of the order occurred

during the order suspension period. If, after a judgment is rendered, the insurer still does not comply with the order, the commissioner may commence a new action of forfeiture, and may continue commencing actions in forfeiture until the insurer complies. All proceeds from actions of forfeiture shall be paid to the director of finance and paid into the compliance resolution fund.

(g) A monetary penalty and restitution may be imposed in addition to any applicable suspension, revocation, or denial of a license or certificate of authority. [L 1987, c 347, pt of §2; am L 1995, c 232, §6; am L 1999, c 163, §15(1) and c 246, §2; am L 2000, c 4, §6; am L 2002, c 39, §4; am L 2009, c 149, §3; am L 2012, c 66, §2]

**§431:2-204 Commissioner's power to subpoena.** (a) The commissioner, either on the commissioner's own behalf or on behalf of any interested party, may take depositions, and subpoena witnesses or documentary evidence. The commissioner may administer oaths, and examine under oath any individual relative to the affairs of any person being examined, or relative to the subject of any hearing or investigation.

(b) The subpoena shall have the same force and effect and shall be served in the same manner as if issued from a court of record.

(c) Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a court of record. Witness fees, mileage, and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized, and shall be paid by the person as to whom the examination is being made, or by the person if other than the commissioner, at whose request the hearing is held.

(d) When the commissioner, through the insurance fraud investigations branch, is conducting an investigation of possible violations of part IV, the commissioner shall pay to a financial institution that is served a subpoena issued under this section a fee for reimbursement of the costs that are necessary and which have been directly incurred in searching for, reproducing, or transporting books, papers, documents, or other objects designated by the subpoena. Reimbursement shall be paid at a rate not to exceed the rate set forth in section 28-2.5(d). [L 1987, c 347, pt of §2; am L 1998, c 155, §1; am L 2009, c 149, §4]

**Cross References**

Witness fees, mileage, see §607-12.

**§431:2-205 Commissioner to receive service of legal process on foreign or alien insurer.** (a) Each authorized foreign or alien insurer shall appoint the commissioner as its attorney to receive service of, and upon whom may be served, all legal process issued against it in this State upon causes of action arising within this State. Service upon the commissioner as attorney shall constitute service upon the insurer.

(b) With the appointment, the insurer shall designate by a name and address the person to whom the commissioner shall forward legal process so served upon the commissioner. The insurer may change such person by filing a new designation. However, the insurer's last known principal office may be used by the commissioner in lieu of the designated person.

(c) The insurer shall file with the commissioner a resolution adopted by its board of directors or other governing board consenting

that service of process upon the commissioner in any action or proceeding against the insurer brought or pending in this State upon any cause of action arising in or growing out of business transacted in this State, shall be valid service upon the insurer, and the consent shall be irrevocable, so long as a policy of insurance of such insurer shall remain in force in this State, or any loss remains unpaid therein.

(d) The insurer shall also file the name and business address of its authorized resident agent upon whom process may be served in all cases. Until such time as the agent's authority is revoked by a notice in writing filed in the office of the commissioner, service may be had upon the insurer by personal service upon the agent. In case a corporation is designated as an agent, service of process may be had by serving the same upon the president, vice-president, secretary, treasurer, or any director thereof; and in case a partnership is designated as an agent, service of process may be had by serving the same upon any member thereof. Service may be had on either the authorized agent or the commissioner. [L 1987, c 347, pt of §2]

**§431:2-206 How service on commissioner made.** (a) A person competent to serve a summons shall serve upon the commissioner triplicate copies of legal process against an insurer for whom the commissioner is attorney. In the absence of the commissioner, the process may be served upon the chief deputy or the deputy in charge of the insurance function. At the time of service the plaintiff shall pay to the commissioner $25, taxable as costs in the action.

(b) In lieu of service on the commissioner, legal process may be served upon a domestic reciprocal insurer by serving the insurer's attorney-in-fact at the attorney-in-fact's principal offices.

(c) The commissioner shall forthwith send one of the copies of the process to the person designated for the purpose by the insurer in its most recent designation filed with the commissioner, or to the insurer at its last known principal office if no such designation is on file, and return one copy to the plaintiff with the commissioner's acknowledgment of service.

(d) The commissioner shall keep a record of the day and hour of service upon the commissioner of all such legal process. No proceedings shall be had against the insurer, and the insurer shall not be required to appear, plead, or answer until the expiration of forty days after the date of service upon the commissioner. [L 1987, c 347, pt of §2; am L 1997, c 368, §1; am L 2011, c 81, §3]

**§431:2-207 Contempt proceedings.** If any individual fails to obey the subpoena, or obeys the subpoena but refuses to testify when required concerning any matter under examination, investigation or the subject of the hearing, the commissioner shall file a written report thereof and proof of service of the commissioner's subpoena in the circuit court of the county where the examination, investigation or hearing is being conducted. Thereupon the court shall forthwith cause the individual to be brought before it to show cause why the individual should not be held in contempt, and if so held, may punish the individual as if the failure or refusal related to a subpoena from or testimony in that court. [L 1987, c 347, pt of §2]

**§431:2-208 Access to records.** (a) Every person and its officers,

employees, and representatives subject to investigation or examination by the commissioner, shall produce and make freely accessible to the commissioner the accounts, records, documents, and files in the person's possession or control relating to the subject of the investigation or examination, and shall otherwise facilitate the investigation or examination.

(b) If the commissioner finds the accounts to be inadequate, improperly kept, or improperly posted, the commissioner may employ experts to rewrite, post, or balance the accounts at the expense of the person being examined, if the person has failed to correct the accounting records after the commissioner has given the person written notice and a reasonable opportunity to do so.

(c) An insurer or licensee shall issue a written response with reasonable promptness, in no case more than fifteen working days, to any written inquiry made by the commissioner regarding a claim, consumer complaint, or sales or marketing practice. The response shall be more than an acknowledgment that the commissioner's communication has been received, and shall adequately address the concerns stated in the communication. [L 1987, c 347, pt of §2; am L 1997, c 83, §1; am L 2004, c 122, §4; am L 2010, c 116, §1(3)]

**§431:2-209 Records and reports.** (a) The commissioner shall preserve in permanent form records and reports of the commissioner's proceedings, hearings, investigations, and examinations, and shall file the records in the commissioner's office.

(b) The records of the commissioner and insurance filings in the commissioner's office shall be open to public inspection, except as otherwise provided in this code.

(c) One year after conclusion of the transactions to which they relate, the commissioner may destroy any correspondence, void or obsolete filings relating to rates, certificate of authority applications, self-insurance applications, registrations, foreign or alien insurers' annual statements, valuation reports, certificates of compliance and deposits, cards, and expired bonds. Three years after the conclusion of the transactions to which they relate, the commissioner may destroy any claim files, working papers of examinations, reports of examination by insurance supervisory officials of other states, void or obsolete filings relating to license applications, records of hearings and investigations, and any similar records, documents, or memoranda now or hereafter in the commissioner's possession.

(d) Three years after the date filed or within three years of the due date prescribed for the filing of the tax report, whichever is later, the commissioner may destroy the tax reports of any foreign or alien insurers, surplus lines brokers, or independently procured insureds, or similar records or reports now or hereafter in the commissioner's possession.

(e) The following records and reports on file with the commissioner shall be confidential and protected from discovery, production, and disclosure for so long as the commissioner deems prudent:

(1) Complaints and investigation reports;

(2) Working papers of examinations, complaints, and investigation reports;

(3) Proprietary information, including trade secrets, commercial information, and business plans, which, if disclosed may result in competitive harm to the person providing the information; and

(4) Any documents or information received from the National Association of Insurance Commissioners, the federal government, insurance regulatory agencies of foreign countries, or insurance departments of other states, territories, and commonwealths that are confidential in other jurisdictions. The commissioner may share information, including otherwise confidential information, with the National Association of Insurance Commissioners, the federal government, insurance regulatory agencies of foreign countries, or insurance departments of other states, territories, and commonwealths so long as the statutes or regulations of the other jurisdictions permit them to maintain the same level of confidentiality as required under Hawaii law.

(f) The commissioner shall:

(1) Treat and maintain an applicant's fingerprints and any criminal history record information obtained under this code as confidential;

(2) Apply security measures consistent with the Federal Bureau of Investigation Criminal Justice Information Services Division's standards for the electronic storage of fingerprints and necessary identifying information; and

(3) Limit the use of the records solely to purposes authorized by law.

Fingerprints and criminal history record information shall not be subject to subpoena, other than subpoenas issued in criminal actions or investigations, and shall be confidential by law and privileged and not subject to discovery or admissible in evidence in any private civil action.

(g) The commissioner shall not disclose any information that is exempt from disclosure by federal or Hawaii statutes. [L 1987, c 347, pt of §2; am L 1989, c 195, §10; am L 1991, c 248, §1; am L 1993, c 205, §2; am L 1995, c 232, §7; am L 2000, c 182, §4; am L 2004, c 122, §5; am L 2007, c 233, §26; am L 2009, c 77, §14; am L 2014, c 186, §5]

**Cross References**

Uniform Information Practices Act (Modified), see chapter 92F.

**§431:2-210 Copies and certificates as evidence.** (a) Copies of records or documents in the commissioner's office certified to by the commissioner shall be received as evidence in all courts in the same manner and to the same effect as if they were the originals.

(b) When required for evidence in court, the commissioner shall furnish the commissioner's certificate as to the authority of an insurer or other licensee in this State on any particular date, and the court shall receive the certificate in lieu of the commissioner's testimony. [L 1987, c 347, pt of §2]

**Cross References**

Requirement of original, see §626-1, rule 1002.

**§431:2-211 Annual report.** The commissioner, as early each year as accurate preparation enables, shall prepare and submit to the legislature a report which shall contain:

(1) The condition of all insurers authorized to do business in this State during the preceding year.

(2) A summary of abuses and deficiencies in benefit payments, the complaints made to the commissioner

and their disposition, and the extent of compliance and noncompliance by each insurer with the provisions of this code.

(3) Such additional information and comments relative to insurance activities in this State as the commissioner deems proper. [L 1987, c 347, pt of §2]

**§431:2-212 Interstate cooperation.** (a) The commissioner shall to the extent the commissioner deems useful for the proper discharge of the commissioner's responsibilities under this code:

(1) Consult and cooperate with the public officials having supervision over insurance in the other states.

(2) Share jointly with any one or more of the other states in the employment of actuaries, statisticians, and other insurance technicians, whose services or the products thereof are made available and are useful to the participating states and to the commissioner.

(3) Share jointly with any one or more of the other states in establishing and maintaining offices and clerical facilities for purposes useful to the participating states and to the commissioner.

(b) All arrangements made jointly with any one or more of the other states under subsection (a) shall be in writing executed on behalf of this State by the commissioner. Any such arrangement, as to participation of this State therein, shall be subject to termination by the commissioner at any time upon reasonable notice.

(c) For the purposes of this code the National Association of Insurance Commissioners means that voluntary organization of the public officials having supervision of insurance in the respective states, districts, and territories of the United States, whatever other name the organization may hereafter adopt, and in the affairs of which each of the public officials are entitled to participate subject to the constitution and bylaws of the organization. [L 1987, c 347, pt of §2; am L 2004, c 122, §6]

**§431:2-214 The commissioner's education and training fund.** (a) The commissioner may establish a separate fund designated as the commissioner's education and training fund.

(b) This fund may be used to compensate or reimburse staff and personnel of the insurance division for education and training. Upon approval by the commissioner, staff and personnel may be compensated or reimbursed for:

(1) Actual travel expenses in amounts customary for these expenses;

(2) A reasonable living expense allowance at a rate customary for these expenses;

(3) Per diem compensation at a customary rate; and

(4) Any fees or charges necessary to attend educational and training conferences, workshops, seminars, and any other event of this nature.

(c) Any person receiving reimbursement or compensation from the commissioner's education and training fund shall submit to the commissioner, for approval, a detailed account of all expenses and compensation necessarily incurred on account of any education and training for the insurance division.

(d) The commissioner's education and training fund may be used to

pay the cost of consumer education and information, including publication of information, brochures, and consumer guides and costs related to conferences, workshops, seminars, and any other event of this nature which the commissioner sponsors or in which the commissioner or insurance division staff participates. [L 1987, c 348, §1; am L 1989, c 195, §11; am L 1993, c 205, §3]

**§431:2-215 Deposits to compliance resolution fund.** (a) All assessments, fees, fines, penalties, and reimbursements collected by or on behalf of the insurance division under title 24, except for the commissioner's education and training fund (section 431:2-214), the patients' compensation fund (Act 232, Session Laws of Hawaii 1984), the drivers education fund underwriters fee (sections 431:10C-115 and 431:10G-107), and the captive insurance administrative fund (section 431:19-101.8) to the extent provided by section 431:19-101.8(b), shall be deposited into the compliance resolution fund under section 26-9(o). All sums transferred from the insurance division into the compliance resolution fund may be expended by the commissioner to carry out the commissioner's duties and obligations under title 24.

(b) Sums from the compliance resolution fund expended by the commissioner shall be used to defray any administrative costs, including personnel costs, associated with the programs of the division, and costs incurred by supporting offices and divisions. Any law to the contrary notwithstanding, the commissioner may use the moneys in the fund to employ or retain, by contract or otherwise, without regard to chapter 76, hearings officers, attorneys, investigators, accountants, examiners, and other necessary professional, technical, administrative, and support personnel to implement and carry out the purposes of title 24; provided that any position, except any attorney position, that was subject to chapter 76 prior to July 1, 1999, shall remain subject to chapter 76.

(c) Moneys deposited by the commissioner in the fund shall not revert to the general fund.

(d) The amount or amounts to be assessed for each line or type of insurance or entity regulated under title 24 shall be determined and assessed as provided below:

(1) The insurers or entities regulated under title 24 shall be provided at least sixty days notice of when their respective assessments are due;

(2) The total amount or amounts to be assessed of insurers or entities regulated under title 24 in all lines or types of insurance shall be calculated based on the commissioner's proposed fiscal year budget, less funds in the insurance regulation sub-account of the compliance resolution fund on June 30 of the fiscal year immediately preceding the fiscal year of the proposed budget and less the commissioner's anticipated revenues;

(3) The assessments by line or type shall bear a reasonable relationship to the costs of regulating the line or type of insurance, including any administrative costs of the division; and

(4) The sum total of all assessments made and collected shall not exceed the special fund ceiling or ceilings related to the fund that are established by the legislature; provided that the total assessments for all lines or types of insurance in any one fiscal year shall not exceed $5,000,000.

(e) The commissioner may suspend an assessment of any insurer if the commissioner determines that an insurer or entity may reach insolvency or other financial difficulty if the assessment is made against that insurer or entity. [L 1999, c 163, §7; am L 2000, c 182, §5 and c 253, §150; am L 2002, c 39, §5; am L Sp 2005, c 1, §1; am L 2006, c

154, §1; am L 2009, c 77, §2]

## Case Notes

Amounts assessed against insurers for payment into the insurance regulation fund under this section was a regulatory fee and not an unconstitutional tax where (1) the charges were assessed by the commissioner; (2) the assessments were placed into a special fund intended to reimburse the division for insurance industry regulating costs; and (3) moneys from the fund to pay for services provided by the departments of commerce and consumer affairs and budget and finance, and to buttress the division's reserve fund were "used for the regulation or benefit of the parties upon whom the assessment was imposed". 120 H. 51, 201 P.3d 564 (2008).

Where insurance commissioner imposed a substantial portion of the administrative cost of operating the insurance division and its supporting offices and divisions upon insurers pursuant to this section, and the insurance division's regulatory costs were necessitated by the business of insurers, this section did not violate the equal protection clauses of the Hawaii or U.S. Constitutions. 120 H. 51, 201 P.3d 564 (2008).

Where regulatory fees assessed against insurers by the insurance commissioner, an officer of the executive branch, for payment into the insurance regulation fund under this section were transferred by the legislature via transfer bills from the insurance division into the general fund, and the regulatory fees became available for general purposes as if derived from general tax revenues, the transfers violated the separation of powers doctrine under the Hawaii constitution, article VIII, §3, and §26-10(b). 120 H. 51, 201 P.3d 564 (2008).

Amounts assessed by the state insurance division against insurers for payment into the insurance regulation fund under this section did not violate the equal protection clauses of the state and federal constitutions where the regulatory fees were rationally related to the statutory objective of defraying any administrative costs and costs incurred by supporting offices and divisions. 117 H. 454 (App.), 184 P.3d 769 (2008).

**§431:2-216 Assessments of health insurers.** (a) Each mutual benefit society under article 1 of chapter 432, health maintenance organization under chapter 432D, and any other entity offering or providing health benefits or services under the regulation of the commissioner, except an insurer licensed to offer accident and health or sickness insurance under article 10A, shall deposit with the commissioner by July 1 of each year an assessment of $10,000 for the first seventy thousand private, nongovernment members the entity covers and an additional assessment on a pro rata basis to be determined and imposed by the commissioner for covered members exceeding seventy thousand; provided that in the third year and each year thereafter, assessments shall be borne on a pro rata basis. The aggregate annual assessment shall not exceed $1,000,000. This assessment shall be credited to the compliance resolution fund. If assessments are increased, the commissioner shall provide to any organization or entity subject to the increased assessment, justification for the increase.

(b) The assessments shall be used to defray any administrative costs, including personnel costs, associated with the programs of the

division, and costs incurred by supporting offices and divisions. Any law to the contrary notwithstanding, the commissioner may use the moneys from assessments to employ or retain, by contract or otherwise, without regard to chapter 76, hearings officers, attorneys, investigators, accountants, examiners, and other necessary professional, technical, administrative, and support personnel to implement and carry out the purposes of title 24 as it relates to accident and health or sickness insurance; provided that any position, except any attorney position, that was subject to chapter 76 prior to July 1, 1999, shall remain subject to chapter 76.

(c) Moneys credited to the compliance resolution fund that are not used for insurance regulation, general administration purposes, or as otherwise allowed pursuant to section 26-9(o) shall not revert to the general fund nor shall be used for other purposes.

(d) The commissioner may suspend any assessment made against any mutual benefit society under article 1 of chapter 432, health maintenance organization under chapter 432D, and any other entity offering or providing health benefits or services under the regulation of the commissioner if the commissioner determines that the entity may reach insolvency or other financial difficulty if the assessment is made against the entity. [L 1999, c 127, §1; am L 2000, c 243, §§6, 11(2) and c 253, §150; am L 2002, c 39, §§6, 7; am L 2003, c 3, §20, c 197, §4, and c 212, §§16, 131; am L 2006, c 154, §2]

## PART III. INVESTIGATIONS, EXAMINATIONS, HEARINGS AND APPEALS

**§431:2-301 Purpose.** The purpose of this part is to provide an effective and efficient system for examining the activities, operations, financial condition, and affairs of all persons transacting the business of insurance in this State and all persons otherwise subject to the jurisdiction of the commissioner. The provisions of this part are intended to enable the commissioner to adopt a flexible system of examinations that directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance-related laws of this State. [L 1987, c 347, pt of §2; am L 1993, c 321, §5]

**[§431:2-301.5] Examiner defined.** For purposes of this part, "examiner" means any individual or firm authorized by the commissioner to conduct an examination under the insurance code. [L 1993, c 321, pt of §2]

**[§431:2-301.6] Conflict of interest.** (a) No examiner may be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this part. This section shall not be construed to automatically preclude an examiner from being:

(1) A policyholder or claimant under an insurance policy;

(2) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(3) An investment owner in shares of regulated diversified investment companies; or

(4) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

(b) Notwithstanding the requirements of this section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though those persons from time to time may be similarly employed or retained by persons subject to examination under the insurance code. [L 1993, c 321, pt of §2]

**[§431:2-301.7] Conduct of examinations.** (a) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiners shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

(b) Every company or person from whom information is sought, including its officers, directors, and agents, shall provide to the examiners appointed under subsection (a) timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, and agents of the company or person shall facilitate the examination and aid in the examination insofar as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to section 431:3-217.

(c) The commissioner or any authorized examiner shall have the power to issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the subpoena may be enforced pursuant to section 431:2-207.

(d) When conducting an examination, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the cost of which shall be borne by the company that is the subject of the examination.

(e) Nothing contained in this part shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this State. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(f) Nothing contained in this part shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers, or other documents, or any other information discovered or

developed during the course of any examination in the furtherance of any legal or regulatory action that the commissioner may, in the commissioner's sole discretion, deem appropriate. [L 1993, c 321, pt of §2]

**§431:2-301.8 Immunity from liability.** (a) No cause of action shall arise nor shall any liability be imposed against any examiner appointed or otherwise designated as an examiner by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of the insurance code.

(b) No cause of action shall arise, nor shall any liability be imposed against any person, for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under the insurance code, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(c) This section does not abrogate nor modify in any way common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (a).

(d) A person identified in subsection (a) shall be entitled to an award of attorneys' fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the insurance code, and the party bringing action is not substantially justified to do so. For the purposes of this section, a proceeding is substantially justified if it has a reasonable basis in law or fact at the time that it is initiated. [L 1993, c 321, pt of §2; am L 2006, c 189, §2]

**§431:2-302 Authority, scope, and scheduling of examinations.** (a) The commissioner or any authorized examiner may conduct an examination of any company as often as the commissioner deems appropriate, but, at a minimum, shall conduct an examination of each domestic insurer at least once every five years. In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners and in effect, when the commissioner exercises discretion under this section.

(b) For purposes of completing an examination of any insurer, the commissioner may examine or investigate any person, or the business of any person, insofar as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the insurer.

(c) In lieu of an examination of any foreign or alien insurer licensed in this State, the commissioner may accept an examination report on the insurer as prepared by the state regulatory agency for insurance for the insurer's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports may only be accepted under the following conditions:

(1) The state's regulatory agency for insurance was, at the time of the examination, accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or

(2) The examination was performed:

(A) Under the supervision of an accredited state regulatory agency for insurance; or

(B) With the participation of one or more examiners who are employed by an accredited state regulatory agency for insurance and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their state regulatory agency for insurance. [L 1987, c 347, pt of §2; am L 1989, c 195, §12; am L 1993, c 321, §6; am L 2005, c 132, §1]

**§431:2-303 Examination of producers, adjusters, promoters, and independent bill reviewers.** For the purpose of ascertaining its condition, or compliance with this code, the commissioner may as often as the commissioner deems advisable examine the insurance accounts, records, documents, and transactions of:

(1) Any insurance producer, adjuster, or independent bill reviewer, including insurance agencies and surplus lines agencies; or

(2) Any person engaged in, proposing to be engaged in, or assisting in the promotion or formation of a domestic insurer, a stock corporation to finance a domestic mutual insurer or the production of its business, or a corporation to be attorney-in-fact for a domestic reciprocal insurer. [L 1987, c 347, pt of §2; am L 2000, c 288, §3; am L 2001, c 216, §3]

**§431:2-304 Examination of guaranty associations.** (a) The Hawaii Insurance Guaranty Association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(b) The Hawaii Life and Disability Insurance Guaranty Association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year not later than one hundred twenty days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. [L 1987, c 347, pt of §2; am L 2003, c 212, §17]

**§431:2-305 Examination reports.** (a) All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the insurer, its producers, or other persons examined, or as ascertained from the testimony of its officers, producers, or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(b) No later than sixty days following completion of the examination, the examiner in charge shall file with the insurance division a verified written report of examination under oath. Upon receipt of the verified report, the insurance division shall transmit the report to the insurer or person examined, together with a notice that shall afford the insurer or person examined a reasonable opportunity for

not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) Within thirty days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and enter an order to:

(1) Adopt the examination report as filed, or with modifications or corrections. If the examination report reveals that the insurer or person is operating in violation of any law, rule, or prior order of the commissioner, the commissioner may order the insurer or person to take any action the commissioner considers necessary and appropriate to cure the violation;

(2) Reject the examination report with directions to the examiner to reopen the examination for the purpose of obtaining additional data, documentation, or information, and refiling pursuant to subsection (b); or

(3) Call for an investigatory hearing with no fewer than twenty days notice to the insurer or person for purposes of obtaining additional documentation, data, information, or testimony.

(d) Orders shall be issued and hearings conducted as follows:

(1) All orders entered pursuant to subsection (c)(1) shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. Any order shall be considered a final administrative decision and may be appealed pursuant to chapter 91, and shall be served upon the insurer or person by certified mail, together with a copy of the adopted examination report. Within thirty days of the issuance of the adopted report, the insurer or person shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders, except that for examinations of producers, adjusters, independent bill reviewers, or surplus lines brokers, serving the copy of the adopted report and related orders by certified mail, return receipt requested, shall satisfy the service requirement and no affidavits shall be required; and

(2) Any hearing conducted under subsection (c)(3) by the commissioner or authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as may be necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or raised by the written submission or rebuttal of the insurer or person. Within twenty days of the conclusion of any hearing, the commissioner shall enter an order pursuant to subsection (c)(1):

(A) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the insurer or person limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation, whether under the control of the division, the insurer, or other persons. The documents produced shall be included in the record and testimony taken by the commissioner or the commissioner's representative shall be under oath and preserved for the record;

(B) The hearing shall proceed in accordance with departmental rules adopted under chapter 91; and

(C) Nothing contained in this section shall require the insurance division to disclose any information or records

that would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(e) The examination report shall be disseminated as follows:

(1) Upon the adoption of the examination report under subsection (c)(1), the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of fifteen days, except to the extent provided in subsection (b). Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication; and

(2) Nothing contained in this code shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the regulatory agency for insurance of any state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this part.

(f) All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination, shall be confidential and not subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subsection (e). Access may be granted to the National Association of Insurance Commissioners. Any person shall agree in writing, prior to receiving the information, to provide to it the same confidential treatment as required by this part, unless the prior written consent of the insurer to which the information pertains has been obtained. [L 1987, c 347, pt of §2; am L 1993, c 205, §4 as superseded by c 321, §7; am L 1995, c 232, §8; am L 2000, c 288, §4; am L 2001, c 216, §4; am L 2004, c 122, §7]

**§431:2-306 Examination expense.** (a) Examinations of:

(1) Any insurer;

(2) Any person subject to examination under section 431:2-303(2); or

(3) Any insurance guaranty fund established pursuant to article 16;

shall be at the expense of the insurer, person, or guaranty fund examined. Examination expenses shall include fees, mileage, and expenses incurred as to witnesses or any other person, as defined in article 1, subject to an examination by the commissioner.

(b) The insurer, person, or guaranty fund examined and liable therefor shall pay to the commissioner's examiners upon presentation of an itemized statement, their actual travel expenses, their reasonable living expense allowance, and their per diem compensation at a reasonable rate approved by the commissioner, incurred on account of the examination. All payments collected by the commissioner shall be remitted to:

(1) The compliance resolution fund; or

(2) The captive insurance administrative fund if independent contractor examiners or captive staff examiners were employed for a captive insurer's examination.

The commissioner or the commissioner's examiners shall not receive or accept any additional emolument on account of any examination.

(c) The commissioner may assess all examination costs of any person subject to examination under section 431:2-303(1) and article 16 when there is a premium trust fund shortage due to substantial noncompliance with section 431:9A-123.5. [L 1987, c 347, pt of §2; am L 1995, c 232, §9; am L 1997, c 261, §3; am L 1998, c 71, §1; am L 1999, c 163, §11; am L 2002, c 39, §8; am L 2006, c 189, §3]

**§431:2-307 REPEALED.** L 1999, c 163, §20.

**Note**

L 1999, c 128, §§1 and 2 purport to amend this section.

**§431:2-307.5 Reimbursement and compensation of examiners; source of funds; disposition of receipts.** (a) All moneys necessary for the compensation and reimbursement of independent contractor examiners and insurance division staff examiners for actual travel expenses, reasonable living expenses, and per diem expenses, at customary rates approved by the commissioner shall be allocated by the legislature through appropriations out of the state compliance resolution fund. The department shall include in its budgetary request for each upcoming fiscal period, the amounts necessary to effectuate the purposes of this section.

(b) All moneys, fees, and other payments received by the commissioner under this part shall be deposited to the credit of the state compliance resolution fund. [L 1995, c 61, §1 as superseded by c 232, §1; am L 1999, c 163, §15(1); am L 2002, c 39, §9]

**§431:2-308 Administrative procedure act applies.** (a) The rules, notices, hearings, orders, and appeals provided for in this code are in all applicable respects subject to chapter 91, unless it is expressly provided otherwise.

(b) The commissioner shall hold a hearing if required by this code. The commissioner may hold other hearings as the commissioner deems necessary for such purposes as are within the scope of this code.

(c) The hearings shall be held at a place designated by the commissioner and, at the commissioner's discretion, may be open to the public.

(d) Application for a hearing made to the commissioner pursuant to this code shall be in writing and shall specify in what respects the person so applying was aggrieved and the grounds to be relied upon as a basis for the relief to be demanded at the hearing. Where the commissioner has used the authority contained in section 431:9-235 or section 431:9A-112 to suspend, revoke, or refuse to extend a license subject to the right of the licensee to have a hearing and has suspended the license pending the hearing, the commissioner shall hold the hearing within thirty days after the commissioner's receipt of the application unless postponed by mutual consent.

(e) Any appeal made from a decision by the commissioner shall be made pursuant to chapter 91. [L 1987, c 347, pt of §2; am L 1994, c 128, §1; am L 2003, c 212, §18; am L 2006, c 154, §3]

## [PART IV.] INSURANCE FRAUD

**[§431:2-401] Definitions.** As used in this part:

"Branch" means the insurance fraud investigations branch of the insurance division of the department of commerce and consumer affairs.

"Insurance policy" means a contract issued by an insurer or other licensee.

"Intentionally" shall have the same meaning as under section 702-206.

"Knowingly" shall have the same meaning as under section 702-206.

"Licensee" means an entity licensed under and governed by title 24, including an insurer governed by chapter 431, a mutual benefit society governed by article 1 of chapter 432, a fraternal benefit society governed by article 2 of chapter 432, or a health maintenance organization governed by chapter 432D, and their respective agents and employees engaged in the business of the licensee.

"Person" means any individual, company, association, organization, group, partnership, business, trust, or corporation; but shall exclude:

(1) Insurers, as defined in section 431:1-202, and other licensees, as defined in this part; and

(2) Licensed attorneys acting in their capacity as attorneys for a claimant other than the licensed attorney. [L 2009, c 149, pt of §2]

**§431:2-402 Insurance fraud investigations branch.** (a) There is established in the insurance division the insurance fraud investigations branch for the purposes set forth in this part.

(b) The branch shall:

(1) Conduct a statewide program for the prevention of insurance fraud under title 24, including chapters 431, 432, and 432D; provided that the branch shall not have jurisdiction over workers' compensation under chapter 386;

(2) Notwithstanding any other law to the contrary, investigate and prosecute in administrative hearings and courts of competent jurisdiction all persons involved in insurance fraud violations; and

(3) Promote public and industry-wide education about insurance fraud.

(c) The branch may review and take appropriate action on complaints of fraud relating to insurance under title 24, including chapters 431, 432, and 432D, but excluding workers' compensation insurance under chapter 386.

(d) The commissioner shall employ or retain, by contract or otherwise, attorneys, investigators, investigator assistants, auditors, accountants, physicians, health care professionals, paralegals, consultants, experts, and other professional, technical, and support staff as necessary to promote the effective and efficient conduct of the branch's activities. The commissioner may hire these employees without regard to chapters 76 or 89.

(e) Notwithstanding any other law to the contrary, an attorney employed or retained by the branch may represent the State in any criminal, civil, or administrative proceeding to enforce all applicable state laws relating to insurance fraud, including criminal prosecutions, disciplinary actions, and actions for declaratory and injunctive relief. The attorney general may designate an attorney as a special deputy attorney general for purposes of this subsection.

(f) Investigators appointed and commissioned under this part shall have and may exercise all of the powers and authority of a police officer or of a deputy sheriff.

(g) Funding for the branch shall come from the compliance resolution fund established by section 26-9(o). [L 2009, c 149, pt of §2; am L 2014, c 186, §6]

**[§431:2-403] Insurance fraud.** (a) A person commits the offense of insurance fraud if the person:

(1) Intentionally or knowingly misrepresents or conceals material facts, opinions, intention, or law to obtain or attempt to obtain coverage, benefits, recovery, or compensation:

(A) When presenting, or causing or permitting to be presented, an application, whether written, typed, or transmitted through electronic media, for the issuance or renewal of an insurance policy or reinsurance contract;
(B) When presenting, or causing or permitting to be presented, false information on a claim for payment;
(C) When presenting, or causing or permitting to be presented, a claim for the payment of a loss;
(D) When presenting, or causing or permitting to be presented, multiple claims for the same loss or injury, including knowingly presenting such multiple and duplicative claims to more than one insurer;
(E) When presenting, or causing or permitting to be presented, any claim for payment of a health care benefit;
(F) When presenting, or causing or permitting to be presented, a claim for a health care benefit that was not used by, or provided on behalf of, the claimant;
(G) When presenting, or causing or permitting to be presented, improper multiple and duplicative claims for payment of the same health care benefit;
(H) When presenting, or causing or permitting to be presented, for payment any undercharges for benefits on behalf of a specific claimant unless any known overcharges for benefits under this article for that claimant are presented for reconciliation at the same time;
(I) When fabricating, altering, concealing, making an entry in, or destroying a document whether typed, written, or through an audio or video tape or electronic media;
(J) When presenting, or causing or permitting to be presented, to a person, insurer, or other licensee false, incomplete, or misleading information to obtain coverage or payment otherwise available under an insurance policy;
(K) When presenting, or causing or permitting to be presented, to a person or producer, information about a person's status as a licensee that induces a person or insurer to purchase an insurance policy or reinsurance contract; and
(L) When making, or causing or permitting to be made, any statement, either typed, written, or through audio or video tape or electronic media, or claims by the person or on behalf of a person with regard to obtaining legal recovery or benefits;

(2) Intentionally or knowingly aids, agrees, or attempts to aid, solicit, or conspire with any person who

engages in an unlawful act as defined under this section; or

(3) Intentionally or knowingly makes, causes, or permits to be presented, any false statements or claims by any person or on behalf of any person during an official proceeding as defined by section 710-1000.

(b) Violation of subsection (a) is a criminal offense and shall constitute:

(1) A class B felony if the value of the benefits, recovery, or compensation obtained or attempted to be obtained is more than $20,000;

(2) A class C felony if the value of the benefits, recovery, or compensation obtained or attempted to be obtained is more than $300; or

(3) A misdemeanor if the value of the benefits, recovery, or compensation obtained or attempted to be obtained is $300 or less.

(c) This section shall not supersede any other law relating to theft, fraud, or deception. Insurance fraud may be prosecuted under this part, or any other applicable statute or common law, and all such remedies shall be cumulative. [L 2009, c 149, pt of §2]

**[§431:2-404] Restitution.** Any person convicted under this part shall be ordered by a court to make restitution to any insurer, person, or licensee for any financial loss sustained by that insurer, person, or licensee that was caused by the act or acts for which the person was convicted. [L 2009, c 149, pt of §2]

**[§431:2-405] Insurance fraud; administrative penalties.** (a) In addition to or in lieu of criminal penalties under section 431:2-403(b), any person who commits insurance fraud as defined under section 431:2-403, may be subject to the administrative penalties in this section.

(b) If a person is found to have knowingly committed insurance fraud under this part, the commissioner may assess any or all of the following penalties:

(1) Restitution to any insurer or any other person of benefits or payments fraudulently received or other damages or costs incurred;

(2) A fine of not more than $10,000 for each violation; and

(3) Reimbursement of attorneys' fees and costs of the party sustaining a loss under this part; provided that the State shall be exempt from paying attorneys' fees and costs to other parties.

(c) Administrative actions brought for insurance fraud under this part shall be brought within six years after the insurance fraud is discovered or by exercise of reasonable diligence should have been discovered and, in any event, no more than ten years after the date on which a violation of this part is committed. [L 2009, c 149, pt of §2]

**[§431:2-406] Administrative procedures.** (a) An administrative penalty may be imposed upon a judgment by a court of competent jurisdiction or upon an order by the commissioner.

(b) The commissioner shall hold a hearing in accordance with chapter 91, prior to imposing any administrative remedy. [L 2009, c 149, pt of §2]

**[§431:2-407] Acceptance of payment.** A provider's failure to dispute a reduced payment by an insurer shall not constitute an implied admission that a fraudulent billing was submitted. [L 2009, c 149, pt of §2]

**[§431:2-408] Civil cause of action for insurance fraud; exemption.** (a) An insurer or other licensee shall have a civil cause of action to recover payments or benefits from any person who has violated section 431:2-403; provided that no recovery shall be allowed if the person has made restitution pursuant to section 431:2-404 or 431:2-405(b)(1).

(b) A person, insurer, or other licensee, including an insurer's or other licensee's adjusters, bill reviewers, producers, representatives, or common-law agents shall not be subject to civil liability for providing information, including filing a report, furnishing oral, written, audiotaped, videotaped, or electronic media evidence, providing documents, or giving testimony concerning suspected, anticipated, or completed insurance fraud to:

(1) A court;

(2) The commissioner;

(3) The branch;

(4) The National Association of Insurance Commissioners;

(5) The National Insurance Crime Bureau;

(6) Any federal, state, or county law enforcement or regulatory agency; or

(7) Another insurer or other licensee,

if acting without actual malice and if the information is provided for the purpose of preventing, investigating, or prosecuting insurance fraud, except if the person commits perjury.

(c) Civil actions for insurance fraud under this part shall be filed within six years after the insurance fraud is discovered or should have been discovered by exercise of reasonable diligence; provided that no civil action shall be filed more than ten years after the date on which a violation of this part is committed. [L 2009, c 149, pt of §2]

**[§431:2-409] Mandatory reporting.** (a) Within sixty days of an insurer or other licensee's employee or agent discovering credible information indicating a violation of section 431:2-403, or as soon thereafter as practicable, the insurer or licensee shall provide to the branch information, including documents and other evidence, regarding the alleged violation of section 431:2-403. The insurance fraud investigations branch shall work with the insurer or licensee to determine what information shall be provided.

(b) Information provided pursuant to this section shall be protected from public disclosure to the extent authorized by chapter 92F and section 431:2-209; provided that the branch may release the information in an administrative or judicial proceeding to enforce this part to federal, state, or local law enforcement or regulatory authorities, the National Association of Insurance Commissioners, the National Insurance Crime Bureau, or an insurer or other licensee aggrieved by the alleged violation of section 431:2-403. [L 2009, c 149, pt of §2]

**[§431:2-410] Deposit into the compliance resolution fund.** All moneys that have been recovered by the department of commerce and consumer affairs as a result of prosecuting insurance fraud violations pursuant to this part, including civil fines, criminal fines, administrative fines, and settlements, but not including restitution made pursuant to section 431:2-404, 431:2-405(b)(1), or 431:2-408, shall be deposited into the compliance resolution fund established pursuant to section 26-9(o). [L 2009, c 149, pt of §2]

## [ARTICLE 2D]
## MARKET CONDUCT

**[§431:2D-101] Legislative intent.** The purpose of this article is to establish a framework for insurance division market conduct actions, including:

(1) Processes and systems for identifying, assessing, and prioritizing market conduct problems that have a substantial adverse impact on consumers, policyholders, and claimants;

(2) Market conduct actions by the commissioner to substantiate those market conduct problems and a means to remedy significant market conduct problems; and

(3) Procedures to communicate and coordinate market conduct actions among states to foster the most efficient and effective use of resources. [L 2007, c 227, pt of §1]

**§431:2D-102 Definitions.** As used in this article, unless the context indicates otherwise:

"Commissioner" means the insurance commissioner of the State of Hawaii.

"Complaint" means a written or documented oral communication to the insurance division primarily expressing a grievance, meaning an expression of dissatisfaction. For health companies, a grievance is a written complaint submitted by or on behalf of a covered person.

"Comprehensive market conduct examination" means a review of one or more lines of business of an insurer domiciled in this State that is not conducted for cause. The term includes a review of rating, tier classification, underwriting, policyholder service, claims, marketing and sales, producer licensing, complaint handling practices, and compliance procedures and policies.

"Insurance compliance audit" means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with, or promoting compliance

with laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of an insurer, or which involves an insurer activity regulated by the commissioner.

"Insurance compliance self-evaluative audit document" means documents prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self-evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer generated or electronically recorded information, telephone records, maps, charts, graphs, and surveys; provided that this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit.

"Market analysis" means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports, and other sources to develop a baseline and to identify patterns or practices of insurers licensed to do business in this State that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

"Market conduct action" means any of the full range of activities that the commissioner may initiate to assess the market and practices of individual insurers, beginning with market analyses and extending to targeted examinations. The commissioner's activities to resolve an individual consumer complaint or other reports of a specific instance of misconduct are not market conduct actions for purposes of this article.

"Market conduct examination" means the examination of the insurance operations of an insurer licensed to do business in this State to evaluate compliance with the applicable laws and rules of this State. A market conduct examination may be either a comprehensive examination or a targeted examination. A market conduct examination is separate and distinct from a financial examination of an insurer performed pursuant to article 2, but may be conducted at the same time.

"Market conduct surveillance personnel" means those individuals employed or contracted by the commissioner to collect, analyze, review, or act on information about the insurance marketplace, which identifies patterns or practices of insurers.

"National Association of Insurance Commissioners" means the organization of insurance regulators from the fifty states, the District of Columbia, and the four United States territories.

"Qualified contract examiner" means a person under contract to the commissioner, who is qualified by education, experience and, where applicable, professional designations, to perform market conduct actions.

"Targeted examination" means a focused examination conducted for cause, based on the results of market analysis indicating the need to review either a specific line of business or specific business practices, including but not limited to underwriting and rating, marketing and sales, complaint handling operations, advertising materials, licensing, policyholder services, non-forfeitures, claims handling, or policy forms and filings. A targeted examination may be conducted by desk examination or by an on-site examination.

"Third party model or product" means a model or product provided by an entity separate from and not under direct or indirect corporate control of the insurer using the model or product. [L 2007, c 227, pt of §1; am L 2015, c 63, §3]

**[§431:2D-103] Domestic responsibility and deference to other states.** (a) The commissioner shall be responsible for conducting market conduct examinations for policyholder protection, which shall be accomplished by comprehensive or targeted examinations of domestic insurers or the affiliates of domestic insurers and targeted examinations of foreign insurers or the affiliates of foreign insurers as deemed necessary by the commissioner, based on the results of market analysis. The commissioner may delegate responsibility for conducting an examination of a domestic insurer, foreign insurer, or an affiliate of an insurer to the insurance commissioner of another state if that state's insurance commissioner agrees to accept the delegated responsibility for the examination.

(b) The commissioner may delegate responsibility to an insurance commissioner of a state in which the domestic insurer, foreign insurer, or affiliate has a significant number of policies or significant premium volume, as determined by the commissioner by rule.

(c) If the commissioner elects to delegate responsibility for examining an insurer, the commissioner shall accept a report of the examination prepared by the commissioner to whom the responsibility has been delegated.

(d) In lieu of conducting a market conduct examination of an insurer, the commissioner shall accept a report of a market conduct examination on the insurer prepared by the insurance commissioner of the insurer's state of domicile or another state; provided:

(1) The laws of that state applicable to the subject of the examination are deemed by the commissioner to be substantially similar to those of this State;

(2) The examining state has a market conduct surveillance system that the commissioner deems comparable to the market conduct surveillance system required under this article; and

(3) The examination from the other state's insurance commissioner has been conducted within the past three years.

(e) If the insurance commissioner to whom the examination responsibility was delegated pursuant to subsection (a) or the report of a market conduct examination prepared by the insurance commissioner of another state pursuant to subsection (d), did not evaluate the specific area or issue of concern to the commissioner, the commissioner may pursue a targeted examination or market analysis of the unexamined area pursuant to this article.

(f) The commissioner's determination under subsection (d) is discretionary and is not subject to appeal.

(g) Subject to a determination under subsection (d), if a market conduct examination conducted by another state results in a finding that an insurer should modify a specific practice or procedure, the commissioner shall accept documentation that the insurer has made a similar modification in this State, in lieu of initiating a market conduct action or examination related to that practice or procedure. The commissioner may require other or additional practice or procedure modifications as are necessary to achieve compliance with specific state laws or regulations, which differ substantially from those of the state that conducted the examination. [L 2007, c 227, pt of §1]

**[§431:2D-104] Market analysis procedures.** (a) The commissioner

shall gather information from data currently available to the insurance division, as well as surveys and required reporting requirements, information collected by the National Association of Insurance Commissioners and a variety of other sources in both the public and private sectors, information from within and outside the insurance industry from objective sources, information from websites for insurers, agents, and other organizations, and information from other sources; provided that prior to use, the sources are published at least annually in a bulletin or circular.

The information shall be analyzed to develop a baseline understanding of the marketplace and to identify for further review insurers or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer. The commissioner shall use procedures that are substantially similar to the National Association of Insurance Commissioners' guidelines on market analysis as one resource in performing this analysis.

The commissioner shall use the following policies and procedures in performing the analysis required under this section:

(1) Identify key lines of business for systematic review; and

(2) Identify companies for further analysis based on available information.

(b) If the analysis compels the commissioner to inquire further into a particular insurer or practice, the following continuum of market conduct actions may be considered prior to conducting a targeted, on-site market conduct examination. The action selected shall be made known to the insurer in writing. These actions may include but are not limited to:

(1) Correspondence with the insurer;

(2) Insurer interviews;

(3) Information gathering;

(4) Policy and procedure reviews;

(5) Interrogatories; and

(6) Review of insurer self-evaluation and compliance programs, including membership in an organization such as a best-practice organization that has as its central mission the promotion of high ethical standards in the marketplace.

(c) The commissioner shall select a market conduct action that is cost-effective for the insurance division and the insurer, while still protecting the insurance consumer.

(d) The commissioner shall take those steps reasonably necessary to:

(1) Eliminate requests for information that duplicate:

(A) Information provided as part of an insurer's annual financial statement, the annual market conduct statement of the National Association of Insurance Commissioners, or other required schedules, surveys, or reports that are regularly submitted to the commissioner; or

(B) Data requests made by other states if that information is

available to the commissioner, unless the information is state-specific; and

(2) Coordinate market conduct actions and findings with other states. [L 2007, c 227, pt of §1]

**[§431:2D-105] Protocols for market conduct actions.** (a) Market conduct actions taken as a result of a market analysis shall focus on the general business practices and compliance activities of insurers, rather than identifying infrequent or unintentional random errors that do not cause consumer harm.

(b) The commissioner may determine the frequency and timing of such market conduct actions. The timing shall depend upon the specific market conduct action to be initiated, unless extraordinary circumstances indicating a risk to consumers require immediate action.

If the commissioner has information that more than one insurer is engaged in common practices that may violate the law, the commissioner may schedule and coordinate multiple examinations simultaneously.

(c) The insurer shall be notified of any practice or procedure which is to be the subject of a market conduct action and shall be given an opportunity to resolve such matters that arise as a result of a market analysis to the satisfaction of the commissioner before any additional market conduct actions are taken against the insurer. If the insurer has modified the practice or procedure as a result of a market conduct action taken by the insurance commissioner of another state, the commissioner shall accept appropriate documentation that the insurer has satisfactorily modified the practice or procedure and made similar modification to such practice or procedure in this State. [L 2007, c 227, pt of §1]

**[§431:2D-106] Protocols for market conduct examinations.** (a) When market analysis identifies a pattern of conduct or practice by an insurer which requires further investigation, and less intrusive market conduct actions identified in section 431:2D-104(b) are not appropriate, the commissioner has the discretion to conduct targeted market conduct examinations in accordance with procedures that are substantially similar to the National Association of Insurance Commissioners' guidelines on market conduct examination procedures.

(b) Causes or conditions, if identified through market analysis, that may trigger a targeted examination, are:

(1) Information obtained from a market conduct annual statement, market survey, or report of financial examination indicating potential fraud, that the insurer is conducting the business of insurance without a license or is engaged in a potential pattern of unfair trade practice in violation of article 13;

(2) A number of complaints against the insurer or a complaint ratio sufficient to indicate potential fraud, conducting the business of insurance without a license, or a potential pattern of unfair trade practice in violation of article 13. For the purposes of this section, a complaint ratio shall be determined for each line of business;

(3) Information obtained from other objective sources, such as published advertising materials indicating potential fraud, conducting the business of insurance without a license, or evidencing a potential pattern of unfair trade practice in violation of article 13; or

(4) Patterns of violations of this chapter and the rules adopted thereunder regarding rate filings, form filings, and termination requirements.

(c) If the insurer to be examined is not a domestic insurer, the commissioner shall communicate with and may coordinate the examination with the insurance commissioner of the state in which the insurer is organized.

(d) Concomitant with the notification requirements established in subsection (f), the commissioner shall post notification on the National Association of Insurance Commissioners' examination tracking system, or comparable product as determined by the commissioner, that a market conduct examination has been scheduled.

(e) Prior to commencement of a targeted on-site market conduct examination, market conduct surveillance personnel shall prepare a work plan and proposed budget. The proposed budget, which shall be reasonable for the scope of the examination, and work plan, shall be provided to the insurer under examination. Market conduct examinations, to the extent feasible, shall use desk examinations and data requests prior to a targeted on-site examination.

Market conduct examinations shall be conducted in accordance with procedures that are substantially similar to the National Association of Insurance Commissioners' guidelines on market conduct examination procedures.

Prior to the conclusion of a market conduct examination, the individual among the market conduct surveillance personnel who is designated as the examiner-in-charge shall schedule an exit conference with the insurer.

(f) Announcement of the examination shall be sent to the insurer and posted on the National Association of Insurance Commissioners' examination tracking system or comparable product, as determined by the commissioner, as soon as possible but not later than sixty days before the estimated commencement of the examination. The announcement shall contain:

(1) The name and address of the insurer being examined;

(2) The name and contact information of the examiner-in-charge;

(3) The reason for and the scope of the targeted examination;

(4) The date the examination is scheduled to begin;

(5) Identification of any non-insurance department personnel who will assist in the examination, if known at the time the notice is prepared;

(6) A time estimate for the examination;

(7) A budget and work plan for the examination and identification of reasonable and necessary costs and fees that will be included in the bill, if the cost of the examination is billed to the insurer; and

(8) A request for the insurer to name its examination coordinator.

(g) If a targeted examination is expanded beyond the reasons provided to the insurer in the notice of the examination required under this section, the commissioner shall provide written notice to the insurer, explaining the extent of the expansion and the reasons for the expansion. The commissioner shall provide a revised work plan to the insurer before the beginning of any significantly expanded examination, unless extraordinary circumstances indicating a risk to consumers require immediate action.

(h) The commissioner shall conduct a pre-examination conference

with the insurer examination coordinator and key personnel to clarify expectations thirty days prior to commencement of the examination.

(i) In requesting the information, the commissioner shall use the National Association of Insurance Commissioners' standard data request or comparable product.

An insurer responding to a commissioner's request to produce information shall produce it as it is kept in the usual course of business or shall organize and label it to correspond with the categories in the request.

If a commissioner's request does not specify the form or forms for producing electronically stored information, an insurer responding to the request shall produce the information in a form or forms in which the insurer ordinarily maintains it or in a form or forms that are reasonably usable.

An insurer responding to an information request need not produce the same electronically stored information in more than one form.

An insurer responding to an information request need not provide the electronically stored information from sources that the company identifies as not reasonably accessible because of undue burden or cost.

(j) The commissioner shall adhere to the following timeline, unless a mutual agreement is reached with the insurer to modify the timeline:

(1) The commissioner shall deliver the draft report to the insurer within sixty days of the completion of the examination. Completion of the examination shall be defined as the date the commissioner confirms in writing that the examination is completed;

(2) The insurer shall respond with written comments within thirty days of receipt of the draft report;

(3) The commissioner shall make a good faith effort to resolve issues and prepare a final report within thirty days of receipt of the insurer's written comments, unless a mutual agreement is reached to extend the deadline. The commissioner may make corrections and other changes, as appropriate; and

(4) The insurer, within thirty days, shall accept the final report, accept the findings of the report, file written comments, or request a hearing. An additional thirty days shall be allowed if agreed to by the commissioner and the insurer. Any such hearing request shall be made in writing and shall follow chapter 91.

The final written and electronic market conduct report shall include the insurer's written response and any agreed-to corrections or changes. The response may be included either as an appendix or in the text of the examination report. The insurer shall not be obligated to submit a response. References to specific individuals by name shall be limited to an acknowledgment of their involvement in the conduct of the examination.

(k) Upon adoption of the examination report pursuant to subsection (j), the commissioner shall continue to hold the content of the examination report as private and confidential for a period of thirty days, except as provided in this subsection. During this time, the report shall not be subject to subpoena and shall not be subject to discovery or admissible as evidence in any private action; provided that no court of competent jurisdiction has ordered production. Thereafter, the commissioner shall open the report for public inspection; provided no court of competent jurisdiction has stayed its publication. This section shall not be construed to limit the commissioner's authority to use any final or preliminary market conduct examination report, and examiner or insurer work papers or other documents, or any other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, may deem appropriate.

Nothing contained in this article shall prevent or be construed as

preventing the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance division of this or any other state or agency of the federal government at any time; provided that the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this article.

(l) Where the reasonable and necessary cost and fees of a market conduct examination are to be assessed against the insurer under examination, the costs and fees shall be consistent with that otherwise authorized by law. Costs and fees shall be itemized and bills shall be provided to the insurer on a monthly basis for review prior to submission for payment.

The commissioner shall maintain active management and oversight of examination costs and fees, including costs and fees associated with the use of insurance division personnel and examiners and with retaining qualified contract examiners necessary to perform an examination. To the extent the commissioner retains outside assistance, the commissioner shall have written protocols that:

(1) Clearly identify the types of functions subject to outsourcing;

(2) Provide specific timelines for completion of the outsourced review;

(3) Require disclosure of contract examiners' recommendations;

(4) Establish and use a dispute resolution or arbitration mechanism to resolve conflicts with insurers regarding examination costs and fees; and

(5) Require disclosure of the terms of the contracts with the outside consultants that will be used, specifically the costs and fees or hourly rates, or both, that can be charged.

The commissioner shall review and affirmatively endorse detailed billings from the qualified contract examiner before the detailed billings are sent to the insurer.

The commissioner may contract in accordance with applicable state contracting procedures, for qualified contract actuaries and examiners as the commissioner deems necessary; provided that the compensation and per diem allowances paid to the contract persons shall not exceed one hundred twenty-five per cent of the compensation and per diem allowances for examiners set forth in the guidelines adopted by the National Association of Insurance Commissioners, unless the commissioner demonstrates that one hundred twenty-five per cent is inadequate under the circumstances of the examination.

(m) The commissioner may not conduct a comprehensive market conduct examination more frequently than once every three years. The commissioner may waive conducting a comprehensive market conduct examination based on market analysis. [L 2007, c 227, pt of §1]

**§431:2D-107 Confidentiality requirements.** (a) Except as otherwise provided by law, market conduct surveillance personnel shall have free and full access to all books and records, employees, officers, and directors, as practicable, of the insurer during regular business hours. An insurer using a third-party model or product for any of the activities under examination shall provide, upon the request of market conduct surveillance personnel, the details of those models or products to those personnel. All documents, whether from a third party or an insurer, including but not limited to working papers, third-party models or

products, complaint logs, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in the course of any market conduct actions made pursuant to this article, or in the course of market analysis by the commissioner of the market conditions of an insurer, or obtained by the National Association of Insurance Commissioners as a result of any of the provisions of this article, shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(b) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section.

(c) Market conduct surveillance personnel shall be vested with the power to issue subpoenas and examine insurer personnel under oath when such action is ordered by the commissioner.

(d) Notwithstanding any other law to the contrary, the commissioner may:

(1) Share documents, materials, or other information, including confidential and privileged documents, materials, or information subject to subsection (a), with other state, federal, and international regulatory agencies, law enforcement authorities, and the National Association of Insurance Commissioners and its affiliates and subsidiaries; provided that the recipient agrees to and has the legal authority to maintain the confidentiality and privileged status of the documents, materials, communications, or other information;

(2) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Enter into agreements governing the sharing and use of information consistent with this subsection.

(e) No insurer shall be compelled to disclose an insurance compliance self-evaluative audit document or waive any statutory or common law privilege, but may voluntarily disclose such document to the commissioner in response to any market analysis, market conduct action, or examination as provided in this article.

(f) To encourage insurance companies and persons conducting activities regulated under this code, both to conduct voluntary internal audits of their compliance programs and management systems and to access and improve compliance with state and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communication relating to voluntary internal compliance with this State's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance problems. It is further declared that limited expansion of the protection against disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.

(g)(1) Except as provided in subsections (h) and (i), an insurance compliance self-evaluative audit is privileged information and is not discoverable or admissible as evidence in any legal action in any civil, criminal, or administrative proceeding. The privilege created herein is a matter of substantive law of this State and is not merely a procedural matter governing civil or criminal procedures in the courts of this State;

(2) If any company, person, or entity performs or directs the performance of an insurance compliance audit, an officer, employee, or agent involved with the insurance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit may not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this section. This subsection does not apply if the privilege set forth in paragraph (1) is determined under subsection (h) or (i) not to apply;

(3) A company may voluntarily submit, in connection with examinations conducted under this article, an insurance compliance self-evaluative audit document to the commissioner or the commissioner's designee, as a confidential document under this section without waiving the privilege set forth in this section to which the company would otherwise be entitled; provided that the provisions in this section permitting the commissioner to make confidential documents public pursuant to this section and access to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document under other provisions of applicable law, any such report furnished to the commissioner shall not be provided to any other persons or entities and shall be accorded the same confidentiality and other protections as provided above for voluntarily submitted documents. Any use of an insurance compliance self-evaluative audit document shall be limited to determining whether or not any disclosed defects in an insurer's policies and procedures or inappropriate treatment of customers has been remedied or that an appropriate remedy is in place.

A company's insurance compliance self-evaluative audit document submitted to the commissioner shall remain subject to all applicable statutory or common law privileges including, but not limited to, the work product doctrine, attorney-client privilege, or the subsequent remedial measures exclusion.

Any compliance self-evaluative audit document so submitted and in the possession of the commissioner shall remain the property of the company and shall not be subject to any disclosure or production under chapter 92F;

(4) Disclosure of an insurance compliance self-evaluative audit document to a governmental agency, whether voluntary or pursuant to compulsion of law, shall not constitute a waiver of the privilege set forth in paragraph (1) with respect to any other persons or any other governmental agencies.

(h)(1) The privilege set forth in subsection (g) does not apply to the extent that it is expressly waived by the company that prepared or caused to be prepared the insurance compliance self-evaluative audit document;

(2) In a civil or administrative proceeding, a court of record, after an in camera review, may require disclosure of material for which the privilege set forth in subsection (g) is asserted, if the court determines one of the following:

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(A)  The privilege is asserted for a fraudulent purpose; or
(B)  The material is not subject to the privilege;
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(3) In a criminal proceeding, a court of record, after an in camera review, may require disclosure of material for which the privilege described in subsection (g) is asserted, if the court determines one of the following:

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(A)  The privilege is asserted for a fraudulent purpose;
(B)  The material is not subject to the privilege; or
(C)  The material contains evidence relevant to commission of a
     criminal offense under this code, and all three of the
     following factors are present:
      (i)  The commissioner or attorney general has a compelling
           need for the information; and
     (ii)  The information is not otherwise available; and
    (iii)  The commissioner or attorney general is unable to
           obtain the substantial equivalent of the information
           by any other means without incurring unreasonable
           cost and delay.
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(i)(1) Within thirty days after the commissioner or attorney general serves on an insurer a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document under this subsection, the company that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the company to file a petition waives the privilege for this request only;

(2) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its request for an in camera hearing all of the information set forth in subsection (i)(5);

(3) Upon the filing of a petition under this subsection, the court shall issue an order scheduling, within forty-five days after the filing of the petition, an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this section or subject to disclosure;

(4) The court, after an in camera review, may require disclosure of material for which the privilege in subsection (g) is asserted if the court determines, based upon its in camera review, that any one of the conditions set forth in subsection (h)(2)(A) and (B) is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in subsection (h)(3)(A) through (C) is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure;

(5) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall provide to the commissioner or attorney general, as the case may be, at the time of filing any objection to the disclosure, all of the following information:

(A) The date of the insurance compliance self-evaluative audit document;
(B) The identity of the entity conducting the audit;
(C) The general nature of the activities covered by the insurance compliance audit; or
(D) An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

(j)(1) A company asserting the insurance compliance self-evaluative privilege set forth in subsection (g) has the burden of demonstrating the applicability of the privilege. Once a company has established the applicability of the privilege, the party seeking disclosure under subsection (h)(2)(A) has the burden of proving that the privilege is asserted for a fraudulent purpose. The commissioner or attorney general seeking disclosure under subsection (h)(3) has the burden of proving the elements set forth in subsection (h)(3);

(2) The parties may at any time stipulate in proceedings under subsection (h) or (i) to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privilege provided under subsection (g). Any such stipulation may be limited to the instant proceeding and, absent specific language to the contrary, shall not be applicable to any other proceeding.

(k) The privilege set forth in subsection (g) shall not extend to any of the following:

(1) Documents, communications, data, reports, or other information expressly required to be collected, developed, maintained, or reported to a regulatory agency pursuant to this code, or other federal or state law;

(2) Information obtained by observation or monitoring by any regulatory agency; or

(3) Information contained from a source independent of the insurance compliance audit.

(l) As used in this section:

"Insurance compliance audit" means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing non-compliance with, or promoting compliance with laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of a company licensed or regulated under this code, or which involves an activity regulated under this code.

"Insurance compliance self-evaluative audit document" means documents prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document also includes, but is not limited to, any of the following:

(1) An insurance compliance audit report prepared by an auditor, who may be an employee of the company or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

(2) Memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

(3) An implementation plan that addresses correcting past non-compliance, improving current compliance, and preventing future non-compliance; or

(4) Analytic data generated in the course of conducting the insurance compliance audit.

(m) The insurance compliance self-evaluative privilege created by this legislation shall apply to all litigation or administrative proceedings pending [on July 1, 2007].

(n) Nothing in this section nor the release of any self-evaluative audit document hereunder shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion. [L 2007, c 227, pt of §1; am L 2016, c 141, §2]

**[§431:2D-108] Market conduct surveillance personnel.** (a) Market conduct surveillance personnel shall be qualified by education, experience, and, where applicable, professional designations. The commissioner may supplement the in-house market conduct surveillance staff with qualified outside professional assistance if the commissioner determines that assistance is necessary.

(b) Market conduct surveillance personnel have a conflict of interest, either directly or indirectly, if they are affiliated with the management, have been employed by, or own a pecuniary interest in the insurer subject to any examination under this article within the most recent five years prior to the use of the personnel. This section shall

not be construed to automatically preclude an individual from being:

(1) A policyholder or claimant under an insurance policy;

(2) A grantee of a mortgage or similar instrument on the individual's residence from a regulated entity if done under customary terms and in the ordinary course of business;

(3) An investment owner in shares of regulated diversified investment companies; or

(4) A settlor or beneficiary of a "blind trust" into which any otherwise permissible holdings have been placed. [L 2007, c 227, pt of §1]

**[§431:2D-109] Immunity for market conduct surveillance personnel.** (a) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives, or an examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out this article.

(b) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner, the commissioner's authorized representative, or the examiner pursuant to an examination made under this article, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(c) A person identified in subsection (a) shall be entitled to an award of attorney's fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out this article and the party bringing the action was not substantially justified in doing so. For the purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(d) This section shall not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (a). [L 2007, c 227, pt of §1]

**[§431:2D-110] Fines and penalties.** (a) Fines and penalties levied pursuant to this article or other provisions of this chapter shall be consistent, reasonable, and justified.

(b) The commissioner shall take into consideration actions taken by insurers that maintain membership in best-practice organizations that exist to promote high ethical standards of conduct in the marketplace, and insurers that self-assess, self-report, and remediate problems detected to mitigate fines levied pursuant to this article. [L 2007, c 227, pt of §1]

**[§431:2D-111] Data collection and participation in national market conduct databases.** (a) The commissioner shall collect and report market data to the market information systems of the National Association of Insurance Commissioners, including the complaint database system, the examination tracking system, and the regulatory information retrieval system, or other comparable successor products as determined by the commissioner. In addition to complaint data, the accuracy of insurer-specific information reported to the National Association of Insurance Commissioners to be used for market analysis purposes or as the basis for market conduct actions shall be reviewed by appropriate personnel in the

insurance division and by the insurer.

(b) Information collected and maintained by the insurance division shall be compiled in a manner that meets the requirements of the National Association of Insurance Commissioners.

(c) After completion of any level of market analysis, prior to further market conduct action, the commissioner shall contact the insurer to review the analysis.

(d) An insurer responding to a commissioner's request to produce information shall produce it as it is kept in the usual course of business or shall organize and label it to correspond with the categories in the demand.

If a commissioner's request does not specify the form or forms for producing electronically stored information, an insurer responding to the request shall produce the information in a form or forms in which the insurer ordinarily maintains it or in a form or forms that are reasonably usable.

An insurer responding to an information request need not produce the same electronically stored information in more than one form.

An insurer responding to an information request need not provide the electronically stored information from sources that the insurer identifies as not reasonably accessible because of undue burden or cost. [L 2007, c 227, pt of §1]

**[§431:2D-112] Coordination with other states through the National Association of Insurance Commissioners.** The commissioner shall share information and coordinate the insurance division's market analysis and examination efforts with other states through the National Association of Insurance Commissioners. [L 2007, c 227, pt of §1]

**[§431:2D-113] Additional duties of the commissioner.** (a) At least once per year, or more frequently if deemed necessary, the commissioner shall make available in an appropriate manner to insurers and other entities subject to the scope of this chapter, information on new laws and rules, enforcement actions, and other information the commissioner deems pertinent to ensure compliance with market conduct requirements.

(b) The commissioner shall designate a specific person or persons within the insurance division whose responsibilities shall include the receipt of information from employees of insurers and licensed entities concerning violations of laws, as defined in this section. The person or persons shall be provided with proper training on the handling of the information, which shall be deemed a confidential communication for the purposes of this section.

(c) For any change made to a work product referenced in this article, which materially changes the way in which market analysis, market conduct actions, or market conduct examinations are conducted, the commissioner shall give notice and provide parties with an opportunity for a public hearing pursuant to chapter 91. [L 2007, c 227, pt of §1]

**[§431:2D-114] Data calls.** Whether through market analysis, market conduct action, or in response to another regulatory request, any information provided in response to a data call from the commissioner or the commissioner's designee, shall be treated as confidential and privileged. It shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. No waiver of privilege or confidentiality shall occur as a result of

responding to a data call. [L 2007, c 227, pt of §1]

## ARTICLE 3
## INSURERS GENERAL REQUIREMENTS

### PART I. DEFINITIONS

**§431:3-101 Alien insurer.** An alien insurer is one formed under the laws of a nation other than the United States. [L 1987, c 347, pt of §2]

**§431:3-102 Capital funds.** Capital funds means the excess of the assets of an insurer over its liabilities. Capital stock, if any, shall not be deemed to be a liability for the purposes of this section. [L 1987, c 347, pt of §2]

**§431:3-103 Charter.** Charter means articles of incorporation, of agreement, of association, or other basic constituent document of a corporation, or subscribers' agreement and power of attorney for attorney of a reciprocal insurer. [L 1987, c 347, pt of §2]

**§431:3-104 Domestic insurer.** A domestic insurer is one formed under the laws of this State. [L 1987, c 347, pt of §2]

**§431:3-105 Foreign insurer.** A foreign insurer is one formed under the laws of any state, as defined in section 431:1-213, other than this State. [L 1987, c 347, pt of §2]

**§431:3-106 Mutual insurer.** A mutual insurer means an incorporated insurer without capital stock, the governing body of which is elected by its policyholders. The policyholders, who are the insurer's owners, are known as members. [L 1987, c 347, pt of §2]

**§431:3-107 Reciprocal insurance.** Reciprocal insurance means that insurance resulting from the exchange of insurance contracts among subscribers of an unincorporated association, the interexchange being effectuated through an attorney-in-fact common to all such subscribers, thereby providing insurance coverage on each other. [L 1987, c 347, pt of §2]

**§431:3-108 Reciprocal insurer.** A reciprocal insurer means an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact common to all such persons to provide reciprocal insurance among themselves. [L 1987, c 347, pt of §2]

**§431:3-109 Reinsurance.** Reinsurance means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this code sometimes refers to the insurer transferring the risk as the ceding or withdrawing insurer, while the insurer assuming the risk is sometimes termed the assuming reinsurer or the reinsurer. [L

1987, c 347, pt of §2]

**Attorney General Opinions**

Third party liability coverage provided to the State is insurance, not reinsurance. Att. Gen. Op. 95-2.

**[§431:3-110] Stock insurer.** A stock insurer is an incorporated insurer with capital stock divided into shares and owned by its stockholders to whom the earnings are distributed as dividends on their shares. [L 2000, c 182, §1]

## PART II. CERTIFICATE OF AUTHORITY

**§431:3-201 Authority required.** (a) No person shall act as an insurer and no insurer shall transact insurance business in this State other than as authorized by a certificate of authority granted to it by the commissioner; except as to such transactions as are expressly otherwise provided in this code.

(b) The investigation and adjustment of claims in this State arising under insurance contracts issued by an unauthorized insurer, except surplus line insurance issued pursuant to section 431:8-301, shall be deemed to constitute the transaction of insurance in this State, unless the same are isolated or nonrecurring transactions.

(c) Every certificate of authority shall include but not be limited to:

(1) The name of the insurer and the classes of insurance it is authorized to transact in this State; or

(2) The name of and location of the principal office of its attorney-in-fact if a reciprocal insurer. [L 1987, c 347, pt of §2; am L 1993, c 205, §5; am L 2006, c 189, §4]

**§431:3-202 Insurer's name.** (a) Every insurer shall conduct its business in its own legal name.

(b) No insurer shall assume or use a name deceptively similar to that of any other authorized insurer, nor which tends to deceive or mislead as to the type of organization of the insurer.

(c) When a foreign or alien insurer authorized to do business in this State wants to change the name under which its certificate of authority is issued, the insurer shall file a request for name change with the commissioner at least thirty days prior to the effective date of the name change. If within the thirty-day period the commissioner finds the name change request does not meet the requirements of this chapter or of the corporation laws of this State, the commissioner shall send to the insurer written notice of disapproval of the request specifying in what respect the proposed name change fails to meet the requirements of this chapter or the corporation laws of this State and stating that the name change shall not become effective. [L 1987, c 347, pt of §2; am L 1988, c 363, §2(2)]

**§431:3-203 Qualifications for authority.** (a) To qualify for and hold a certificate of authority, an insurer must:

(1) Be a stock, mutual, or reciprocal insurer of the same general type as may be formed as a domestic insurer under article 4;

(2) Have capital funds as required by this code based upon the type and domicile of the insurer and the classes of insurance which the insurer is authorized to transact in its domicile;

(3) Transact or propose to transact in this State insurances which are among those authorized by its charter, and only such insurance as meets the standards and requirements of this code; and

(4) Fully comply with and qualify according to the provisions of this code.

(b) In addition to the requirements in subsection (a), to qualify for and hold a certificate of authority, foreign and alien insurers must have continuously, actively, and successfully transacted the business of insurance for at least five years immediately prior thereto; provided that in the case of a reorganization (including a merger, corporate acquisition, or formation of a subsidiary) of a capital stock or mutual insurer, the five-year period shall be computed from the date of the organization of the original or parent insurer or insurers if substantially the same management continues. [L 1987, c 347, pt of §2; am L 1997, c 13, §1; am L 2001, c 216, §5]

**§431:3-203.5 Foreign insurer; certification.** (a) Notwithstanding section 431:3-203 or any other law to the contrary in this code, the commissioner shall grant a certificate of authority to any applicant, regardless of the number of previous years experience in the business of insurance, that is an insurer licensed under the insurance laws of one of not fewer than three states annually designated, or redesignated, by the commissioner from among the states that are accredited by the National Association of Insurance Commissioners. The loss of accreditation by a state designated by the commissioner shall not in itself affect the validity of a previously issued certificate of authority by the commissioner to a foreign insurer licensed under the insurance laws of the previously accredited state. Nor shall the commissioner's de-selection of a state affect the validity of a previously issued certificate of authority to a foreign insurer licensed by that state.

(b) The commissioner may waive the filing of any document required to be submitted under section 431:3-212.

(c) Nothing in this section shall limit the commissioner's authority to require a foreign insurer to proceed with the certification process under this article if the commissioner, at the commissioner's discretion, determines that it would be in the public interest. [L 1995, c 129, §1; am L 1997, c 36, §1; am L 1998, c 2, §100; am L 2004, c 122, §8]

**§431:3-204 Classes of insurance authorized.** An insurer which otherwise qualifies therefor may be authorized to transact any one or more classes of insurance as defined in sections 431:1-204 to 431:1-211; provided that:

(1) A life insurer shall not transact any insurance in addition to life insurance except accident and health or sickness insurance; provided that nothing herein shall limit a life insurer existing and authorized on July 1, 1988, from writing any authorized insurance stated in its charter; and

(2) A reciprocal insurer shall not transact life or accident and health or sickness insurance. [L 1987, c 347, pt of §2; am L 2003, c 212, §19]

**§431:3-205 Funds required of new insurers.** Subject to section 431:3-203(a)(2), to qualify to transact any one class of insurance, an insurer, not existing and authorized in this State on July 1, 1988, shall:

(1) Deposit in a federally insured financial institution within the State, paid-up capital stock in the case of a stock insurer, or unimpaired surplus if (A) a reciprocal insurer, or (B) a mutual insurer which does not seek to qualify upon the basis of applications and premiums collected as provided in sections 431:4-303 to 431:4-307, in an amount not less than shown in the applicable Schedule "A";

(2) Maintain this deposit at all times while the insurer is licensed and transacting insurance in this State; and

(3) Secure the approval of the commissioner before making withdrawals from the depository.

Schedule "A"

| Class of Insurance | Amount Required |
|---|---|
| Life | $ 600,000 |
| Accident and Health or Sickness | 450,000 |
| Property | 750,000 |
| Marine and Transportation | 1,000,000 |
| Vehicle | 1,000,000 |
| General Casualty | 1,500,000 |
| Surety | 1,000,000 |
| Title | 400,000 |

[L 1987, c 347, pt of §2 as superseded by c 348, §2; am L 1989, c 195, §13; am L 2003, c 212, §20]

**§431:3-206 Additional funds required, new insurers.** In addition to the paid-up capital stock or unimpaired surplus as required under section 431:3-205 and section 431:3-208, the following insurers shall possess when first authorized:

(1) In the case of domestic stock or reciprocal insurers not existing and authorized in this State on July 1, 1988, or domestic mutual insurers not existing and authorized in this State on July 1, 1988, which qualify upon the basis of possession of surplus in lieu of applications and premiums collected as provided in section 431:4-303 to section 431:4-307, bona fide additional surplus equaling in amount not less than fifty per cent of the capital stock or surplus otherwise required for the class or classes of insurance proposed to be transacted; or

(2) In the case of foreign and alien insurers which have been insurers for less than five years except if as a result of a reorganization (including a merger, corporate acquisition, or formation of a subsidiary), bona fide additional surplus in an amount not less than fifty per cent of the capital stock or surplus otherwise required for the class or classes of insurance which the insurer is authorized to transact in its domicile. [L 1987, c 347, pt of §2; am L 1989, c 207, §2]

**§431:3-207 Noncompliance as to capital stock and surplus permitted certain insurers for five years.** (a) A domestic or foreign insurer holding a valid certificate of authority to transact insurance in this State as of July 1, 1988, for a period of five years after that date, may continue to transact the kinds of insurance permitted by the certificate of authority by complying with this code and by maintaining unimpaired

not less than the same amount of paid-in capital stock or surplus, if a mutual or reciprocal insurer, as required under the laws of this State immediately prior to July 1, 1988, and as if the laws had continued in force. After the five-year period, the insurer shall have and maintain not less than the same amount of paid-in capital stock and surplus as is then required of domestic stock insurers newly formed.

(b) An insurer specified in subsection (a) shall not be granted authority to transact any other or additional kinds of insurance after the five-year period specified unless it then fully complies with the capital and surplus requirements applied to all the kinds of insurance it then proposes to transact, as provided under section 431:3-205 as to new domestic insurers. [L 1987, c 347, pt of §2]

**§431:3-208 Funds required of existing and new insurers for transacting additional classes of insurance.** (a) An insurer otherwise qualified may be authorized to transact combinations of classes of insurance while having on deposit in a federally insured financial institution within the State, additional paid- up capital stock in the case of a stock insurer, or additional unimpaired surplus in the case of a mutual or reciprocal insurer, subject to subsection (c) as to domestic mutual or reciprocal insurers, and subject to section 431:3-203(a)(2). An insurer wanting to transact additional classes of insurance must:

(1) Maintain at all times, in a federally insured financial institution within the State, capital if a stock insurer, or surplus, if a mutual or reciprocal insurer, equal to the sum required of each individual class of insurance it desires to transact, as listed in Schedule "A" of section 431:3-205;

(2) Maintain a sum total not to exceed $2,500,000; and

(3) Obtain first the approval by the commissioner for any withdrawals from this deposit.

(b) An insurer while possessing in a federally insured financial institution within the State, $2,500,000 of capital in the case of a stock insurer, or of unimpaired surplus in the case of a reciprocal or mutual insurer, may be authorized to transact all classes of insurance, subject to sections 431:3-204 to 431:3-206.

(c) To qualify for authority to transact a combination of classes of insurance, a domestic mutual or reciprocal insurer shall deposit in a federally insured financial institution within the State, surplus in an amount equal to the paid-up capital stock required of stock insurers for authority to transact a like combination of classes of insurance. [L 1987, c 347, pt of §2 as superseded by c 348, §3]

**§431:3-209 Deposits of alien and foreign insurers; special deposits.** (a) To qualify for and hold a certificate of authority, an alien or foreign insurer must deposit and maintain on deposit assets equal in amount to either the amount of paid-up capital stock in the case of a stock insurer, or surplus, in the case of a mutual or reciprocal insurer, required of a domestic insurer to transact a business of insurance in like class or classes of insurance, or the amount of $500,000, whichever amount is the greater.

(b) The deposit shall be for the security of all policyholders and obligees of the insurer in the United States. It shall not be subject to diminution below the amount currently determined in accordance with subsection (a) so long as the insurer has outstanding any liabilities arising out of its business transacted in the United States.

(c) The deposit shall be maintained with the commissioner. In lieu of the deposit or part thereof, the commissioner shall accept the certificate of the public official having supervision over insurance in another state showing that deposits by the insurer, or like part thereof, maintained by the insurer in that state for the benefit of all of the insurer's policyholders in the United States or all of its policyholders and obligees in the United States, if the total deposit in this State and those evidenced by the certificate or certificates is in an amount not less than the amount required pursuant to subsection (a).

(d) The commissioner may require the foreign or alien insurer to place in a special deposit an amount determined by the commissioner in a federally insured financial institution within the State. [L 1987, c 347, pt of §2 as superseded by c 348, §4]

**§431:3-210 Determination of capital funds of alien insurer.** (a) The capital funds of an alien insurer shall be deemed to be the amount by which its assets exceed its liabilities with respect to its business transacted in the United States.

(b) Assets of such insurer held in any state for the special protection of policyholders and obligees in such state shall not constitute assets of the insurer for the purpose of this code. Liabilities of the insurer so secured by such assets but not exceeding the amount of such assets, may be deducted in computing the insurer's liabilities for the purpose of this section. [L 1987, c 347, pt of §2]

**§431:3-211 REPEALED.** L 1997, c 12, §1 and c 233, §6.

**§431:3-212 Application for authority.** To apply for an original certificate of authority, an insurer shall:

(1) File with the commissioner its request showing:

(A) Its name, home office location, type of insurer, organization date, and state or country of its domicile, and name and location of principal office of its attorney-in-fact if a reciprocal insurer;
(B) The classes of insurance it proposes to transact; and
(C) Additional information as the commissioner may reasonably require;

(2) File with the commissioner:

(A) A copy of its charter as amended or such copy certified by the proper public officer of the state or country of domicile if a foreign or alien insurer;
(B) A copy of its bylaws as amended, certified by its proper officer;
(C) A copy of its annual statement as of December 31 last preceding;
(D) An appointment of the commissioner as its attorney to receive service of legal process, if a foreign or alien insurer, or a domestic reciprocal insurer;
(E) The name and business address of its authorized resident agent upon whom process may be served in all cases, if a foreign or alien insurer;

(F) A copy of the appointment and authority of its United States manager, certified by its proper officer, if an alien insurer;

(G) A certificate from the proper public official of its state or country of domicile showing that it is duly organized and is authorized to transact the classes of insurance proposed to be transacted, if a foreign or alien insurer;

(H) The declaration required by section 431:4-409 if a domestic reciprocal insurer;

(I) Certificate of the proper public official as to any deposit made or held in compliance with this code;

(J) Copy of report of the last examination made of the insurer certified by the insurance supervisory official of its state of domicile or entry into the United States, if a foreign or alien insurer; and

(K) Other documents or stipulations as the commissioner may reasonably require to evidence compliance with this code; and

(3) Deposit with the commissioner the appropriate fees required by this code. [L 1987, c 347, pt of §2; am L 2002, c 155, §7; am L 2003, c 212, §21]

**§431:3-212.5 Redomestication of authorized insurers.** (a) The certificate of authority, producer appointments and licenses, rates, and other items allowed by the commissioner, which are in existence at the time an insurer authorized to transact insurance business in this State transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon such transfer if the insurer remains qualified to transact insurance business in this State. For purposes of this section, an insurer transferring its corporate domicile to this State remains qualified to transact insurance business in this State if it meets the organization and licensing requirements applicable to the same type of domestic insurer. All outstanding policies of a transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner.

(b) Each transferring insurer shall file new policy forms on or before the effective date of the transfer if such forms are required to be approved by the commissioner. The insurer may use existing policy forms with appropriate endorsements if permitted by, and under such conditions as approved by, the commissioner. Every such transferring insurer shall notify the commissioner of the details of the proposed transfer and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the commissioner.

(c) The commissioner may apply this section to any domestication occurring in another state by an authorized United States branch of an alien insurer. [L 1991, c 181, §1; am L 2002, c 155, §8; am L 2004, c 122, §9]

**Cross References**

Redomestication--captive insurers, see §§431:19-102.3 and 431:19-102.4.

**§431:3-213 Authority issued or denied.** (a) If the commissioner

finds that an insurer has met the requirements for and is fully entitled thereto under this code, the commissioner shall issue to it a proper certificate of authority.

(b) If the commissioner does not so find, the commissioner shall deny the insurer certificate of authority within a reasonable length of time following filing of the application by the insurer.

(c) The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer. [L 1987, c 347, pt of §2]

**§431:3-214 Extension; amendment.** (a) No certificate of authority shall contain an expiration date, but all certificates of authority shall be extended by the commissioner from time to time in order to continue to be valid. When the commissioner issues or extends a certificate of authority, the commissioner shall determine the date prior to which the certificate of authority must be extended and shall so notify the insurer in writing. This date is called the extension date. The extension date shall be any date not less than one year and not more than three years after date of issue or extension of the certificate of authority. If the insurer qualifies, its certificate of authority shall be extended. The commissioner shall provide each holder of a certificate of authority at least thirty days' advance written notice of the applicable extension date.

(b) The commissioner shall amend a certificate of authority at any time in accordance with changes in the insurer's charter or insuring powers. [L 1987, c 347, pt of §2; am L 2015, c 63, §4]

**§431:3-215 Withdrawal from State; obligations.** (a) No insurer other than a life insurer shall withdraw from this State until its direct liability to its policyholders and obligees under all its insurance contracts then in force in this State has been assumed by another authorized insurer under an agreement approved by the commissioner.

(b) The assuming insurer shall, within a reasonable time, replace the assumed insurance contracts with its own, or by endorsement thereon acknowledge its liability under the assumed contracts.

(c) Six months prior to withdrawing from this State, an insurer shall file an affidavit with the commissioner showing that:

(1) It desires to withdraw from this State and to discontinue business in this State; and

(2) All of its outstanding policies have been either reinsured or have expired. If the outstanding policies are reinsured, the withdrawing insurer shall also submit the reinsurer's affidavit stating that it has reinsured all the outstanding policies of the withdrawing insurer upon risks in this State or upon business originating in this State. The reinsurer shall be an insurer authorized to carry on the business of insurance in this State.

(d) The insurer shall return for cancellation its current certificate of authority and licenses for producers issued by the commissioner.

(e) Six months prior to withdrawing from this State, an insurer shall, in addition to other requirements, publish in this State a notice of withdrawal once each week for the first eight successive weeks, and again in the last four successive weeks in the sixth month in a newspaper of daily circulation; provided that the commissioner shall have the discretion to waive the notice requirement. The notice of withdrawal as published shall have the prior approval of the commissioner. [L 1987, c

347, pt of §2; am L 1993, c 199, §1; am L 2002, c 155, §9; am L 2004, c 122, §10]

**§431:3-216 Mandatory refusal, suspension or revocation provisions.** The commissioner shall suspend, revoke, or refuse to extend an insurer's certificate of authority in addition to other grounds in this code, if the insurer:

(1) Is a domestic stock insurer and has assets less in amount than its liabilities, including its capital stock less amounts required for the class of insurance or combination of classes of insurance as a liability, and has failed to make good such deficiency as required by the commissioner.

(2) Is a domestic mutual or domestic reciprocal insurer, and fails to make good a deficiency of assets as required by the commissioner.

(3) Is a foreign or alien insurer and no longer qualifies or meets the requirements for the authority.

(4) Knowingly exceeds its charter powers or its certificate of authority. [L 1987, c 347, pt of §2]

**§431:3-217 Discretionary refusal, suspension or revocation provisions.** After a hearing the commissioner may suspend, revoke, or refuse to extend an insurer's certificate of authority, in addition to other grounds in this code, if the insurer:

(1) Knowingly fails to comply with or, in the case of a reciprocal insurer, if the attorney fails to comply with, or violates any provision of this code other than those for violation of which refusal, suspension or revocation is mandatory;

(2) Knowingly fails to comply with any proper order of the commissioner;

(3) Is found by the commissioner upon examination, or other evidence, to be in unsound condition or in a condition as to render its further proceedings in this State hazardous to the public or to its policyholders in this State;

(4) Refuses to remove or discharge a director or officer who has been convicted of any crime involving fraud or dishonesty;

(5) Commits or performs with a frequency as to indicate a general business practice any act which compels claimants under policies either to accept less than the amount due them or to bring suit against it to secure full payment of the amount due;

(6) Is affiliated with and under the same general management, interlocking directorate, or ownership as another insurer which transacts insurance other than reinsurance in this State without having a certificate of authority therefor, except as is permitted by this code;

(7) Refuses to be examined, or if its directors, officers, employees, or representatives refuse to submit to examination or give testimony concerning its affairs, or to produce its accounts, records, and files for examination by the commissioner when required by this code, or refuses to perform any legal obligation relative to the examination;

(8) Fails to pay any final judgment rendered against it upon any policy, bond, recognizance, or undertaking issued or guaranteed by it, within sixty days after the judgment became final or within sixty days after time for taking an appeal has expired or within sixty days after dismissal of an appeal before final determination, whichever date is the later; or

(9) Fails to file its annual statement when due or within any extension of time which the commissioner

may for good cause have granted. [L 1987, c 347, pt of §2 as superseded by c 349, §2]

**§431:3-218 Procedure upon revocation; suspension of certificate of authority.** Upon revoking, suspending, or refusing to extend an insurer's authority to transact insurance, the commissioner shall forthwith:

(1) Give notice thereof to the insurer not fewer than ten days in advance of the effective date of the revocation or suspension;

(2) Likewise revoke or suspend all producers' authority to represent the insurer in this State and give notice thereof to the producers; and

(3) Give notice thereof to the insurance supervisory official of each other state in which the insurer is authorized to transact insurance; provided that notice to the National Association of Insurance Commissioners shall satisfy this requirement. [L 1987, c 347, pt of §2; am L 2001, c 216, §6; am L 2004, c 122, §11]

**§431:3-219 Suspension period; revocation.** (a) Except as otherwise expressly provided in this code, the commissioner may suspend an insurer's certificate of authority for a period not to exceed one year. The commissioner shall state in the commissioner's order of suspension the period during which it shall be effective.

(b) After the completion of the original suspension period, the commissioner may order additional extensions of the suspension or revoke an insurer's certificate of authority pursuant to section 431:3-218, provided there is a basis for the extended suspension or revocation and the insurer has an opportunity for a hearing prior to the imposition of the extended suspension or revocation. [L 1987, c 347, pt of §2; am L 2005, c 132, §2]

**§431:3-220 Revival.** An insurer whose certificate of authority has been suspended, revoked, or refused may subsequently be authorized if:

(1) The grounds for the suspension, revocation, or refusal no longer exist and the insurer is otherwise fully qualified; and

(2) The insurer has reimbursed the commissioner for all reasonable and necessary expenses incurred by virtue of the suspension, revocation, or reinstatement of the certificate of authority. [L 1987, c 347, pt of §2]

**§431:3-221 Power to fine.** In addition to or in lieu of the suspension, revocation, or refusal to extend any certificate of authority, the commissioner, after hearing, may levy a fine upon the insurer in an amount not less than $500 and not more than $50,000. The order levying the fine shall specify the period within which the fine shall be fully paid, which shall not be less than thirty nor more than forty-five days from the date of the order. Upon failure to pay the fine when due, the commissioner shall revoke the insurer's certificate of authority if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the commissioner by the attorney general. Any fine so collected shall be paid by the commissioner to the director of finance for the account of the compliance resolution fund. [L 1987, c 347, pt of §2; am L 1999, c 163, §15(1); am L 2002, c 39, §10]

## PART III. ANNUAL REQUIREMENTS AND LIMITING PROVISIONS

**§431:3-301 Annual and quarterly filings with commissioner.** (a) Each domestic, foreign, and alien insurer that is authorized to transact insurance in this State shall file annually with the commissioner, on or before March 1 of each year, a copy of its annual statement convention blank, statement of actuarial opinion by a qualified actuary or specialist, and additional filings as prescribed by the commissioner for the preceding year. Each insurer shall file quarterly, on or before the forty-fifth day after each quarter, a copy of its quarterly statement. The statements shall be prepared in accordance with the National Association of Insurance Commissioners' annual statement instructions, following the practices and procedures prescribed by the National Association of Insurance Commissioners' accounting practices and procedures manuals. The annual and quarterly statements shall be verified by oaths of at least two of the insurer's principal officers, or the attorney-in-fact in the case of a reciprocal insurer, or the United States manager in the case of an alien insurer. The statement of an alien insurer shall relate only to its transactions and affairs in the United States. Foreign and alien insurers that are in compliance with section 431:3-302 are not required to file annual and quarterly statements with this State.

(b) Each insurer shall file the tax statement provided for by section 431:7-201.

(c) Any insurer failing or refusing to submit the annual or quarterly filing or any of the documents in accordance with this section shall be liable for a fine in an amount not less than $100 and not more than $500 for each day of delinquency. The commissioner may suspend or revoke the certificate of authority of any insurer that fails to file any of the documents required pursuant to this section. [L 1987, c 347, pt of §2; am L 1992, c 176, §9; am L 1993, c 205, §6 as superseded by c 321, §9; am L 1994, c 128, §2; am L 1995, c 232, §11; am L 1997, c 36, §2; am L 2003, c 212, §22]

**§431:3-302 Annual and quarterly filings with the National Association of Insurance Commissioners.** (a) Each domestic, foreign, and alien insurer that is authorized to transact insurance in this State shall file annually with the National Association of Insurance Commissioners, on or before March 1 of each year, a copy of its annual statement convention blank, statement of actuarial opinion by a qualified actuary or specialist, and additional filings as prescribed by the commissioner for the preceding year. Each insurer shall file quarterly, on or before the forty-fifth day after each quarter, a copy of its quarterly statement with the National Association of Insurance Commissioners. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addenda to the statement filing subsequently filed with the commissioner shall also be filed with the National Association of Insurance Commissioners. In addition to the printed annual and quarterly filings addressed in this section, the annual and quarterly filings shall also be filed electronically in the format prescribed by the National Association of Insurance Commissioners' annual statement instructions. The annual and quarterly electronic

filings shall be due on the same dates as the corresponding printed information.

(b) Any insurer failing or refusing to submit the annual or quarterly filings in accordance with this section shall be liable for a penalty in an amount not less than $100 and not more than $500 for each day of delinquency. [L 1987, c 347, pt of §2; am L 1993, c 205, §7; am L 1994, c 190, §§2, 10; am L 1995, c 61, §2 as superseded by c 232, §§4, 12; am L 1997, c 368, §2; am L 1999, c 302, §9 as superseded by c 128, §2; am L 2003, c 212, §23]

**§431:3-302.5 Annual audit.** (a) Annually on or before June 1, or such later date as the commissioner upon request or for cause may specify, each domestic insurer shall file an audit by a designated independent certified public accountant or accounting firm of the financial statements reporting the financial condition and the results of operations of the insurer. The insurer shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit within sixty days of retention. The commissioner may disapprove the insurer's designation within fifteen days of receipt of the insurer's notice, and the insurer shall be required to designate another independent certified public accountant or accounting firm.

(b) An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred per cent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool.

(c) The audit required in subsection (a) and the audited consolidated or combined financial statements as may be approved under subsection (b) shall be prepared in accordance with the National Association of Insurance Commissioners accounting practices and procedures manual and rules adopted by the commissioner following the practices and procedures prescribed by the National Association of Insurance Commissioners.

(d) Any insurer failing or refusing to submit the annual audit or any of the documents required under subsection (a) or as may be approved under subsection (b), on or before June 1, or a later date as the commissioner upon request or for cause may specify, shall be liable for a penalty in an amount not less than $100 and not more than $500 for each day of delinquency. The commissioner may suspend or revoke the certificate of authority of any insurer who fails to file any of the documents required in subsection (a). [L 1991, c 103, §1; am L 1994, c 128, §3; am L 1997, c 368, §3; am L 2004, c 122, §12; am L 2009, c 77, §3]

**§431:3-303 Immunity.** In the absence of actual malice, members of the National Association of Insurance Commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, National Association of Insurance Commissioners employees, and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating information from the filing of the annual statement convention blanks shall be acting as agents of the commissioner under the authority of this code and will not be subject to civil liability for

libel, slander or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information from the filings required hereunder. [L 1987, c 347, pt of §2]

**§431:3-304 Confidentiality.** All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the insurance division by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the insurance division. [L 1987, c 347, pt of §2]

**§431:3-304.5 Statement of actuarial opinion; property and casualty insurance; confidentiality.** (a) The statement of actuarial opinion shall be provided with the annual statement in accordance with the property and casualty annual statement instruction as adopted by the National Association of Insurance Commissioners and shall be treated as a public document.

(b) Documents, materials, or other information related to or provided in connection with an actuarial report, working papers, or actuarial opinion summary that are in possession or control of the commissioner shall be confidential by law and privileged, shall not be made public, shall not be subject to subpoena or discovery, and shall not be admissible as evidence in any private civil action; provided that:

(1) The commissioner may release the documents to the Actuarial Board for Counseling and Discipline or its successor to the extent that the material is required for the purpose of professional disciplinary proceedings and that the Actuarial Board for Counseling and Discipline or its successor establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents;

(2) This section shall not be construed to limit the commissioner's authority to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties; and

(3) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to this subsection.

(c) The commissioner may share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsections (a) and (b), with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities; provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or information and has the legal authority to do so.

(d) The commissioner may receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions. The commissioner shall maintain as confidential or privileged, subject to subsection (b)(3), any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the

source of the document, material, or information.

(e) The commissioner may enter into agreements governing sharing and use of information consistent with subsections (b), (c), and (d).

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information subject to this section shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsections (b), (c), and (d). [L 2010, c 116, §1(1); am L 2011, c 43, §13]

**§431:3-305 Accounts; records.** Every insurer shall keep full and adequate accounts and records of its assets, obligations, transactions, and affairs. Every domestic insurer shall maintain said accounts and records at its principal office in this State. [L 1987, c 347, pt of §2]

**§431:3-306 Limit of risk.** (a) No insurer shall retain net any risk on any one subject of insurance, whether located or to be performed in this State or elsewhere, in an amount exceeding ten per cent of its surplus to policyholders.

(b) For the purposes of this section, a subject of insurance as to insurance against fire includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire.

(c) Reinsurance in any reinsurer not qualified under article 4A may not be deducted in determining risk retained for the purposes of this section.

(d) In the case of surety insurance, the net retention shall be computed after deduction of reinsurances, the amount assumed by any co-surety, the value of any security deposited, pledged, or held subject to the consent of the surety and for the protection of the surety.

(e) This section shall not apply to insurance of marine risks or marine protection and indemnity risks. [L 1987, c 347, pt of §2; am L 1993, c 321, §10; am L 2004, c 122, §13]

**§431:3-306.5 Residential hurricane coverage.** (a) Upon written request of the commissioner by certified mail, an insurer writing the peril of residential hurricane coverage in this State shall within thirty days after receipt of the request, make accessible to the commissioner or commissioner's designee information verifying that the insurer has the financial assets and ability to cover its hurricane insurance exposure. The information to be made accessible shall include:

(1) The aggregate amount of hurricane coverage premiums and aggregate limits of coverage by type of coverage, which shall be compiled on a quarterly basis;

(2) The probable maximum loss associated with the above aggregate limits, assuming the occurrence of a hurricane of a severity unlikely to occur more frequently than once every one hundred years, as that loss is estimated in a report prepared by a recognized hurricane modeling company;

(3) All financial information relating to the insurer's capital base and reinsurance program for hurricane losses, such as:

(A) Information describing the reinsurance program in place as of the date notice was received;
(B) The names and financial ratings of each reinsurer;

(C) Aggregate limits of reinsurance coverage available; and
(D) Reinstatement provisions; and

(4) Any other related information the commissioner may require to evaluate the adequacy of the program.

(b) If the commissioner determines that the loss estimated pursuant to subsection (a) exceeds the sum of an insurer's capitalization and available reinsurance, the commissioner may further examine that insurer's financial position as allowed by article 2 and commence supervisory and other appropriate proceedings under article 15.

(c) The cost of an examination under this section shall be assessed against the insurer being examined and remitted to the commissioner for deposit into the compliance resolution fund.

(d) Any final order or decision of the commissioner under this section shall be made pursuant to chapter 91. [L 2001, c 120, §1; am L 2003, c 212, §24]

**§431:3-307 Free insurance.** Except as otherwise provided by law, no insurer, either domestic, foreign or alien, shall issue or cause to be issued any policy of insurance of any type or description upon life or property, real or personal, whenever the policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, either as an inducement to purchase or bailment of the property, real or personal, or as a part of the consideration for the purchase or bailment of the property, real or personal. [L 1987, c 347, pt of §2]

**§431:3-308 Alien government owned insurers.** No license to transact any kind of insurance business in this State shall be issued or renewed to any foreign or alien insurer or issued or continued in effect to any domestic insurer which is owned or financially controlled by another state of the United States other than this State, or by a foreign government, or by any political subdivision of either, or which is an agency or instrumentality of any such state, government, or subdivision, unless the insurer was so owned or controlled prior to January 1, 1957, and was authorized to do business in this State on or prior to that date. [L 1987, c 347, pt of §2]

**§431:3-309 Disclosure of profits by insurers.** All insurance companies transacting business in this State under authority provided by this code or any other provision of Hawaii law shall, within three months following the completion of the calendar year, submit to the commissioner a full and accurate written disclosure of:

(1) All profits derived from each line of insurance written for the applicable calendar year, and

(2) All profits for the entire company for the applicable calendar year.

All disclosures submitted pursuant to this section shall be in a form prescribed by the commissioner. [L 1987, c 347, pt of §2]

## PART IV. RISK-BASED CAPITAL FOR INSURERS

### Note

Part heading amended by L 1997, c 75, §2.

**Cross References**

Civil relief for state military forces, see chapter 657D.

**§431:3-401 Definitions.** For purposes of this part unless the context otherwise requires:

"Adjusted risk-based capital report" means a risk-based capital report which has been adjusted by the commissioner in accordance with section 431:3-402(e).

"Benefit society" means a mutual benefit society registered under section 432:1-301 or a fraternal benefit society organized under section 432:2-301.

"Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

"Domestic insurer" includes an insurer, a benefit society or a health maintenance organization.

"Health maintenance organization" means a health maintenance organization authorized under section 432D-2.

"Life or accident and health or sickness insurer" means any insurer that is within the definition of section 431:1-204 or 431:1-205 and is licensed under article 3, or a licensed property and casualty insurer writing only accident and health or sickness insurance.

"NAIC" means the National Association of Insurance Commissioners.

"Negative trend" means, with respect to a life or accident and health or sickness insurer, a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the risk-based capital instructions.

"Property and casualty insurer" means any insurer that is within the definition of section 431:1-206, 431:1-207, 431:1-208, 431:1-209, 431:1-210, or 431:1-211 and is licensed under article 3, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

"Risk-based capital instructions" means the risk-based capital report including risk-based capital instructions adopted by the National Association of Insurance Commissioners, as such risk-based capital instructions may be amended by the National Association of Insurance Commissioners from time to time in accordance with the procedures adopted by the National Association of Insurance Commissioners.

"Risk-based capital level" means an insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital where:

(1) "Company action level risk-based capital" means, with respect to any insurer, the product of 2.0 and its authorized control level risk-based capital;

(2) "Regulatory action level risk-based capital" means, with respect to any insurer, the product of 1.5 and its authorized control level risk-based capital;

(3) "Authorized control level risk-based capital" means, with respect to any insurer, the number determined under the risk-based capital formula in accordance with the risk-based capital instructions; and

(4) "Mandatory control level risk-based capital" means, with respect to any insurer, the product of 0.70 and the authorized control level risk-based capital.

"Risk-based capital plan" means a comprehensive financial plan containing the elements specified in section 431:3-403(b). If the commissioner rejects the risk-based capital plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised risk-based capital plan".

"Risk-based capital report" means the report required in section 431:3-402.

"Total adjusted capital" means the sum of:

(1) An insurer's statutory capital and surplus, or net worth, as determined in accordance with the statutory accounting applicable to the annual financial statements or reports required to be filed under section 431:3-301, 432:1-404, 432:2-602, or 432D-5; and

(2) Any other items that the risk-based capital instructions may provide. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §3; am L 1999, c 128, §2; am L 2003, c 212, §25; am L 2010, c 4, §7; am L 2011, c 80, §1]

**§431:3-402 Risk-based capital reports.** (a) Every domestic insurer, on or before each March 1, the filing date, shall prepare and submit to the commissioner a report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing any information that is required by the risk-based capital instructions. In addition, every domestic insurer shall file its risk-based capital report:

(1) With the National Association of Insurance Commissioners in accordance with the risk-based capital instructions; and

(2) With the insurance commissioner in any state in which the insurer is authorized to do business, if the commissioner has notified the insurer of its request in writing, in which case the insurer shall file its risk-based capital report not later than the later of:

(A) Fifteen days from the receipt of notice to file its risk-based capital report with that state; or

(B) The filing date.

(b) A life or accident and health or sickness insurer's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance among the following, which shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions:

(1) The risk with respect to the insurer's assets;

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) The interest rate risk with respect to the insurer's business; and

(4) All other business risks and any other relevant risks that are set forth in the risk-based capital instructions.

(c) A property and casualty insurer's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance among the following, which shall be determined in each

case by applying the factors in the manner set forth in the risk-based capital instructions:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and any other relevant risks as set forth in the risk-based capital instructions.

(d) A benefit society or health maintenance organization's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance among the following, which shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and any other relevant risks as set forth in the risk-based capital instructions.

(e) An excess of capital, or net worth, over the amount produced by the risk-based capital requirements contained in this part and the formulas, schedules, and instructions referenced in this part is desirable in the business of insurance. Accordingly, insurers shall seek to maintain capital above the risk-based capital levels required by this part. Additional capital is used and useful in the business of insurance and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this part.

(f) If a domestic insurer files a risk-based capital report which, in the judgment of the commissioner, is inaccurate, then the commissioner shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. A risk-based capital report adjusted pursuant to this subsection is referred to as an adjusted risk-based capital report. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §4; am L 1998, c 71, §2; am L 1999, c 128, §2; am L 2003, c 212, §26; am L 2011, c 80, §2]

**§431:3-403 Company action level event.** (a) "Company action level event" means any of the following events:

(1) The filing of a risk-based capital report by an insurer which indicates that:

(A) The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital;

(B) If a life or accident and health or sickness insurer, the insurer has total adjusted capital greater than or equal to its company action level risk-based capital but less

than the product of its authorized control level risk-based capital and three, and has a negative trend;

(C) If a property and casualty insurer, the insurer has a total adjusted capital greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and three, and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions; or

(D) If a benefit society or health maintenance organization, the benefit society or health maintenance organization has a total adjusted capital greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and three, and triggers the trend test determined in accordance with the trend test calculation included in the health risk-based capital instructions;

(2) The notification by the commissioner to the insurer of an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), if the insurer does not challenge the adjusted risk-based capital report under section 431:3-407; or

(3) If, pursuant to section 431:3-407, the insurer challenges an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the commissioner a risk-based capital plan which shall:

(1) Identify the conditions in the insurer which contribute to the company action level event;

(2) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(3) Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions having an impact on the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

(c) The risk-based capital plan shall be submitted:

(1) Within forty-five days of the company action level event; or

(2) If the insurer challenges an adjusted risk-based capital report pursuant to section 431:3-407, within forty-five days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within sixty days after the submission by an insurer of a risk-based capital plan to the commissioner, the commissioner shall notify the

insurer whether the risk-based capital plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the risk-based capital plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the risk-based capital plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised risk-based capital plan to the commissioner:

(1) Within forty-five days after the notification from the commissioner; or

(2) If the insurer challenges the notification from the commissioner under section 431:3-407, within forty-five days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the commissioner, at the commissioner's discretion, subject to the insurer's right to a hearing under section 431:3-407, may specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic insurer that files a risk-based capital plan or revised risk-based capital plan with the commissioner shall file a copy of the risk-based capital plan or revised risk-based capital plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) That state has a risk-based capital provision substantially similar to section 431:3-408(a); and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the risk-based capital plan or revised risk-based capital plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with that state; or

(B) The date on which the risk-based capital plan or revised risk-based capital plan is filed under subsections (c) and (d). [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §5; am L 1999, c 128, §2; am L 2003, c 212, §27; am L 2011, c 80, §3; am L 2013, c 190, §1]

**§431:3-404 Regulatory action level event.** (a) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(1) The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital;

(2) The notification by the commissioner to an insurer of an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), if the insurer does not challenge the adjusted risk-based capital report under section 431:3-407;

(3) If, pursuant to section 431:3-407, the insurer challenges an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to file a risk-based capital report by the filing date, unless the insurer has provided an explanation for the failure which is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(5) The failure of the insurer to submit a risk-based capital plan to the commissioner within the time set forth in section 431:3-403(c);

(6) Notification by the commissioner to the insurer that:

(A) The risk-based capital plan or revised risk-based capital plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and
(B) The notification constitutes a regulatory action level event with respect to the insurer, if the insurer has not challenged the determination under section 431:3-407;

(7) If, pursuant to section 431:3-407, the insurer challenges a determination by the commissioner under paragraph (6), the notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the challenge;

(8) Notification by the commissioner to the insurer that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the commissioner has so stated in the notification, and if the insurer has not challenged the determination under section 431:3-407; or

(9) If, pursuant to section 431:3-407, the insurer challenges a determination by the commissioner under paragraph (8), the notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the challenge.

(b) In the event of a regulatory action level event the commissioner shall:

(1) Require the insurer to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;

(2) Perform any examination or analysis that the commissioner deems necessary of the assets, liabilities, and operations of the insurer including a review of its risk-based capital plan or revised risk-based capital plan; and

(3) Subsequent to the examination or analysis, issue a corrective order specifying the corrective actions the commissioner determines are required.

(c) In determining corrective actions, the commissioner may take into account any relevant factors with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including but not limited to the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan shall be submitted:

(1) Within forty-five days after the occurrence of the regulatory action level event;

(2) If the insurer challenges an adjusted risk-based capital report pursuant to section 431:3-407 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to

the insurer that the commissioner, after a hearing, has rejected the insurer's challenge; or

(3) If the insurer challenges a revised risk-based capital plan pursuant to section 431:3-407 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after notification to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants that may be necessary, in the judgment of the commissioner, to review the insurer's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities, and operations of the insurer, and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or any other party as directed by the commissioner. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §§6, 7; am L 1999, c 128, §2]

**§431:3-405 Authorized control level event.** (a) "Authorized control level event" means any of the following events:

(1) The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital;

(2) The notification by the commissioner to the insurer of an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), if the insurer does not challenge the adjusted risk-based capital report under section 431:3-407;

(3) If, pursuant to section 431:3-407, the insurer challenges an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge;

(4) The failure of the insurer to respond in a manner satisfactory to the commissioner to a corrective order; provided the insurer has not challenged the corrective order under section 431:3-407; or

(5) If the insurer has challenged a corrective order under section 431:3-407 and the commissioner, after a hearing, has rejected the challenge or modified the corrective order, the failure of the insurer to respond in a manner satisfactory to the commissioner to the corrective order subsequent to rejection or modification by the commissioner.

(b) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(1) Take any actions that are required under section 431:3-404 regarding an insurer with respect to which a regulatory action level event has occurred; or

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take any actions that are necessary to cause the insurer to be placed under regulatory control under article 15. In the event the commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the commissioner to take action under article 15, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in article 15. In the event the commissioner takes actions under this paragraph pursuant to an adjusted risk-based capital report, the insurer shall be entitled to the protections that are afforded to insurers under the provisions of section 431:15-201. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §8; am L 1999, c 128, §2]

**§431:3-406 Mandatory control level event.** (a) "Mandatory control level event" means any of the following events:

(1) The filing of a risk-based capital report which indicates that the insurer's total adjusted capital is less than its mandatory control level risk-based capital;

(2) Notification by the commissioner to the insurer of an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), if the insurer does not challenge the adjusted risk-based capital report under section 431:3-407; or

(3) If, pursuant to section 431:3-407, the insurer challenges an adjusted risk-based capital report that indicates the occurrence of the event in paragraph (1), notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(b) In the event of a mandatory control level event:

(1) With respect to a life or accident and health or sickness insurer, the commissioner shall take any actions that are necessary to cause the insurer to be placed under regulatory control under article 15. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under article 15, and the commissioner shall have the rights, powers, and duties with respect to the insurer as provided by article 15. In the event the commissioner takes actions pursuant to an adjusted risk-based capital report, the insurer shall be entitled to the protections afforded to insurers under section 431:15-201. Notwithstanding the requirements of this paragraph, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period;

(2) With respect to a property and casualty insurer, the commissioner shall take any actions that are necessary to cause the insurer to be placed under regulatory control under article 15, or, in the case of an insurer that is writing no business and is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the commissioner. In either event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under article 15 and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in article 15. In the event the commissioner takes actions pursuant to an adjusted risk-based capital report, the insurer shall be entitled to the protections afforded to insurers under section 431:15-201. Notwithstanding the requirements of this paragraph, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period; or

(3) With respect to a benefit society or health maintenance organization, the commissioner shall take any actions that are necessary to cause the insurer to be placed under regulatory control under article 15. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under article 15, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in article 15. In the event the commissioner takes actions pursuant to an adjusted risk-based capital report, the insurer shall be entitled to the protections that are afforded to insurers under section 431:15-201. Notwithstanding the requirements of this paragraph, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §9; am L 1999, c 128, §2; am L 2003, c 212, §28; am L 2011, c 80, §4]

**§431:3-407 Hearing.** (a) The insurer shall have the right to a hearing pursuant to chapter 91 upon being notified of any of the following:

(1) Notification to an insurer by the commissioner of an adjusted risk-based capital report;

(2) Notification to an insurer by the commissioner that:

(A) The insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory; and
(B) The notification constitutes a regulatory action level event with respect to the insurer;

(3) Notification to any insurer by the commissioner that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its risk-based capital plan or revised risk-based capital plan; or

(4) Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

(b) The insurer shall have the right to a confidential hearing exempt from chapter 92, on the record, and pursuant to chapter 91, at which the insurer may challenge any determination or action by the commissioner. The insurer shall notify the commissioner of its request for a hearing within five days after receiving the notification by the commissioner pursuant to subsection (a). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten days, nor more than thirty days, after the date of the insurer's request. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §10; am L 1999, c 128, §2]

**§431:3-408 Confidentiality and prohibition on announcements; prohibition on use in ratemaking.** (a) All risk-based capital reports, to the extent the information contained in the report is not required to be set forth in a publicly available annual statement schedule, and risk-based capital plans, including the results or report of any examination or analysis of an insurer performed pursuant to this part and any corrective order issued by the commissioner pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer that are in the possession or under the control of the commissioner shall be confidential by law and shall be privileged. Risk-based capital reports and risk-based capital plans subject to this section shall not be made public, shall not be subject to subpoena or discovery, and shall not be admissible as evidence in any private civil action; provided that:

(1) This section shall not be construed to limit the commissioner's authority to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties; and

(2) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to this subsection.

(b) The commissioner may share documents, materials, or other information, including confidential and privileged documents, materials, or information subject to subsection (a), with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities; provided that the recipient agrees to maintain the confidential and privileged status of the document, material, or other information and has the legal authority to do so.

(c) The commissioner may receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions. The commissioner shall maintain as confidential or privileged, pursuant to subsection (a)(2), any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(d) The commissioner may enter into agreements governing sharing and use of information consistent with subsections (b) and (c).

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information subject to this section shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsections (b) and (c).

(f) The comparison of an insurer's total adjusted capital to any of its risk-based capital levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Except as otherwise required under this part, making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication; in the form of a notice, circular, pamphlet, letter, or poster; over any radio or television station; or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation by any insurer, producer, or other person engaged in any manner in the insurance business is misleading and is prohibited. If any materially false statement with respect to the comparison of an insurer's total adjusted capital to any or all of its risk-based capital levels or any inappropriate comparison of any other amount to the insurer's risk-based capital levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity or inappropriateness of the statement then the insurer may publish an announcement in a written publication for the sole purpose of rebutting the materially false or inappropriate statement.

(g) Risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the commissioner for ratemaking, considered or introduced as evidence in any rate proceeding, or used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §11; am L 1999, c 128, §2; am L 2003, c 212, §29; am L 2011, c 80, §5]

**§431:3-409 Supplemental provisions; rules; exceptions.** (a) This part is supplemental to any other laws of this State, and shall not

preclude or limit any other powers or duties of the commissioner under those laws, including but not limited to article 15.

(b) The commissioner may adopt rules pursuant to chapter 91 necessary for the implementation of this part.

(c) The commissioner may exempt from the application of this part any domestic property and casualty insurer that:

(1) Writes direct business in this State;

(2) Writes direct annual premiums of $2,000,000 or less; and

(3) Assumes no reinsurance in excess of five per cent of direct premiums written.

(d) The commissioner may exempt from the application of this part any domestic benefit society or health maintenance organization that:

(1) Writes direct business only in this State;

(2) Assumes no reinsurance in excess of five per cent of direct premiums written; and

(3) Writes direct annual premiums for comprehensive medical business of $2,000,000 or less; or

(4) Is a benefit society or health maintenance organization that covers fewer than two-thousand lives. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §12; am L 1999, c 128, §2; am L 2011, c 80, §6]

**§431:3-410 Foreign insurers.** (a) Any foreign insurer, upon the written request of the commissioner, shall submit to the commissioner a risk-based capital report as of the end of the calendar year just ended by the later of:

(1) The date a risk-based capital report would be required to be filed by a domestic insurer under this part; or

(2) Fifteen days after the request is received by the foreign insurer.

Any foreign insurer, at the written request of the commissioner, shall promptly submit to the commissioner a copy of any risk-based capital plan that is filed with the insurance commissioner of any other state.

(b) In the event of a company action level event, regulatory action level event, or authorized control level event with respect to any foreign insurer as determined under the risk-based capital statute applicable in the state of domicile of the insurer, or if no risk-based capital provision is in force in that state, under this part, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under the risk-based capital law of that state, or if no risk-based capital provision is in force in that state, under section 431:3-403, the commissioner may require the foreign insurer to file a risk-based capital plan with the commissioner. In this event, the failure of the foreign insurer to file a risk-based capital plan with the commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this State.

(c) In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation

statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to the circuit court of the first judicial circuit of this State under article 15 with respect to the liquidation of property of foreign insurers found in this State, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §13; am L 1999, c 128, §2]

**[§431:3-411] Severability.** If any provision of this part, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or application of this part which can be given effect without the invalid provision or application, and to that end the provisions of this part are severable. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1999, c 128, §2]

**[§431:3-412] Notices.** All notices by the commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail or, in the case of any other transmission, shall be effective upon the insurer's receipt of the notice. [L 1994, c 190, pt of §1 am L 1995, c 61, §2 as superseded by c 232, §4; am L 1999, c 128, §2]

§**431:3-413 Phase-in provision.** (a) For risk-based capital reports required to be filed by life or health insurers with respect to 1994, the following requirements shall apply in lieu of sections 431:3-403, 431:3-404, 431:3-405, and 431:3-406:

(1) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder;

(2) In the event of a regulatory action level event under section 431:3-404(a)(1), (2), or (3), the commissioner shall take the actions required under section 431:3-403;

(3) In the event of a regulatory action level event under section 431:3-404(a)(4), (5), (6), (7), (8), or (9), or an authorized control level event, the commissioner shall take the actions required under section 431:3-404 with respect to the insurer; and

(4) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under section 431:3-405 with respect to the insurer.

(b) For risk-based capital reports required to be filed by property and casualty insurers with respect to 1997, the following requirements shall apply in lieu of sections 431:3-403, 431:3-404, 431:3-405, and 431:3-406:

(1) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder;

(2) In the event of a regulatory action level event under section 431:3-404(a)(1), (2), or (3), the commissioner shall take the actions required under section 431:3-403;

(3) In the event of a regulatory action level event under section 431:3-404(a)(4), (5), (6), (7), (8), or (9), or an authorized control level event, the commissioner shall take the actions required under section 431:3-404

with respect to the insurer; and

(4) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under section 431:3-405 with respect to the insurer. [L 1994, c 190, pt of §1; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1997, c 75, §14; am L 1999, c 128, §2]

**[§431:3-414] Immunity.** There shall be no liability on the part of, and no cause of action shall rise against, the State, the commissioner, or the insurance division or its employees, agents, or independent contractors for any action taken by them in the performance of their powers and duties under this part. [L 1997, c 75, §1]

## [ARTICLE 3A]
## PRIVACY OF CONSUMER FINANCIAL INFORMATION

### Note

Personal information protection requirements. L Sp 2008, c 10, §§7 to 15.

### Cross References

Information privacy and security council; personal information security, see §§487N-5 to 487N-7.

Personal information policy and oversight responsibilities for government agencies, see §487J-5.

## PART I. GENERAL PROVISIONS

**[§431:3A-101] Purpose; scope; applicability.** (a) This article governs the treatment of nonpublic personal financial information about individuals by all insurance licensees. This article:

(1) Requires licensees to provide notice to individuals about its privacy policies and practices;

(2) Establishes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

(3) Provides methods for individuals to prevent a licensee from disclosing that information.

(b) This article shall apply to nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of a licensee's products or services primarily for personal, family, or household purposes. This article shall not apply to information about companies or about individuals that obtain products or services for business, commercial, or agricultural purposes.

(c) Notice provisions under part II of this article shall not apply to licensees in liquidation or receivership. [L 2001, c 220, pt of §1]

**§431:3A-102 Definitions.** As used in this article:

"Affiliate" means any company that controls, is controlled by, or is under common control with another company.

"Clear and conspicuous" means reasonably understandable and designed

to call attention to the nature and significance of the information in the notice.

"Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, without regard to the source of the underlying information.

"Commissioner" means the insurance commissioner of the State.

"Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, mutual benefit society, health maintenance organization, nonprofit corporation, or similar organization.

"Consumer" means an individual, or that individual's legal representative, who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information.

"Consumer reporting agency" has the same meaning as in section 603(f) of the federal Fair Credit Reporting Act, Title 15 United States Code section 168la(f), as amended.

"Control" means:

(1) Ownership, control, or power to vote twenty-five per cent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(2) Control in any manner over the election of a majority of the directors, trustees, or general partners or individuals exercising similar functions of the company; or

(3) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

"Customer" means a consumer who has a customer relationship with a licensee.

"Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes.

"Financial institution" means any institution in the business of engaging in activities that are financial in nature or incidental to financial activities as described in the Bank Holding Company Act of 1956, Title 12 United States Code section 1843(k), as amended. "Financial institution" shall not include:

(1) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act, Title 7 United States Code section 1, et seq., as amended;

(2) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971, Title 12 United States Code section 2001, et seq., as amended; or

(3) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights), or similar transactions relating to a transaction of a consumer, if the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

"Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to a financial activity under the Bank Holding Company Act of 1956, Title 12 United States Code section 1843(k). "Financial product or service" includes a financial

institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

"Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(1) The past, present, or future physical, mental, or behavioral health or condition of an individual;

(2) The provision of health care to an individual; or

(3) Payment for the provision of health care to an individual.

"Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this State. "Insurance product or service" includes a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

"Licensee" means every licensed insurer, producer, and any other person licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered, under chapter 431 or 432, or holding a certificate of authority under chapter 432D. A licensee shall not be subject to part II of this article if the licensee is an employee, agent, or other representative of another licensee acting as the principal if:

(1) The principal otherwise complies with, and provides the notices required by this article; and

(2) The licensee does not disclose any nonpublic personal financial information to any person other than to the principal or its affiliates in a manner permitted by this article.

"Licensee" includes an unauthorized insurer that accepts business placed through a licensed surplus lines broker in this State, but only in regard to the surplus lines placements under article 8, chapter 431. A surplus lines broker or surplus lines insurer shall be deemed to be in compliance with part II of this article if:

(1) The broker or insurer does not disclose nonpublic personal financial information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under section 431:3A-401, except as permitted by sections 431:3A-402 and 431:3A-403; and

(2) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in sixteen point type:

"PRIVACY NOTICE: NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL FINANCIAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW."

"Nonaffiliated third party" means any person except:

(1) A licensee's affiliate; or

(2) A person employed jointly by a licensee and any company that is not the licensee's affiliate; provided that for purposes of this paragraph, a nonaffiliated third party includes the other company that jointly employs

the person.

"Nonaffiliated third party" includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) of the federal Bank Holding Company Act, Title 12 United States Code section 1843(k)(4)(H), as amended, or insurance company investment activities of the type described in the federal Bank Holding Company Act, Title 12 United States Code section 1843(k)(4)(H) and (I).

"Nonpublic personal financial information" means:

(1) Personally identifiable financial information; and

(2) Any list, description, or other grouping of consumers and publicly available information pertaining to them, that is derived using any personally identifiable financial information that is not publicly available.

"Nonpublic personal financial information" shall not include health information, publicly available information except as included on a list described under paragraph (2) of this definition, or any list, description, or other grouping of consumers and publicly available information pertaining to them that is derived without using any personally identifiable financial information that is not publicly available.

"Opt out" means a direction by a consumer that a licensee not disclose nonpublic financial information about that consumer to a nonaffiliated third party, other than as permitted by part IV of this article.

"Personally identifiable financial information" means any information:

(1) Provided by a consumer to a licensee to obtain an insurance product or service from the licensee;

(2) About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(3) The licensee otherwise obtains about a consumer in connection with providing a service to that consumer.

"Personally identifiable financial information" shall not include:

(1) Health information;

(2) A list of names and addresses of customers of an entity that is not a financial institution; or

(3) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names, or addresses.

"Producer" means a person required to be licensed under the laws of this State to sell, solicit, or negotiate insurance.

"Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(1) Federal, state, or local government records;

(2) Widely distributed media; or

(3) Disclosures to the general public that are required to be made by federal, state, or local law.

For purpose of this definition, a licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine that:

(1) The information is of the type that is available to the general public; and

(2) The licensee's consumer has made the information available to the general public, for information that is of a nature that an individual can direct not be made available to the general public. [L 2001, c 220, pt of §1; am L 2003, c 212, §30]

## PART II. PRIVACY AND OPT OUT NOTICES FOR FINANCIAL INFORMATION

**§431:3A-201 Initial privacy notice to consumers required.** (a) A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to a consumer:

(1) Not later than when the licensee establishes a customer relationship, except as provided in subsection (d); and

(2) Before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by sections 431:3A-402 and 431:3A-403.

(b) A licensee shall not be required to provide an initial notice to a consumer under subsection (a)(2) if:

(1) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by sections 431:3A-402 and 431:3A-403, and the licensee does not have a customer relationship with the consumer; provided that for purpose of this paragraph, a licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship; and

(2) A notice has been provided by an affiliated licensee, if the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

(c) When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, the licensee shall be deemed to satisfy the initial notice requirements of subsection (a) if:

(1) The licensee provides a revised privacy notice, under section 431:3A-205, that covers the customer's new insurance product or service; or

(2) The initial, revised, or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, in which case the licensee does not need to provide a new privacy notice under subsection (a).

(d) A licensee may provide the initial notice under subsection (a)(1) within a reasonable time after the licensee establishes a customer relationship if:

(1) Establishing the customer relationship is not at the customer’s election; or

(2) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer’s transaction and the customer agrees to receive the notice at a later time.

(e) When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to section 431:3A-206. If the licensee uses a short-form initial notice for noncustomers according to section 431:3A-203(c), the licensee may deliver its privacy notice according to section 431:3A-206. [L 2001, c 220, pt of §1; am L 2003, c 212, §31]

**[§431:3A-202] Annual privacy notice to customers required.** (a) A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve consecutive months during which that relationship exists. A licensee may define the twelve consecutive month period, but the licensee shall apply it to the customer on a consistent basis.

(b) A licensee shall not be required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

(c) If a licensee is required under this section to deliver an annual privacy notice, the licensee shall deliver it according to section 431:3A-206. [L 2001, c 220, pt of §1]

**[§431:3A-203] Information to be included in privacy notices.** (a) The initial, annual, and revised privacy notices that a licensee provides under sections 431:3A-201, 431:3A-202, and 431:3A-205 shall include the following information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(1) The categories of nonpublic personal financial information that the licensee collects;

(2) The categories of nonpublic personal financial information that the licensee discloses;

(3) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under sections 431:3A-402 and 431:3A-403;

(4) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses, and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under sections 431:3A-402 and 431:3A-403;

(5) A separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted, if a licensee discloses nonpublic personal financial information to a nonaffiliated third party under section 431:3A-401 and no other exception in sections 431:3A-402 and 431:3A-403 applies to that disclosure;

(6) An explanation of the consumer's right under section 431:3A-301(a) to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(7) Any disclosures that the licensee makes under section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act, Title 15 United States Code section 1681a(d)(2)(A)(iii), as amended;

(8) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(9) Any disclosure that the licensee makes under subsection (b).

(b) If a licensee discloses nonpublic personal financial information under sections 431:3A-402 and 431:3A-403, the licensee is not required to list those exceptions in the initial or annual privacy notices required by sections 431:3A-201 and 431:3A-202. When describing the categories of parties to whom disclosure is made, the licensee shall state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(c) A licensee may satisfy the initial notice requirements in sections 431:3A-201(a) and 431:3A-204(c) for a consumer who is not a customer by providing a short form initial notice at the same time the licensee delivers an opt out notice under section 431:3A-204. A short form initial notice shall:

(1) Be clear and conspicuous;

(2) State that the licensee's privacy notice is available upon request; and

(3) Explain a reasonable means by which the consumer may obtain that notice.

The licensee shall deliver a short form initial notice in accordance with section 431:3A-206. The licensee shall not be required to deliver its privacy notice with its short form initial notice; provided that the licensee provides the consumer a reasonable means to obtain a privacy notice. If a consumer receives the licensee's short form notice and requests a privacy notice, the licensee shall deliver a privacy notice under section 431:3A-206.

(d) The privacy notice may include:

(1) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

(2) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information. [L 2001, c 220, pt of §1]

**[§431:3A-204] Form of opt out notice to consumers and opt out methods.** (a) A licensee shall provide an opt out notice to each of the licensee's consumers that is clear and conspicuous and accurately explains the right to opt out. The notice shall state:

(1) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(2) That the consumer has the right to opt out of that disclosure; and

(3) A reasonable means by which the consumer may exercise the opt out right.

(b) A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with section 431:3A-201.

(c) If a licensee provides the opt out notice later than required for the initial notice in accordance with section 431:3A-201, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(d) If two or more consumers jointly obtain an insurance product or

service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain that any of the joint consumers may exercise the right to opt out; provided that the licensee may:

(1) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(2) Permit each joint consumer to opt out separately; provided that if a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(e) A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

(f) A consumer may exercise the right to opt out at any time.

(g) A consumer's direction to opt out under this section shall be effective until the consumer revokes it in writing or, if the consumer agrees, electronically. When a customer relationship terminates, the customer's opt out direction shall continue to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship shall not apply to the new relationship.

(h) If a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it in accordance with section 431:3A-206. [L 2001, c 220, pt of §1]

**[§431:3A-205] Revised privacy notices.** (a) Except as otherwise provided in this article, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under section 431:3A-201, unless:

(1) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) The licensee has provided to the consumer a new opt out notice;

(3) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) The consumer does not opt out.

(b) If a licensee is required to deliver a revised privacy notice under subsection (a), the licensee shall deliver it in accordance with section 431:3A-206. [L 2001, c 220, pt of §1]

**[§431:3A-206] Delivery.** (a) A licensee shall provide any notices required under this article so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

(b) A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(1) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(2) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(c) A licensee shall not provide any notice required under this article solely by oral explanation of the notice, either in person or over the telephone.

(d) For customers only, a licensee shall provide the initial notice required by section 431:3A-201(a), the annual notice required by section 431:3A-202(a), and the revised notice required by section 431:3A-205, so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(e) A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, if the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

(f) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual, and revised notice requirements of sections 431:3A-201(a), 431:3A-202(a), and 431:3A-205(a), by providing one notice to those consumers jointly. [L 2001, c 220, pt of §1]

## PART III. LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

**[§431:3A-301] Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties.** (a) Except as otherwise authorized under this article, a licensee may not disclose, directly or through any affiliate, any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(1) The licensee has provided to the consumer an initial notice as required under section 431:3A-201;

(2) The licensee has provided to the consumer an opt out notice as required under section 431:3A-204;

(3) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) The consumer does not opt out.

(b) A licensee shall comply with this section, whether or not the licensee and the consumer have established a customer relationship. If a licensee fails to comply with this section, the licensee may not disclose, directly or through any affiliate, any nonpublic personal financial information about a consumer that the licensee has collected, whether or not the licensee collected it before or after receiving the direction to opt out from the consumer.

(c) A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out. [L 2001, c 220, pt of §1]

**§431:3A-302 Limits on redisclosure and reuse of nonpublic personal financial information.** (a) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in section 431:3A-402 or 431:3A-403, the licensee's disclosure and use of that information shall be as follows:

(1) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(2) The licensee may disclose the information to its affiliates who may disclose and use the information only to the extent that the licensee may disclose and use the information; and

(3) The licensee may disclose and use the information pursuant to an exception under section 431:3A-402 or 431:3A-403, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(b) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in section 431:3A-402 or 431:3A-403, the licensee may disclose the information only:

(1) To the affiliates of the financial institution from which the licensee received the information;

(2) To its affiliates who may disclose the information only to the extent that the licensee may disclose the information; and

(3) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(c) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in section 431:3A-402 or 431:3A-403, the third party may disclose and use that information, as follows:

(1) Disclose to the licensee's affiliates;

(2) Disclose to its affiliates, who may disclose and use the information only to the extent that the third party may disclose and use the information; and

(3) Disclose and use the information pursuant to an exception under section 431:3A-402 or 431:3A-403 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(d) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception under section 431:3A-402 or 431:3A-403, the third party may disclose the information only:

(1) To the licensee's affiliates;

(2) To the third party's affiliates who may disclose the information only to the extent the third party can disclose the information; and

(3) To any other person, if the disclosure would be lawful if the licensee made it directly to that person. [L 2001, c 220, pt of §1; am L 2003, c 212, §32]

**[§431:3A-303] Limits on sharing account number information for**

**marketing purposes.** (a) A licensee shall not disclose, directly or through an affiliate other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Subsection (a) does not apply if a licensee discloses a policy number or similar form of access number or access code:

(1) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, if the service provider is not authorized to directly initiate charges to the account;

(2) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(3) To a participant in an affinity or similar program if the participants in the program are identified to the customer when the customer enters into the program. [L 2001, c 220, pt of §1]

## PART IV. EXCEPTIONS TO LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

**[§431:3A-401] Exception to opt out requirements for disclosure of nonpublic personal financial information for service providers and for joint marketing.** (a) The opt out requirements in sections 431:3A-204 and 431:3A-301 shall not apply if a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(1) Provides the initial notice in accordance with section 431:3A-201; and

(2) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in sections 431:3A-402 and 431:3A-403 in the ordinary course of business to carry out those purposes.

(b) The services a nonaffiliated third party performs for a licensee under subsection (a) include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

(c) For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse, or sponsor a financial product or service. [L 2001, c 220, pt of §1]

**[§431:3A-402] Exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions.** (a) The requirements for initial notice under section 431:3A-201, for the opt out in sections 431:3A-204 and 431:3A-301, and for service providers and joint marketing in [section] 431:3A-401 shall not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with:

(1) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(2) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of the entity;

(3) A proposed or actual securitization, secondary market sale including sales of servicing rights, or similar transaction related to a transaction of the consumer; or

(4) Reinsurance, stop loss, or excess loss insurance.

(b) As used in this section, "necessary to effect, administer, or enforce a transaction" means that the disclosure is:

(1) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(2) Required, or is a usual, appropriate, or acceptable method:

(A) To carry out the transaction or the product or service business of which the transaction is a part, and to record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(B) To administer, service the benefits, or process the claims relating to the transaction or the product or service business of which it is a part;

(C) To provide a confirmation, statement, or other record of the transaction or to provide information on the status or value of the insurance product, or to service to the consumer or the consumer's agent or broker;

(D) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(E) To underwrite insurance at the consumer's request or for purposes, as they relate to the consumer's insurance, of account administration, reporting, investigating, or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits including utilization review activities, participating in research projects, or as otherwise required or specifically permitted by federal or state law; or

(F) In connection with:

(i) The authorization, settlement, billing, processing, clearing, transferring, reconciling, or collection of amounts charged, debited, or otherwise paid using a debit, credit or other payment card, check, or account number, or by other payment means;

(ii) The transfer of receivables, accounts, or interests therein; or

(iii) The audit of debit, credit, or other payment information. [L 2001, c 220, pt of §1]

**[§431:3A-403] Other exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information.** (a) The requirements for initial notice in section 431:3A-201, the opt out in sections 431:3A-204, and 431:3A-301, and service providers and joint

marketing in section 431:3A-401 shall not apply if a licensee discloses nonpublic personal financial information:

(1) With the consent or at the direction of the consumer, who has not revoked the consent or direction;

(2) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction;

(3) To protect against or prevent actual or potential fraud or unauthorized transactions;

(4) For required institutional risk control;

(5) For resolving consumer disputes or inquiries;

(6) To persons holding a legal or beneficial interest relating to the consumer or to persons acting in a fiduciary or representative capacity on behalf of the consumer;

(7) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, or the licensee's attorneys, accountants, and auditors;

(8) To the extent specifically permitted or required under other provisions of law and in accordance with the Right to Financial Privacy Act of 1978, Title 12 United States Code section 3401 et seq., as amended, to law enforcement agencies including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, and the Secretary of the Treasury, with respect to Title 31 United States Code chapter 53, subchapter II (Records and Reports on Monetary Instruments and Transactions), as amended, and Title 12 United States Code chapter 21 (Financial Recordkeeping), as amended, a state insurance authority, and the Federal Trade Commission, self-regulatory organizations, or for an investigation on a matter related to public safety;

(9) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act, Title 15 United States Code section 1681, et seq., as amended, or from a consumer report reported by a consumer reporting agency;

(10) In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

(11) To comply with federal, state, or local laws, rules, and other applicable legal requirements;

(12) To comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state, or local authorities;

(13) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; or

(14) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or a workers' compensation plan.

(b) A consumer may revoke a consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under section 431:3A-204. [L 2001, c 220, pt of §1]

## PART V. ADDITIONAL PROVISIONS

**[§431:3A-501] Protection of Fair Credit Reporting Act.** Nothing in this article shall be construed to modify, limit, or supersede the

federal Fair Credit Reporting Act, Title 15 United States Code section 1681, et seq., as amended, and no inference shall be drawn on the basis of the provisions of this article regarding whether information is transaction or experience information under Title 15 United States Code section 602, et seq., as amended. [L 2001, c 220, pt of §1]

**[§431:3A-502] Nondiscrimination.** A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of nonpublic personal financial information under this article. [L 2001, c 220, pt of §1]

**[§431:3A-503] Violation.** A violation of this article shall be deemed an unfair method of competition or unfair or deceptive trade act or practice in the business of insurance in violation of section 431:13-102. [L 2001, c 220, pt of §1]

**[§431:3A-504] Rules.** The commissioner may adopt rules pursuant to chapter 91 to further the purposes of this article. [L 2001, c 220, pt of §1]

## [ARTICLE 3D]
## RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT

**[§431:3D-101] Scope and purpose.** (a) This article shall apply to all insurers domiciled in this State unless exempt pursuant to section 431:3D-106.

(b) The purposes of this article shall be to:

(1) Provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment; and

(2) Provide guidance and instructions for filing an own risk and solvency assessment summary report with the commissioner. [L 2016, c 140, pt of §1]

**[§431:3D-102] Definitions.** As used in this article:

"Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in article 11.

"Insurer" shall have the same meaning as set forth in article 1, except that it shall not include:

(1) Agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(2) Fraternal benefit societies;

(3) Nonprofit medical and hospital service associations that are exempt from state and federal income taxes; or

(4) Unauthorized insurers.

"Own risk and solvency assessment" means a confidential internal

assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group and conducted by that insurer or insurance group, of the material and relevant risks associated with the insurer or insurance group's current business plan and the sufficiency of capital resources to support those risks.

"Own Risk and Solvency Assessment Guidance Manual" means the Own Risk and Solvency Assessment Guidance Manual as developed and adopted by the National Association of Insurance Commissioners and as amended from time to time. A change in the Own Risk and Solvency Assessment Guidance Manual shall take effect on the January 1 following the calendar year in which the changes have been adopted by the National Association of Insurance Commissioners.

"Own risk and solvency assessment summary report" means a confidential, high-level summary of an insurer or insurance group's own risk and solvency assessment. [L 2016, c 140, pt of §1]

**[§431:3D-103] Risk management framework.** An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer. [L 2016, c 140, pt of §1]

**[§431:3D-104] Own risk and solvency assessment requirement.** Subject to section 431:3D-106, an insurer or the insurance group of which the insurer is a member shall regularly conduct an own risk and solvency assessment consistent with a process comparable to the Own Risk and Solvency Assessment Guidance Manual. The own risk and solvency assessment shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member. [L 2016, c 140, pt of §1]

**[§431:3D-105] Own risk and solvency assessment summary report.**
(a) Upon the commissioner's request, and no more than once each year beginning in 2018, an insurer shall submit to the commissioner an own risk and solvency assessment summary report or any combination of reports that together contain the information described in the Own Risk and Solvency Assessment Guidance Manual, which is applicable to the insurer, the insurance group of which it is a member, or both.

(b) Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit any reports required by this section if the commissioner is the lead state commissioner of the insurance group as determined by the procedures in the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(c) Any reports filed pursuant to this section shall include a signature of the insurance group's chief risk officer or another executive responsible for the oversight of the insurer's enterprise risk management process attesting, to the best of the person's belief and knowledge, that:

(1) The insurer applies the enterprise risk management process described in the own risk and solvency assessment summary report; and

(2) A copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(d) An insurer may comply with subsection (a) by providing the most recent and substantially similar report, which is provided by the insurer or another member of an insurance group of which the insurer is a member, or any combination of reports that together contain the information described in the Own Risk and Solvency Assessment Guidance Manual, to the commissioner of another state or a supervisor or regulator of a foreign jurisdiction if that report provides information comparable to that described in the Own Risk and Solvency Assessment Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language. [L 2016, c 140, pt of §1]

**[§431:3D-106] Exemption.** (a) An insurer shall be exempt from the requirements of this article if:

(1) The insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, is less than $500,000,000; and

(2) The insurance group of which the insurer is a member has an annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, less than $1,000,000,000.

(b) If an insurer qualifies for exemption pursuant to subsection (a)(1), but the insurance group of which the insurer is a member does not qualify for exemption pursuant to subsection (a)(2), then the own risk and solvency assessment summary report required pursuant to section 431:3D-105 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one own risk and solvency assessment summary report for any combination of insurers; provided that any combination of reports includes every insurer within the insurance group.

(c) If an insurer does not qualify for exemption pursuant to subsection (a)(1), but the insurance group of which it is a member qualifies for exemption pursuant to subsection (a)(2), then the only own risk and solvency assessment summary report required pursuant to section 431:3D-105 shall be the report applicable to that insurer.

(d) An insurer that does not qualify for exemption pursuant to subsection (a) may apply to the commissioner for a waiver from the requirements of this article based upon unique circumstances.

(1) In deciding whether to grant the insurer's request for waiver, the commissioner may consider:

(A) The type and volume of business written;
(B) The ownership and organizational structure; and
(C) Any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member.

(2) If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and other domiciliary commissioners in

considering whether to grant the insurer's request for a waiver.

(e) Notwithstanding the exemptions stated in this section:

(1) The commissioner may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment, and file an own risk and solvency assessment summary report based upon unique circumstances including but not limited to the type and volume of business written, the ownership and organizational structure, federal agency requests, and international supervisor requests.

(2) The commissioner may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment, and file an own risk and solvency assessment summary report if the insurer:

(A) Has risk-based capital for company action level event as set forth in section 431:3-403;
(B) Meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in section 431:15-103.5; or
(C) Otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(f) If an insurer that qualifies for an exemption pursuant to subsection (a) subsequently no longer qualifies for that exemption due to changes in premium, as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one year following the year the threshold is exceeded to comply with the requirements of this article. [L 2016, c 140, pt of §1]

**[§431:3D-107] Contents of own risk and solvency assessment summary report.** (a) The own risk and solvency assessment summary report shall be prepared consistent with the Own Risk and Solvency Assessment Guidance Manual and subject to the requirements of subsection (b). Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

(b) The review of the own risk and solvency assessment summary report and any additional requests for information shall be made using similar procedures currently used in the analysis and examination of multi-state or global insurers and insurance groups. [L 2016, c 140, pt of §1]

**[§431:3D-108] Confidentiality.** (a) Documents, materials, or other information, including the own risk and solvency assessment summary report, in the possession or control of the commissioner that are obtained by, created by, or disclosed to the commissioner or any other person under this article are recognized as proprietary and containing trade secrets.

All such documents, materials, or other information shall be confidential by law and privileged, shall not be disclosable under chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

The commissioner is authorized to use the documents, materials, or other information to further any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public

without prior written consent of the insurer.

(b) Neither the commissioner nor any person who received documents, materials, or other own risk and solvency assessment information through examination or otherwise, while acting under the authority of the commissioner or with whom such documents, materials, or other information are shared pursuant to this article, shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a).

(c) To assist in performing the commissioner's regulatory duties, the commissioner:

(1) May, upon request, share information subject to subsection (a) and proprietary and trade secret documents with:

(A) Other state, federal, and international financial regulatory agencies; and

(B) Members of any supervisory college referred to in section 431:11-107.5, the National Association of Insurance Commissioners, and any third-party consultants designated by the commissioner;

provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the own risk and solvency assessment documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(2) May receive information subject to subsection (a) and proprietary and trade secret documents from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college referred to in section 431:11-107.5, and the National Association of Insurance Commissioners. The commissioner shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Shall enter into a written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided pursuant to this article and consistent with this subsection, which shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees to maintain the confidentiality and privileged status of the own risk and solvency assessment documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(B) Specify that ownership of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article remains with the commissioner and that use of the information by the National Association of Insurance Commissioners or a third-party consultant is subject to the direction of the commissioner;

(C) Prohibit the National Association of Insurance Commissioners or third-party consultant from storing the

information shared pursuant to this article in a permanent database after the underlying analysis is completed;

(D) Require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners or a third-party consultant pursuant to this article is subject to a request or subpoena to the National Association of Insurance Commissioners or a third-party consultant for disclosure or production;

(E) Require the National Association of Insurance Commissioners or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article; and

(F) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(d) The sharing of information and documents by the commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this article.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary, and trade secret materials or other own risk and solvency assessment information shall occur as a result of disclosing any own risk and solvency assessment information or documents to the commissioner pursuant to this section or as a result of sharing as authorized in this article.

(f) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant pursuant to this article shall be confidential by law and privileged, shall not be subject to chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. [L 2016, c 140, pt of §1]

**[§431:3D-109] Sanctions.** (a) Any insurer failing without just cause to timely file the own risk and solvency assessment summary report as required in this article shall be required after notice and hearing to pay a penalty of not less than $100 and not more than $500 for each day's delay, which shall be recovered by the commissioner. Any penalty recovered pursuant to this section shall be paid into the compliance resolution fund.

(b) The maximum penalty under this section is $50,000. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that imposing the penalty would constitute a financial hardship to the insurer. [L 2016, c 140, pt of §1]

**[§431:3D-110] Severability.** If any provision of this article or its application to any person or circumstance is held invalid, that determination shall not affect the provisions or applications of this

article that can be given effect without the invalid provision or application, and to that end, the provisions of this article are severable. [L 2016, c 140, pt of §1]

# ARTICLE 4
# DOMESTIC INSURERS

## PART I. ORGANIZATION, POWERS AND SALE OF SECURITIES OF DOMESTIC INSURERS

**§431:4-101 Definitions.** As used in this article:

(1) Surplus funds means the excess of the insurer's assets over its liabilities, including its capital stock as a liability.

(2) Available surplus means the excess over the minimum amount of surplus required for the classes of insurance the insurer is authorized to transact.

(3) Equity security means any stock or similar security; any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; any such warrant or right; or any security which the commissioner by such rules and regulations as the commissioner may prescribe in the public interest or for the protection of investors designate as an equity security. [L 1987, c 347, pt of §2]

**§431:4-102 Types of insurers permitted.** An insurer formed in this State shall be either:

(1) An incorporated stock insurer,

(2) An incorporated mutual insurer which charges for and collects in advance cash premiums in an amount adequate to maintain full legal reserves and to fully meet and discharge all of its obligations and liabilities under its policies without assessments or calls upon its members for additional premium, except as provided in this article relative to the contingent liability of its members, or

(3) A reciprocal insurer, with respective powers, duties and restrictions as provided in this article. [L 1987, c 347, pt of §2]

**§431:4-103 Corporation law applies in general.** The laws of this State relating to private corporations, except where inconsistent with the express provisions of this code, shall apply to incorporated domestic insurers. [L 1987, c 347, pt of §2]

**§431:4-104 Articles of incorporation.** (a) This section applies to insurers incorporated in this State.

(b) The incorporators shall be individuals who are United States citizens, and a majority of them shall be residents of this State. The number of incorporators shall be:

(1) Not less than five if a stock insurer, or

(2) Not less than ten if a mutual insurer.

(c) After the articles of incorporation have been approved by the department of commerce and consumer affairs and by the commissioner, the original shall be filed with the department, one copy with the commissioner, and one copy retained by the insurer.

(d) The articles of incorporation shall state in addition to the requirements set forth in section 414-32:

(1) The name of the insurer, which shall include the word "Insurance" and, as the last word thereof, one of the words "Corporation", "Incorporated", or "Limited", or one of the abbreviations "Corp.", "Inc.", or "Ltd.". In the case of the reciprocal insurer, the name shall include the word "Reciprocal", "Interinsurer", "Interinsurance", "Exchange", "Underwriters", or "Underwriting";

(2) (A) Whether it is a stock or mutual insurer; and

(B) The classes of insurance it will issue, according to the designations made in this article.

(3) The place of its principal office, which shall be established and maintained in this State.

(4) (A) If a stock insurer, the amount of its capital, the aggregate number of shares, and the par value of each share, which par value shall not be less than $2, and if the privilege of subsequent extension of the authorized capital stock is sought, then the limit of such extension shall be stated;

(B) If a mutual insurer, the maximum contingent liability of its policyholders for the payment of its expenses and losses occurring under its policies.

(5) The names and addresses, both business and residence, of the officers of the insurer for the initial term.

(6) Other provisions, not inconsistent with law, as may be deemed proper by the incorporators. [L 1987, c 347, pt of §2; am L 2002, c 40, §68]

**§431:4-105 Affidavit.** (a) Before applying to the commissioner for an initial certificate of authority, a stock or mutual insurer is required to file with the commissioner an affidavit, sworn to by the president, secretary, and treasurer of the corporation as named in the articles of incorporation.

(b) The affidavit shall set forth:

(1) The number of shares which the corporation is authorized to issue;

(2) The par value of the shares;

(3) The names of the shareholders;

(4) The number of shares owned by each shareholder;

(5) The amount of money paid to the corporation by each shareholder; and

(6) That the required capital has been paid in full in cash. [L 1987, c 347, pt of §2; am L 2003, c 212, §33]

**§431:4-106 Board of directors.** The board of directors of a domestic insurer shall consist of not less than five individuals, at

least three-fourths of the individuals shall be United States citizens, and a majority of the individuals shall be residents of this State. [L 1987, c 347, pt of §2]

**§431:4-106.5 Membership in mutual or subscriber in reciprocal insurers; no personal liability of representative.** Any person may make application to enter into agreement for and hold policies or contracts in or with and be a member or subscriber of any domestic, foreign, or alien mutual or reciprocal insurer. Any officer, representative, or trustee, receiver, or legal representative of any such member or policyholder shall be recognized as acting for or on its behalf for the purpose of such contracts or membership, but shall not be personally liable upon the contract by reason of acting in such representative capacity. [L 1989, c 195, §1]

**§431:4-107 Solicitation permit required.** (a) No person forming or proposing to form in this State any of the following shall advertise, solicit or receive any funds, agreement, stock subscription or membership on account thereof, unless the person has applied for and has received from the commissioner a solicitation permit:

(1) An insurer,

(2) An insurance holding corporation,

(3) A stock corporation to finance an insurer or insurance production, or

(4) A corporation to manage an insurer.

(b) Any person violating this section shall be fined not more than $10,000 or imprisoned not more than ten years, or both. [L 1987, c 347, pt of §2]

**§431:4-108 Application for a solicitation permit.** To apply for a solicitation permit a person shall:

(1) File with the commissioner a request showing:

(A) Name, type and purpose of insurer or corporation proposed to be formed;
(B) Names, addresses and business records of each person associated or to be associated with in the formation of the proposed insurer or corporation;
(C) Full disclosure of the terms of all understandings and agreements existing or proposed among persons so associated relative to the proposed insurer or corporation or the formation thereof;
(D) The plan according to which solicitations are to be made;
(E) Such additional information as the commissioner may reasonably require.

(2) File with the commissioner:

(A) (i) The articles of incorporation, or
(ii) The proposed subscribers' agreement and power of attorney, if the proposed insurer is a reciprocal;

(B) Original and one copy of any proposed bylaws;
(C) Copy of any security proposed to be issued and copy of application or subscription agreement therefor;
(D) Copy of any insurance contract proposed to be offered and copy of application therefor;
(E) Copy of any prospectus, advertising or literature proposed to be used;
(F) Copy of proposed form of any escrow agreement required.

(3) Deposit with the commissioner the appropriate fees required by this code. [L 1987, c 347, pt of §2]

**§431:4-109 Permit issued or denied.** (a) The commissioner shall expeditiously examine the application for a solicitation permit and make any investigation relative thereto deemed necessary.

(b) The commissioner shall give notice to the applicant that the commissioner will issue a solicitation permit, stating the terms to be contained therein, if the commissioner finds:

(1) The application is complete;

(2) The documents therewith filed are equitable in terms and proper in form;

(3) The agreements made or proposed are equitable to present and future shareholders, subscribers, members, or policyholders; and

(4) None of the persons named in the application as being associated or to be associated with the formation of the insurer or corporation is untrustworthy.

(c) After such notice, the commissioner shall issue to the applicant a solicitation permit upon the applicant's filing of the following:

(1) The bond required by section 431:4-110; and

(2) The articles of incorporation of the incorporated insurer or other corporation with the department of commerce and consumer affairs and upon presentation of evidence of such filing to the commissioner.

(d) If the commissioner denies the application for a solicitation permit, the commissioner shall give notice to the applicant that the permit will not be granted, state the grounds therefor, and refund to the applicant all sums so deposited except the application fee. [L 1987, c 347, pt of §2]

**§431:4-110 Bond or cash deposit.** (a) The commissioner shall not issue a solicitation permit until the person applying therefor files with the commissioner a corporate surety bond in the penalty sum of $150,000, in favor of this State and for the use and benefit of this State and of subscribers and creditors of the proposed organization. The bond shall be conditioned upon the payment of costs incurred by this State in the event of any legal proceedings for liquidation or dissolution of the proposed organization before completion of organization or in the event a certificate of authority is not granted; upon a full accounting for funds received until the proposed insurer has been granted its certificate of authority; or until the proposed corporation has completed its organization as defined in the solicitation permit.

(b) In lieu of filing the bond described in subsection (a), the

person may deposit with the director of finance through the commissioner $150,000 in cash or in United States government bonds at par value, to be held in trust upon the same conditions as required for the bond.

(c) The commissioner may waive the requirement for a bond or deposit in lieu thereof if the permit provides that:

(1) The proposed securities are to be distributed solely and finally to those few persons who are the active promoters intimate to the formation of the insurer or other corporation, or to the formation of the insurer or other corporation; or

(2) The securities are to be issued in connection with subsequent financing as provided in section 431:4-120, and distribution thereof is not to be made to the general public.

(d) Any bond filed, or any deposit or remaining portion thereof held under this section shall be released and discharged upon settlement or termination of all liabilities against it. [L 1987, c 347, pt of §2; am L 1993, c 205, §8]

**§431:4-111 Expiration and contents.** Every solicitation permit issued by the commissioner shall:

(1) Expire two years from its date, unless earlier terminated by the commissioner, and shall so state.

(2) State the securities for which subscriptions are to be solicited, the number, classes, par value, and selling price thereof, or identify the insurance contract for which applications and advance premiums or deposits are to be solicited.

(3) Limit the portion of funds received on account of stock subscriptions, if any are proposed to be taken, which may be used for promotion and organization expenses to such amount as the commissioner deems adequate, but in no event to exceed fifteen per cent of such funds as and when actually received.

(4) If to be for a mutual or reciprocal insurer, limit the portion of funds received on account of applications for insurance which may be used for promotion or organization expenses to a reasonable commission upon such funds, giving consideration to the class or classes of insurance and policy or policies involved and to the costs incurred by insurers generally in the production of similar business, and provide that no such commission shall be deemed to be earned nor be paid until the insurer has received its certificate of authority and the policies applied for, and upon which such commission is to be based, have been actually issued and delivered.

(5) Contain such other information required by this part or reasonable conditions relative to accounting and reports or otherwise as the commissioner deems necessary. [L 1987, c 347, pt of §2]

**§431:4-112 Permit not an inducement.** The granting of a solicitation permit is permissive only and shall not constitute an endorsement by the commissioner of any person or thing related to the proposed insurer or corporation. The existence of the permit shall not be advertised or used as an inducement in any solicitation. The substance of this section in boldfaced type not less than ten point shall be printed at the top of each solicitation permit. [L 1987, c 347, pt of §2]

**§431:4-113 Organization solicitor's license.** Solicitation for sale of securities to members of the public under a solicitation permit shall be made only by individuals registered therefor pursuant to chapter 485A. [L 1987, c 347, pt of §2; am L 2006, c 229, §14]

**§431:4-114 Revocation of solicitation permit.** (a) The commissioner shall revoke a solicitation permit if requested in writing by:

(1) A majority of the incorporators and at least two-thirds of the subscribers to stock or applicants for insurance in the proposed incorporated insurer or corporation; or

(2) A majority of the subscribers of a proposed reciprocal insurer.

(b) The commissioner may, for cause, modify a solicitation permit, or may, after a hearing, revoke any solicitation permit for:

(1) Violation of this code;

(2) Violation of the terms of the permit;

(3) Violation of any proper order of the commissioner; or

(4) Misrepresentation. [L 1987, c 347, pt of §2]

**§431:4-115 Escrow of funds.** (a) All funds received pursuant to a solicitation permit shall be deposited and held in escrow in a bank or trust company under an agreement approved by the commissioner. No part of any such deposit shall be withdrawn except:

(1) For the payment of promotion and organization expenses as authorized by the solicitation permit;

(2) For the purpose of making any deposit with the commissioner required for the issuance of a certificate of authority to an insurer;

(3) Upon completion of payments on stock subscriptions made under the solicitation permit and deposit or appropriation of such funds for the purposes specified in the solicitation permit, if the proposed organization is not to be an insurer; or

(4) For making of refunds as provided in section 431:4-119.

(b) When the commissioner has issued a certificate of authority to an insurer, any such funds remaining in escrow for its account shall be released to the insurer. [L 1987, c 347, pt of §2]

**§431:4-116 Expense pending completion.**

(a)(1) The incorporators of any insurer shall be jointly and severally liable for its debts or liabilities until it has secured a certificate of authority.

(2) The incorporators of a corporation other than an insurer or the persons proposing to form a reciprocal insurer shall be jointly and severally liable for its debts or liabilities until it has completed its organization.

(b) Any portion of funds received on account of stock subscriptions which is allowed under the solicitation permit, may be applied concurrently toward the payment of promotion and organization expenses incurred. [L 1987, c 347, pt of §2]

**§431:4-117 Issuance and forfeiture of securities.** (a) No proposed stock insurer or corporation shall issue any share of stock or participation agreement until:

(1) All subscriptions received under the solicitation permit have been fully paid in:

(A) Cash or securities eligible for investment of funds of insurers, or
(B) Other property after securing the written approval of the commissioner; and

(2) A certificate of authority has been issued to it, if an insurer.

(b) Every subscription contract to shares of a stock insurer or other corporation calling for payment in installments shall provide that such contracts, together with all amounts paid thereon, may be forfeited at the option of the corporation, upon failure to make good a delinquency in any installment upon not less than forty-five days notice in writing. [L 1987, c 347, pt of §2]

**§431:4-118 Insurance application.** All applications for insurance obtained in forming a mutual or reciprocal insurer shall provide that:

(1) Issuance of the policy is contingent upon completion of organization of the insurer and issuance of a certificate of authority to it;

(2) The prepaid premium or deposit will be refunded in full to the applicant if the organization is not completed and the certificate of authority issued prior to the solicitation permit's date of expiration; and

(3) The agreement for insurance is not effective until a policy has been issued under it. [L 1987, c 347, pt of §2]

**§431:4-119 Refund upon failure to complete or qualify or upon revocation of solicitation permit.** (a) The commissioner shall withdraw all funds held in escrow and refund to subscribers or applicants all sums paid in on stock subscriptions, less that part of such sums paid in on subscriptions as has been allowed and used for promotion and organization expenses, and all sums paid in on insurance applications, and shall dissolve the proposed insurer or corporation if:

(1) The proposed insurer or corporation fails to complete its organization and obtain full payment for subscriptions and applications; and

(2) It fails to secure its certificate of authority before expiration of the solicitation permit, if an insurer; or

(b) The commissioner revokes the solicitation permit. [L 1987, c 347, pt of §2]

**§431:4-120 Subsequent financing.** (a) No domestic insurer, insurance holding corporation, stock corporation for financing operations of a mutual insurer, or attorney-in-fact corporation of a reciprocal insurer shall solicit or receive funds in exchange for any new issue of its corporate securities, other than through a stock dividend, until it has applied to the commissioner for, and has been granted, a solicitation permit, after:

(1) It has received a certificate of authority, if an insurer, or

(2) It has completed its initial organization and financing, if a corporation other than an insurer.

(b) The commissioner shall issue a solicitation permit unless the commissioner finds that:

(1) The funds proposed to be secured are excessive in amount for the purpose intended,

(2) The proposed securities or the manner of their distribution are inequitable, or

(3) The issuance of the securities would jeopardize the interests of policyholders or the holders of other securities of the insurer or corporation.

(c) A solicitation permit shall contain such terms and be issued upon such conditions as the commissioner may reasonably specify or require, and shall expire when the new issue of corporate securities has been completed.

(d) A solicitation permit shall limit the portion of funds received on account of such new issue of corporate securities which may be used for promotion and sales expenses for the new issue to such amount as the commissioner deems adequate, but in no event to exceed fifteen per cent of such funds as and when actually received.

(e) For purposes of this section, insurance holding corporation means any domestic corporation:

(1) Which, directly or indirectly through one or more intermediaries, controls a domestic insurer; and

(2) In which the total assets of the insurer, as reported in its most recent annual statement filed with the commissioner pursuant to section 431:3-301, is twenty per cent or more of the consolidated total assets of the corporation as reported in its most recent annual report to its owners. The annual report to owners shall be prepared in accordance with generally accepted accounting principles by a certified public accountant. [L 1987, c 347, pt of §2; am L 1989, c 207, §3]

**§431:4-121 False exhibits.** Every person who, with intent to deceive knowingly exhibits any false account, document or advertisement, relative to the affairs of any insurer, or of any corporation of the kind enumerated in section 431:4-107, formed or proposed to be formed, is punishable in accordance with section 431:2-203. [L 1987, c 347, pt of §2]

**§431:4-122 Depositaries.** The funds of a domestic insurer shall not be deposited in any bank or banking institution which has not first been approved as a depositary by the insurer's board of directors or by a committee designated for the purpose. [L 1987, c 347, pt of §2]

**§431:4-123 Corrupt practices.** No person shall buy, sell or barter a vote or proxy, relative to any meeting of shareholders or members of an incorporated domestic insurer, or engage in any corrupt or dishonest practice in or relative to the conduct of any such meeting. [L 1987, c 347, pt of §2]

**§431:4-124 Prohibited guaranty.** No domestic insurer or its affiliates or subsidiaries shall guarantee the financial obligation of

any director or officer of such insurer or affiliate or subsidiary in the director's or officer's personal capacity, and any such guaranty attempted shall be void. This prohibition shall not apply to obligations of the insurer under surety bonds or insurance contracts issued in the regular course of business. [L 1987, c 347, pt of §2]

**§431:4-125 Fees on use of funds.** (a) No director, officer or employee having any authority in the investment or disposition of the funds of a domestic insurer shall accept, except on behalf of the insurer, or be the beneficiary of any fee, brokerage, gift, or other emolument because of any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the insurer.

(b) The commissioner may adopt rules to define and permit additional exceptions to the prohibition in subsection (a), solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer, for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of such director. [L 1987, c 347, pt of §2; am L 2004, c 122, §14]

**§431:4-126 Comply with foreign laws.** Any domestic insurer doing business in a state, territory or sovereignty may design and issue insurance contracts and transact insurance in such state, territory or sovereignty as required or permitted by the laws thereof. [L 1987, c 347, pt of §2]

**§431:4-127 Solicitation in other states.** (a) No domestic insurer shall knowingly solicit insurance business in any reciprocating state in which it is not then licensed as an authorized insurer.

(b) A reciprocating state, as used herein, is one under the laws of which a similar prohibition is imposed upon and is enforced against insurers domiciled in that state.

(c) This section shall not prohibit:

(1) Advertising through publications and radio broadcasts originating outside the reciprocating state, if the insurer is licensed in a majority of the states in which such advertising is disseminated, and if the advertising is not specially directed to residents of the reciprocating state; and

(2) Insurance covering persons or risks located in a reciprocating state, under contracts solicited and issued in states in which the insurer is then licensed. Nor shall it prohibit insurance effectuated by the insurer as an unauthorized insurer in accordance with the laws of the reciprocating state. [L 1987, c 347, pt of §2]

## PART II. DOMESTIC STOCK INSURERS

**§431:4-201 Other laws applicable.** Domestic stock insurers shall be subject to title 23 and any applicable general laws enacted pertaining to stock corporations except where inconsistent with the express provisions of this article. [L 1987, c 347, pt of §2; am L 1993, c 205, §9]

**§431:4-202 Increase of capital.** (a) A domestic stock insurer may increase its capital stock by complying with section 414-281 and section

431:4-120. The increase in capital shall be effective upon the payment of the increased capital in full in cash.

(b) If the increased capital stock is to be distributed as stock dividend, the increased capital stock may be fully paid in out of any available surplus funds as is provided in section 431:4-204, and the payment shall be effected by a transfer on the insurer's books from its surplus account to its capital account. [L 1987, c 347, pt of §2; am L 1989, c 207, §4; am L 2002, c 40, §69]

**§431:4-203 Decrease of capital.** (a) A domestic stock insurer may decrease its capital stock by:

(1) Vote of not less than seventy-five per cent of the holders of the shares of stock outstanding and entitled to vote; and

(2) Filing a certificate executed in the same manner as provided in section 414-11, that such vote occurred, upon which filing the decrease in capital is effective.

(b) No such decrease shall be made which results in capital stock less in amount than the minimum required by this code for the classes of insurance thereafter to be transacted by the insurer.

(c) No surplus funds of the insurer resulting from a decrease of its capital stock shall be distributed to shareholders, except:

(1) As a stock dividend on a subsequent increase of capital stock;

(2) Upon dissolution of the insurer; or

(3) Upon approval of the commissioner, provided the commissioner has received satisfactory proof that the distribution will not impair the interests of policyholders or the solvency of the insurer.

(d) Upon a decrease of capital stock, the insurer's directors shall call in any outstanding stock certificates required to be changed pursuant thereto and shall issue proper certificates in their stead. [L 1987, c 347, pt of §2; am L 1989, c 195, §14; am L 2004, c 122, §15]

**§431:4-204 Dividends to stockholders.** (a) No domestic stock insurer shall pay any cash dividend to stockholders except out of that part of its available surplus funds which is derived from any realized net profits.

(b) Such an insurer may pay a stock dividend out of any available surplus funds.

(c) No dividend shall be declared or paid which would reduce the insurer's surplus to an amount less than the minimum required for the classes of insurance thereafter to be transacted.

(d) The commissioner may revoke the certificate of authority of any insurer violating this section. [L 1987, c 347, pt of §2]

**§431:4-205 Illegal dividends; reductions.** Any director of a domestic stock insurer who votes for or concurs in the declaration or payment of any dividend to stockholders or a reduction of capital stock not authorized by law shall, in addition to any other liability imposed by law, be guilty of violation of this code. [L 1987, c 347, pt of §2]

**§431:4-206 Repayment of contributed surplus.** Contributions to the

surplus of a domestic stock insurer, other than resulting from sale of its capital stock, shall not be subject to repayment except out of surplus in excess of the minimum surplus initially required of such an insurer transacting like classes of insurance. [L 1987, c 347, pt of §2]

**§431:4-207 Participating policies.** (a) Any domestic stock insurer may, if its charter so provides, issue policies entitled to participate from time to time in the earnings of the insurer through dividends.

(b) The directors of a stock insurer may from time to time apportion and pay to the holders of participating policies dividends only out of that part of its surplus which is in excess of its required capital and minimum surplus. The dividends may be paid or credited according to a reasonable classification of its policies. No dividend shall be paid which unfairly discriminates among policies within the same classification.

(c) No such insurer shall issue in this State both participating and nonparticipating policies for the same class of risks, unless the right or absence of right to participate is reasonably related to the premium charge or the special character of the risk assumed.

(d) Dividends to participating life insurance policies issued by the insurer shall be paid only out of its surplus funds as defined in section 431:4-101. Dividends to participating policies for other classes of insurance shall be paid only out of that part of the surplus funds which is derived from any realized net profits.

(e) No dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy. [L 1987, c 347, pt of §2]

**§431:4-208 Statement by beneficial owner, director, officer.** Every person who is directly or indirectly the beneficial owner of more than ten per cent of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such company, shall file in the office of the commissioner within ten days after the person becomes such beneficial owner, director, or officer a statement, in such form as the commissioner may prescribe, of the amount of all equity securities of such company of which the person is the beneficial owner, and within ten days after the close of each calendar month, if there has been a change in such ownership during such month, shall file in the office of the commissioner a statement, in such form as the commissioner may prescribe, indicating the person's ownership at the close of the calendar month and such changes in the person's ownership as have occurred during the calendar month. [L 1987, c 347, pt of §2]

**§431:4-209 Recovery of profits realized.** For the purpose of preventing the unfair use of information which may have been obtained by the beneficial owner, director, or officer by reason of the owner's, director's, or officer's relationship to the company, any profit realized by the owner, director, or officer from any purchase and sale, or any sale and purchase, of an equity security of the company within any period of less than six months, unless the security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of the beneficial owner, director or officer in entering into the transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover the profit may be instituted in any court of competent jurisdiction by the

company, or by the owner of any security of the company in the name and in behalf of the company if the company fails or refuses to bring the suit within sixty days after request or fails diligently to prosecute the same thereafter; but no suit shall be brought more than two years after the date such profit was realized. This section shall not be construed to cover any transaction where the beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the commissioner by rules and regulations may exempt as not comprehended within the purpose of this section. [L 1987, c 347, pt of §2]

**§431:4-210 Unlawful sales of equity security.** It shall be unlawful for any beneficial owner, director or officer, directly or indirectly, to sell any equity security of such company if the person selling the security or the person's principal (1) does not own the security sold, or (2) if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation. No person shall be deemed to have violated this section if the person proves that notwithstanding the exercise of good faith the person was unable to make such delivery or deposit within the time, or that to do so would cause undue inconvenience or expense. [L 1987, c 347, pt of §2]

**§431:4-211 Exempt transactions.** Section 431:4-209 shall not apply to any purchase and sale, or sale and purchase, and section 431:4-210 shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by the person in an investment account, by a dealer in the ordinary course of the dealer's business and incident to the establishment or maintenance by the dealer of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The commissioner may, by such rules and regulations as the commissioner deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market. [L 1987, c 347, pt of §2]

**§431:4-212 Arbitrage transactions not affected.** Section 431:4-208 to section 431:4-210 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the commissioner may adopt in order to carry out the purposes of section 431:4-208 to section 431:4-214. [L 1987, c 347, pt of §2]

**§431:4-213 Exempt equity securities.** Section 431:4-208 to section 431:4-210 shall not apply to equity securities of a domestic stock insurance company (1) if the equity securities of such company have been registered with the United States Securities and Exchange Commission under section 12 of the Securities Exchange Act of 1934, as amended, (2) if the equity securities of the company are required to be registered with the United States Securities and Exchange Commissioner under section 12 of the Securities Exchange Act of 1934, as amended, or (3) if the domestic stock insurance company shall not have any class of its equity securities held of record by one hundred persons on the last business day

of the year next preceding the year in which equity securities of the company would be subject to section 431:4-208 to section 431:4-210 except for item (3). [L 1987, c 347, pt of §2]

**§431:4-214 Rules and regulations.** The commissioner may make such rules and regulations as may be necessary for the execution of the functions vested in the commissioner by section 431:4-208 to section 431:4-214, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within the commissioner's jurisdiction. No provision of section 431:4-208 to section 431:4-210 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the commissioner, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason. [L 1987, c 347, pt of §2]

## [PART IIA.] PROXIES, CONSENTS, AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

**[§431:4-231] Applicability.** This part is applicable to all domestic stock insurers having one hundred or more stockholders; provided that this part shall not apply to any insurer if ninety-five per cent or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares are held by less than five hundred stockholders. A domestic stock insurer that files with the Securities and Exchange Commission forms of proxies, consents, and authorizations complying with the requirements of the Securities Exchange Act of 1934 (Title 15 United States Code section 78a), the Securities and Exchange Acts Amendments of 1964 (P.L. 88-467), and Regulation X-14 of the Securities and Exchange Commission adopted thereunder shall be exempt from this part. [L 2000, c 24, pt of §2]

**§431:4-232 Schedule A: information required in a proxy statement.** (a) When applicable, information in schedule A shall include, among other things:

(1) Whether or not the person giving the proxy has the power to revoke it;

(2) A brief outline of the rights of appraisal of dissenting stockholders;

(3) A statement as to who is making the solicitation;

(4) A description of the interest of persons in the matters to be acted upon;

(5) A statement as to the class of voting stock to be voted at the meeting, the number of shares outstanding, and the number of votes to which each class is entitled;

(6) Detailed information on nominees for directors;

(7) A statement on remuneration and other transactions with management and others;

(8) Information on the insurer's bonus, profit sharing, and other remuneration plans;

(9) Information on the insurer's pension or retirement plan;

(10) Information on the options, warrants, or rights to purchase stock of the insurer;

(11) Information of the title, amount, and description of stock to be authorized or issued;

(12) Detailed information on mergers, consolidations, acquisitions, and other similar matters; and

(13) Detailed information on any asset, capital, or surplus of the insurer.

(b) If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders, the schedule shall state the nature of the matter, the reason for the matter being submitted to a vote of the stockholders, and the action intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

(c) If action is to be taken with respect to any amendment of the insurer's charter, bylaws, or other such documents as to which information is not required, the schedule shall briefly state the reasons for and the general effect of the amendment and the vote needed for its approval. [L 2000, c 24, pt of §2; am L 2003, c 212, §34]

**[§431:4-233] Schedule B: information to be included in statements filed by or on behalf of a participant other than an insurer in a proxy solicitation in an election contest.** Information in schedule B shall include, among other things:

(1) The name and address of the insurer;

(2) Detailed information about the participant;

(3) The participant's interest in the stock of the insurer;

(4) A description of the time and circumstances in which the participant became involved with the solicitation and the nature and extent of the activities or proposed activities of the participant; and

(5) The date and signature of the participant. [L 2000, c 24, pt of §2]

**[§431:4-234] Proxies, consents, and authorizations.** No domestic stock insurer, or any director, officer, or employee of the insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent, or authorization with respect to any stock of the insurer in contravention of this part or schedule A in section 431:4-232 and schedule B in [section] 431:4-233. [L 2000, c 24, pt of §2]

**[§431:4-235] Schedules and exhibits.** Reporting of the information required in schedule A under section 431:4-232 and in schedule B under section 431:4-233, and the exhibit entitled "stockholders information supplement-financial reporting to stockholder" shall be made on forms or in a format approved by the commissioner. [L 2000, c 24, pt of §2]

**[§431:4-236] Disclosure of equivalent information.** Unless proxies, consents, or authorizations with respect to a stock of a domestic insurer, subject to section 431:4-231, are solicited by or on behalf of the management of the insurer from the holders of record of stock of the

insurer in accordance with this part and the schedules thereunder prior to any annual or other meeting, the insurer shall file with the insurance commissioner and transmit to all stockholders of record information substantially equivalent to the information that would be required to be transmitted if a solicitation were made. [L 2000, c 24, pt of §2]

**[§431:4-237] Definitions.** As used in this part:

"Participant" or "participant in a solicitation" includes:

(1) The insurer;

(2) Any director of the insurer and any proxy for a nominee for whom an election as a director is solicited; or

(3) Any other person acting alone or with one or more other persons, committees, or groups in organizing, directing, or financing the solicitation.

"Participant" or "participant in a solicitation" does not include:

(1) A bank, broker, or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant;

(2) Any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties;

(3) Any person employed in the capacity of attorney, accountant, or advertising, public relations, or financial advisor, and whose activities are limited to the performance of the person's duties in the course of the employment of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant;

(4) Any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or

(5) Any officer, director, or person regularly employed by any other participant, if the officer, director, or employee is not otherwise a participant.

"Solicit" or "solicitation" includes:

(1) Any request for a proxy, whether or not accompanied by or included in a form of proxy;

(2) Any request to execute or not to execute, or to revoke a proxy; or

(3) The furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding, or revocation of a proxy.

"Solicit" or "solicitation" does not include:

(1) Any solicitation by a person in respect to stock of which the person is the beneficial owner;

(2) Action by a broker or other person in respect to stock carried in the person's name;

(3) Action in the name of the nominee in forwarding to the beneficial owner of the stock soliciting material received from the company;

(4) Impartially instructing the beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy;

(5) Impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

or

(6) The furnishing of a form of proxy to a stockholder upon the unsolicited request of the stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy. [L 2000, c 24, pt of §2]

**[§431:4-238] Information to be furnished to stockholders.** (a) No solicitation shall be made unless the person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information required under schedule A pursuant to section 431:4-232.

(b) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to subsection (a) shall be accompanied or preceded by an annual report (in preliminary or final form) to the stockholders containing the financial statements for the last fiscal year as are included in the exhibit entitled "stockholders information supplement-financial reporting to stockholder". Subject to these requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

(c) Two copies of each annual report sent to the stockholders pursuant to this part shall be mailed to the commissioner not later than the date on which the annual report is first sent or given to stockholders or the date on which preliminary copies of solicitation are filed with the commissioner, pursuant to section 431:4-240(a), whichever date is later. [L 2000, c 24, pt of §2]

**[§431:4-239] Requirements as to proxy.** (a) The form of proxy shall:

(1) Indicate in boldface type whether or not the proxy is solicited on behalf of the management;

(2) Provide a specifically designated blank space for dating the proxy; and

(3) Identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management or stockholders. No reference need be made to proposals for which discretionary authority is conferred pursuant to subsection (c).

(b) The proxy shall provide a means by which the person solicited may specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters for which no choice is specified if the form of proxy states in boldface type how it is intended to vote the shares or authorization represented by the proxy in each case.

(c) A proxy may confer discretionary authority with respect to other matters which may come before the meeting; provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided that a specific statement to that effect is made in the proxy statement or in the form of a proxy.

(d) No proxy shall confer authority to:

(1) Vote for the election of any person to office for which a bona fide nominee is not named in the proxy statement; or

(2) Vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

(e) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that where the person solicited specifies, by means of a ballot provided pursuant to subsection (b), a choice with respect to any matter to be acted upon, the vote will be in accordance with the specification so made.

(f) The information included in the proxy statement shall be clearly presented and the statement made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements shall be clearly and legibly presented. [L 2000, c 24, pt of §2]

**[§431:4-240] Material required to be filed.** (a) Two preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the commissioner at least ten days prior to the date final form copies of the material are first sent or given to stockholders, or a shorter period prior to that date as the insurance commissioner may authorize upon a showing of good cause.

(b) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the commissioner at least two days (exclusive of Saturdays, Sundays, or legal state holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to that date as the commissioner may authorize upon a showing of good cause.

(c) Two definitive copies of the proxy statement, final form of proxy, and all other soliciting material, in the form in which the material is furnished to stockholders, shall be filed with, or mailed for filing to, the commissioner not later than the date the material is first sent or given to the stockholders.

(d) Where any proxy statement, form of proxy, or other material filed pursuant to this chapter is amended or revised, two of the copies shall be marked to clearly show the changes.

(e) Copies of replies to inquiries from stockholders requesting further information and copies of communications that only request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this part.

(f) Notwithstanding subsections (a) and (b), and section 431:4-245, copies of soliciting material in the form of speeches, press releases, and radio or television scripts may be filed with the commissioner prior to use or publication. Final form copies, however, shall be filed with or mailed for filing to the commissioner as required by subsection (c) not later than the date the material is used or published. Subsections (a) and (b) and section 431:4-245 shall apply to any reprints or reproductions of all or any part of the material. [L 2000, c 24, pt of §2]

**[§431:4-241] False or misleading statements.** No solicitation subject to this part shall be made by means of any proxy statement, form

of proxy, notice of meeting, or other communication, written or oral, containing any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits any material fact necessary in order to make the statements not false or misleading or necessary to correct any statement in any earlier communication with respect to the solicitation of a proxy for the same meeting or subject matter which has become false or misleading. [L 2000, c 24, pt of §2]

**[§431:4-242] Prohibition of certain solicitations.** No person making a solicitation shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder. [L 2000, c 24, pt of §2]

**[§431:4-243] Election contests; applicability.** This part shall apply to any solicitation by any person or group for the purpose of opposing a solicitation by any person or group with respect to the election or removal of directors at any annual or special meeting of stockholders. [L 2000, c 24, pt of §2]

**[§431:4-244] Filing of information required by schedule B.** (a) No solicitation shall be made by any person, other than the management of an insurer unless at least five business days prior thereto or a shorter period as the commissioner may authorize upon a showing of good cause, there has been filed, with the commissioner, by or on behalf of each participant in the solicitation, a statement in duplicate containing the information specified in schedule B pursuant to section 431:4-233 and a copy of any material proposed to be distributed to stockholders in furtherance of the solicitation. Where preliminary copies of any materials are filed, distribution to stockholders shall be deferred until the commissioner's comments have been received and complied with.

(b) Within five business days after a solicitation is made by the management of an insurer, or a longer period as the commissioner may authorize upon a showing of good cause, there shall be filed with the commissioner by or on behalf of each participant in the solicitation, other than the insurer and by or on behalf of each management nominee or director, a statement in duplicate containing the information specified by schedule B under section 431:4-233.

(c) If any solicitation on behalf of the management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation in opposition thereto, a statement in duplicate containing the information specified in schedule B shall be filed with the commissioner, by or on behalf of each participant in the prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by subsections (a), (b), and (c), additional persons become participants in a solicitation, there shall be filed with the commissioner, by or on behalf of each person, a statement in duplicate containing the information specified in schedule B under section 431:4-233, within three business days after the person becomes a participant, or longer period as the commissioner may authorize upon a showing of good cause.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate

amendment to the statement shall be filed within three business days by or on behalf of each respective participant with the commissioner.

(f) Each statement and amendment thereto filed pursuant to this section shall be part of the public files of the commissioner. [L 2000, c 24, pt of §2]

**[§431:4-245] Solicitations prior to furnishing required written proxy statement.** Notwithstanding section 431:4-238(a), a solicitation subject to this part may be made prior to furnishing stockholders a written proxy statement containing the information specified in schedule A under section 431:4-232 with respect to the solicitation, provided that:

(1) The statements required by section 431:4-244 are filed by or on behalf of each participant in the solicitation;

(2) No form of proxy is furnished to stockholders prior to the time the proxy statement required by section 431:4-238(a) is furnished to such persons. This paragraph shall not apply where a proxy statement then meeting the requirements of schedule A under section 431:4-232 has been furnished to stockholders;

(3) At the minimum, the information specified in paragraphs (2) and (3) of the statements required by schedule B under section 431:4-233 to be filed by each participant, or an appropriate summary thereof, is included in each communication sent or given to stockholders in connection with the solicitation; and

(4) A written proxy statement containing the information specified in schedule A pursuant to section 431:4-232 with respect to a solicitation is sent or given to stockholders at the earliest practicable date. [L 2000, c 24, pt of §2]

**[§431:4-246] Solicitation prior to furnishing required written proxy statement; filing requirements.** Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by section 431:4-238(a) shall be filed with the commissioner in preliminary form at least five business days prior to the date final form copies of the material are first sent or given to the stockholders, or a shorter period as the commissioner may authorize upon a showing of good cause therefor. [L 2000, c 24, pt of §2]

**§431:4-247 Application of this part to annual report.** Notwithstanding section 431:4-238(b) and (c), two copies of any portion of the annual report referred to in section 431:4-238(b), which comments upon or refers to any solicitation subject to this part or to any participant in any solicitation, other than the solicitation by the management, shall be filed with the commissioner as proxy material subject to this part. The portion of the annual report shall be filed with the commissioner in preliminary form at least five business days prior to the date copies of the annual report are first sent or given to stockholders. [L 2000, c 24, pt of §2; am L 2004, c 122, §16]

## PART III. DOMESTIC MUTUAL INSURERS

**§431:4-301 Other articles applicable.** The provisions applicable to domestic stock insurers shall apply except where inconsistent with the

express provisions of this part. [L 1987, c 347, pt of §2]

**§431:4-302 Initial qualifications for mutual insurers.** (a) The commissioner shall not issue a certificate of authority to a domestic mutual insurer unless:

(1) It has fully qualified under this code; and

(2) It has met the minimum requirements for the classes of insurance it proposes to transact as provided in this code.

(b) All applications for insurance submitted by such an insurer as fulfilling qualification requirements shall be bona fide applications from persons resident in this State covering life, property, or risks resident or located in this State.

(c) All qualifying premiums collected and initial surplus funds of such an insurer shall be in cash. [L 1987, c 347, pt of §2]

**§431:4-303 Mutual property insurer.** (a) When applying for a certificate of authority a domestic mutual property insurer must:

(1) Have applications from at least one hundred persons for insurance covering at least two hundred and fifty nonadjacent properties, for insurance aggregating not less than $500,000; and

(2) Have collected from each applicant the proper premium at a rate not less than a rate adopted by a licensed rating organization for a term of at least one year; and

(3) Have a surplus over all liabilities, as at completion of issuance of the insurance contracts so applied for, amounting to not less than $750,000.

(b) The maximum of any single risk proposed to be assumed by the insurer shall not exceed ten per cent of its surplus. Any reinsurance taking effect simultaneously with the policy shall be deducted in determining the amount at risk for purposes of this provision.

(c) In lieu of the applications, premiums, and surplus, it is required to have a surplus amounting to not less than $1,250,000 over all liabilities. [L 1987, c 347, pt of §2 as superseded by c 348, §5]

**§431:4-304 Mutual casualty insurer.** (a) When applying for a certificate of authority a domestic mutual insurer proposing to transact casualty insurance, including vehicle insurance, must:

(1) Have applications for the insurance in a reasonable amount from at least two hundred and fifty persons covering not less than five hundred separate risks; and

(2) Have collected from each applicant the proper premium for a term of not less than one year at a rate filed with and approved by the commissioner; and

(3) Have a surplus over all liabilities, as at completion of issuance of the insurance contracts so applied for, amounting to not less than $1,500,000.

(b) In lieu of the applications, premiums, and surplus, it is required to have a surplus amounting to not less than $2,250,000 over all liabilities. [L 1987, c 347, pt of §2 as superseded by c 348, §6]

**§431:4-305 Mutual vehicle insurer.** (a) When applying for a certificate of authority, a domestic mutual insurer formed to transact vehicle insurance must:

(1) Have applications from at least two hundred persons for insurance covering at least five hundred separate vehicles, for a maximum of retained liability not in excess of $50,000 for any one accident or other liability; and

(2) Have collected from each applicant the proper premium for insurance for one year according to its schedule of premium rates approved by the commissioner; and

(3) Have a surplus over all liabilities, as at completion of issuance of the insurance contracts so applied for, amounting to not less than $1,000,000.

(b) In lieu of the applications, premiums, and surplus, it is required to have a surplus amounting to not less than $1,500,000 over all liabilities. [L 1987, c 347, pt of §2 as superseded by c 348, §7]

**§431:4-306 Mutual life insurer.** (a) When applying for a certificate of authority, a domestic mutual life insurer must:

(1) Have at least five hundred applications for life insurance, other than on the term plan for terms of ten years or less, covering at least five hundred separate insurable lives on an individual basis for a maximum insurance of not less than $5,000,000; and

(2) Have collected from each applicant the proper annual premium for one year, and have so received from all applicants premiums aggregating at least $125,000; and

(3) Have surplus over all liabilities, as at completion of issuance of the insurance contracts so applied for, amounting to not less than $600,000.

(b) In lieu of the applications, premiums, and surplus, it is required to have a surplus amounting to not less than $900,000 over all liabilities. [L 1987, c 347, pt of §2 as superseded by c 348, §8]

**§431:4-307 Mutual accident and health or sickness insurer.** (a) When applying for a certificate of authority, a domestic mutual accident and health or sickness insurer shall:

(1) Have at least five hundred applications from at least five hundred persons for individual accident and health or sickness insurance providing not more than $1,000 of accidental death benefit and not more than $25 of weekly indemnity for each applicant;

(2) Have collected from each applicant the proper premium for one year, and have so received from all applicants premiums aggregating at least $25,000; and

(3) Have a surplus over all liabilities, as at completion of issuance of the insurance contracts so applied for, amounting to not less than $450,000.

(b) In lieu of the applications, premiums, and surplus, it is required to have a surplus amounting to not less than $675,000 over all liabilities. [L 1987, c 347, pt of §2 as superseded by c 348, §9; am L 2002, c 155, §10]

**§431:4-308 Membership.** Each holder of one or more insurance contracts issued by a domestic mutual insurer, other than a contract of

reinsurance, is a member of the insurer, with the rights and obligations of such membership, and each insurance contract issued shall so stipulate. [L 1987, c 347, pt of §2]

**§431:4-309 Rights of members.** (a) A domestic mutual insurer is owned by and shall be operated in the interest of its members.

(b) Each member is entitled to one vote in the election of directors and on matters coming before corporate meetings of members, subject to such reasonable minimum requirements as to duration of membership and amount of insurance held as may be made in the insurer's bylaws. The person named as the policyholder in any group insurance policy issued by the insurer shall be deemed the member, and shall have but one vote regardless of the number of individuals insured by the policy.

(c) With respect to the management, records, and affairs of the insurer, a member shall have the same character of rights and relationship as a stockholder has toward a domestic stock insurer. [L 1987, c 347, pt of §2]

**§431:4-310 Bylaws.** (a) A domestic mutual insurer shall adopt bylaws for the conduct of its affairs.

(b) The bylaws, or any modification of the bylaws, shall be filed with the commissioner.

(c) The commissioner shall disapprove any such bylaws, or as so modified, and the commissioner shall communicate such disapproval to the insurer, if the commissioner finds after a hearing thereon, that:

(1) It is not in compliance with the laws of this State, or

(2) It unreasonably interferes with the rights of members or exercise of such rights.

(d) No bylaws or modification, so disapproved shall be effective during the existence of such disapproval. [L 1987, c 347, pt of §2]

**§431:4-311 Notice of annual meeting.** (a) Notice of the time and place of the annual meeting of members of a domestic mutual insurer shall be given by imprinting the notice plainly on the policies issued by the insurer.

(b) Any change of the date or place of the annual meeting shall be made only at an annual meeting of members. Notice of the change may be given:

(1) By imprinting the new date or place on all policies which will be in effect as of the date of such changed meeting; or

(2) Unless the commissioner otherwise orders:

(A) Through policies issued after the date of the annual meeting at which such change was made, and

(B) In or attached to premium notices and renewal certificates issued during the twenty-four months immediately following the meeting. [L 1987, c 347, pt of §2]

**§431:4-312 Members proxies.** (a) A member of a domestic mutual

insurer may vote in person or by proxy given another member on any matter coming before a corporate meeting of members.

(b) No proxy shall be valid beyond the earlier of the following dates:

(1) The date of expiration set forth in the proxy;

(2) The date of termination of membership; or

(3) Five years from the date of execution of the proxy.

(c) No member's vote upon any proposal to divest the insurer of its business and assets, or the major part thereof, shall be registered or taken except in person or by a proxy newly executed and specific as to the matter to be voted upon. [L 1987, c 347, pt of §2]

**§431:4-313 Directors.** (a) No individual shall be a director of a domestic mutual insurer by reason of the individual's holding public office (i.e. ex officio).

(b) An individual is disqualified from being or acting as a director if such person:

(1) Is adjudged as a bankrupt;

(2) Took the benefit of any insolvency law; or

(3) Made a general assignment for the benefit of creditors. [L 1987, c 347, pt of §2]

**§431:4-314 Limitation on expenses incurred in writing property and casualty.** For any calendar year after its first two full calendar years of operation, no domestic mutual insurer, other than one issuing nonassessable policies, shall incur any costs or expense in the writing or administration of property, accident and health or sickness, and casualty insurances, other than boiler and machinery or elevator, transacted by it which, exclusive of losses paid, loss adjustment expenses, investment expenses, dividends, and taxes exceeds the sum of:

(1) Forty per cent of the net premium income during that year after deducting therefrom net earned reinsurance premiums for the year, plus

(2) All of the reinsurance commissions received on reinsurance ceded by it. [L 1987, c 347, pt of §2; am L 2003, c 212, §35]

**§431:4-315 Violation of expense limitation.** (a) The officers and directors of an insurer violating section 431:4-314 shall be jointly and severally liable to the insurer for any excess of expenses incurred.

(b) For failure or refusal of the insurer to exercise reasonable diligence in enforcing such liability, the commissioner may:

(1) Prosecute action thereon for the benefit of the insurer; and

(2) Revoke the insurer's certificate of authority. [L 1987, c 347, pt of §2]

**§431:4-316 Actions on officers' salaries.** No action to recover, or no action on account of, any salary or other compensation due or claimed to be due any officer or director of a domestic mutual insurer, or on any note or agreement relative thereto, shall be brought against the insurer later than twelve months after the date on which the salary or compensation, or any installment thereof, first accrued. [L 1987, c 347, pt of §2]

**§431:4-317 Contingent liability of members.** (a) Each member of a domestic mutual insurer, except as otherwise provided in this part, shall have a contingent liability, pro rata and not one for another, for the discharge of its obligations. The contingent liability shall be in such maximum amount as is stated in the insurer's articles of incorporation, but shall be not less than one, nor more than five, additional premiums for the member's policy at the annual premium rate and for a term of one year.

(b) Every policy issued by the insurer shall contain a statement of the contingent liability.

(c) Termination of the policy of any member shall not relieve the member of contingent liability for the member's proportion of the obligations of the insurer which accrued while the policy was in force. [L 1987, c 347, pt of §2]

**§431:4-318 Accrual of liability.** (a) If at any time the assets of a domestic mutual insurer are less than its liabilities and the minimum surplus, if any, required of it by this code as prerequisite for continuance of its certificate of authority, and the deficiency is not cured from other sources, its directors may, if approved by the commissioner, make an assessment only on its members who at any time within the twelve months immediately preceding the date assessment was authorized by its directors held policies providing for contingent liability.

(b) The assessment shall be for such an amount of money as is required in the opinion of the commissioner, to render the insurer fully solvent, and provide a reasonable amount of working capital above the minimum amount of surplus, but the working capital so provided shall not exceed five per cent of the insurer's liabilities as of the date on which the amount of deficiency was determined.

(c) A member's proportionate part of any assessment shall be computed by applying to the premium earned within the twelve-month period on the member's contingently liable policy or policies the ratio of the total assessment to the total premium earned during the period on all contingently liable policies which are subject to the assessment.

(d) No member shall have an offset against any assessment for which the member is liable, on account of any claim for unearned premium or losses payable. [L 1987, c 347, pt of §2]

**§431:4-319 Contingent liability as asset.** Any contingent liability to assessment of members of a domestic mutual insurer does not constitute an asset of the insurer in any determination of its financial condition. [L 1987, c 347, pt of §2]

**§431:4-320 Lien on reserves.** As to life insurance, any portion of an assessment of contingent liability upon a policyholder which remains

unpaid following notice of such assessment, demand for payment, and lapse of a reasonable waiting period as specified in such notice, may, if approved by the commissioner, be secured by placing a lien on the reserves held by the insurer to the credit of the policyholder. [L 1987, c 347, pt of §2]

**§431:4-321 Nonassessable policies.** (a) A domestic mutual insurer, after it has established a surplus not less in amount than the minimum capital funds required of a domestic stock insurer to transact like classes of insurance, may extinguish the contingent liability of its members to assessment and omit provisions imposing contingent liability in all policies currently issued.

(b) When the surplus has been so established and the commissioner has so ascertained, the commissioner shall issue to the insurer, at its request, the commissioner's certificate authorizing the extinguishment of the contingent liability of its members and the issuance of policies free therefrom.

(c) While it maintains surplus funds in amount not less than the minimum paid-up capital stock and surplus required of a domestic stock insurer authorized to transact like classes of insurance, a foreign or alien mutual insurer may, if consistent with its charter and the laws of its domicile, issue nonassessable policies covering subjects located, resident, or to be performed in this State. [L 1987, c 347, pt of §2]

**§431:4-322 Applies to all policies.** The commissioner shall not authorize a domestic mutual insurer so to extinguish the contingent liability of any of its members or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its members and in all policies for all classes of insurance transacted by it. Except that, if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its members as may acquire such policies in such state, and need not extinguish the contingent liability applicable to policies theretofore in force in the state. [L 1987, c 347, pt of §2]

**§431:4-323 Revocation of authority.** (a) The commissioner shall revoke the authority of a domestic mutual insurer to extinguish the contingent liability of its members if:

(1) At any time the insurer's assets are less than the sum of its liabilities and the surplus required for such authority, or

(2) The insurer, by resolution of its directors approved by its members, requests that the authority be revoked.

(b) Upon revocation of such authority for any cause, the insurer shall not thereafter issue any policies without contingent liability, nor renew any policies then in force without written endorsement thereon providing for contingent liability. [L 1987, c 347, pt of §2]

**§431:4-324 Dividends.** (a) The directors of a domestic mutual insurer may from time to time apportion and pay to its members dividends only out of that part of its surplus which is in excess of its required

minimum surplus.

(b) The dividends shall be paid or credited to policyholders according to such reasonable classification of its policies as the directors may in their discretion from time to time establish. No dividend shall be paid which unfairly discriminates between policies within the same classification.

(c) No dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy. [L 1987, c 347, pt of §2]

**§431:4-325 Nonparticipating policies.** (a) If its bylaws so provide, a domestic mutual insurer may issue policies not entitled to participate in the insurer's savings and earnings, provided it is authorized to issue policies without contingent liability to assessment.

(b) Such insurer shall not issue in this State both participating and nonparticipating policies for the same class of risks, unless the right or absence of right to participate is reasonably related to the premium charge or the special character of the risks assumed. [L 1987, c 347, pt of §2]

**§431:4-326 Members' share of assets.** (a) Upon the liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness and policy obligations shall be distributed to its members who were members within the thirty-six months prior to the last termination of its certificate of authority.

(b) The distributive share of each member shall be in the proportion that the aggregate premiums earned by the insurer on the policies of the member during the combined periods of the member's membership, bear to the aggregate of all premiums so earned on the policies of all members. If a life insurer, the insurer shall make a reasonable classification of its life insurance policies so held by the members and a formula, based upon such classification, for determining the equitable distributive share of each such member. The classification and formula shall be subject to the commissioner's approval. [L 1987, c 347, pt of §2]

## PART IV. RECIPROCAL INSURERS

**§431:4-401 Application of other sections.** The provisions of article 3, Insurers General Requirements, shall apply except where inconsistent with the express provisions of this article. [L 1987, c 347, pt of §2]

**§431:4-402 Scope.** Except where made expressly applicable to domestic reciprocal insurers, the provisions of this part shall apply to all authorized reciprocal insurers. [L 1987, c 347, pt of §2]

**§431:4-403 Insuring powers of reciprocals.** (a) Upon complying with the provisions of this part, a reciprocal insurer, as defined in section 431:3-108, may transact any class or classes of insurance defined by this code, other than life or accident and health or sickness insurance.

(b) A reciprocal insurer may purchase reinsurance upon the risk of any subscriber, and may grant reinsurance as to any class of insurance

which it is authorized to transact direct. [L 1987, c 347, pt of §2; am L 2003, c 212, §36]

**§431:4-404 Suits.** A reciprocal insurer shall sue and be sued in its own name. [L 1987, c 347, pt of §2]

**§431:4-405 Attorney.** Attorney as used in this part refers to the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, partnership, or corporation. The principal office of the attorney for a domestic reciprocal insurer shall be maintained within this State. [L 1987, c 347, pt of §2; am L 2003, c 212, §37]

**§431:4-406 Power of attorney.** (a) The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

(b) The power of attorney must set forth:

(1) The powers, duties, and compensation of the attorney;

(2) That the attorney is empowered to accept service of process on behalf of the insurer and to authorize the commissioner to receive service of process in actions against the insurer upon contracts exchanged;

(3) Except as to nonassessable policies, a provision for contingent several liability of each subscriber in a specified amount, which amount shall be not less than one nor more than ten times the premium or premium deposit stated in the policy.

(c) The power of attorney may:

(1) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(2) Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

(3) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(4) Contain other lawful provisions deemed advisable.

(d) The terms of any power of attorney, or agreement collateral thereto, shall be reasonable and equitable, and no such power, agreement or any amendment thereof, shall be used or be effective in this State until approved by the commissioner. [L 1987, c 347, pt of §2]

**§431:4-407 Modifications.** Modification of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No modification shall be effective retroactively, nor as to any insurance contract issued prior thereto, nor shall it be effective until approved by the commissioner. [L 1987, c 347, pt of §2]

**§431:4-408 Organization of reciprocal insurers.** Twenty-five or more persons domiciled in this State, may organize a domestic reciprocal insurer and, in compliance with this part, make application to the

commissioner for a certificate of authority to transact insurance. [L 1987, c 347, pt of §2]

**§431:4-409 Application for authority; declaration required.** (a) When applying for a certificate of authority, the original subscribers and the proposed attorney shall fulfill the requirements of section 431:3-212, and execute and file with the commissioner a declaration setting forth:

(1) The name of the insurer, in compliance with section 431:3-202(b) and section 431:4-104(d)(1);

(2) The location of the insurer's principal office, which shall be the same as that of the attorney;

(3) The classes of insurance proposed to be transacted;

(4) The names and addresses of the original subscribers;

(5) The designation and appointment of the proposed attorney and a copy of the power of attorney;

(6) The names and addresses of the officers and directors of the attorney if a corporation, or of its members if a partnership;

(7) The powers of the subscribers' advisory committee and the names and terms of office of the members thereof;

(8) That all moneys paid to the reciprocal, after deducting therefrom any sum payable to the attorney, shall be held by the attorney-in-fact in the name of the reciprocal insurer for the purposes specified in the subscribers' agreement;

(9) A copy of the subscribers' agreement;

(10) A statement that each of the original subscribers has in good faith applied for insurance of the class proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than twelve months at the rate theretofore filed with and approved by the commissioner;

(11) A statement of the financial condition of the insurer, and a schedule of its assets; and

(12) A copy of each policy, endorsement, and application form it then proposes to issue or use.

(b) Such declaration shall be acknowledged by each subscriber and by the attorney before any officer authorized to take acknowledgements of deeds. [L 1987, c 347, pt of §2]

**§431:4-410 Policies effective.** Any policy applied for by an original subscriber shall become effective concurrently with the issuance of a certificate of authority to the reciprocal insurer. [L 1987, c 347, pt of §2]

**§431:4-411 Attorney's bond.** (a) Concurrently with the filing of the declaration provided for in section 431:4-409, the attorney of a domestic reciprocal shall file with the commissioner a bond in favor of this State. The bond shall be executed by the attorney and by an authorized corporate surety, and shall be subject to the commissioner's approval.

(b) The bond shall be in the sum of $25,000 conditioned that the

attorney will faithfully account, before a notary public, in a sworn affidavit, for all moneys and other property of the insurer coming into the attorney's hands, and that the attorney will not withdraw or appropriate for the attorney's own use from the funds of the insurer any moneys or property to which the attorney is not entitled under the power of attorney.

(c) The bond shall provide that it is not subject to cancellation unless sixty days' advance notice in writing of intent to cancel is given to both the attorney and the commissioner. [L 1987, c 347, pt of §2]

**§431:4-412 Deposit in lieu.** In lieu of the bond, the attorney may maintain on deposit with the commissioner a like amount in cash or in value of securities qualified under this code as insurers' investments, and subject to the same conditions as the bond. [L 1987, c 347, pt of §2]

**§431:4-413 Actions on bond.** Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any time by one or more subscribers suffering loss through a violation of the conditions thereof or by a receiver or liquidator of the insurer. Amounts so recovered shall be deposited in and become part of the insurer's funds. [L 1987, c 347, pt of §2]

**§431:4-414 Subscribers.** Any person may make application for, enter into agreement for and hold policies or contracts in or with, and be a subscriber of a domestic, foreign or alien reciprocal insurer. [L 1987, c 347, pt of §2]

**§431:4-415 Subscribers' advisory committee.** (a) The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

(b) Not less than three-fourths of the committee shall be composed of subscribers other than the attorney, or any person employed by, representing, or having a financial interest in the attorney.

(c) The committee shall:

(1) Supervise the finances of the insurer;

(2) Supervise the insurer's operations to such extent as to assure their conformity with the subscribers' agreement and power of attorney;

(3) Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and

(4) Have such additional powers and functions as may be conferred by the subscribers' agreement. [L 1987, c 347, pt of §2]

**§431:4-416 Subscriber's liability.** (a) The liability of each subscriber subject to assessment for the obligations of the reciprocal insurer shall not be joint, but shall be individual and several.

(b) Each subscriber who is subject to assessment shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while the subscriber's policy was in force.

The contingent liability may be at the rate of not less than one nor more than ten times the premium or premium deposit stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in section 431:4-418.

(c) Each assessable policy issued by the insurer shall plainly set forth a statement of contingent liability. [L 1987, c 347, pt of §2]

**§431:4-417 Subscriber's liability on judgments.** (a) No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for thirty days.

(b) Any such judgment, or any judgment against the insurer based upon legal process served in compliance with section 431:2-206, shall be binding upon each of the insurer's subscribers only in such proportion as the subscriber's interests may appear and in an amount not exceeding the subscriber's contingent liabilities. [L 1987, c 347, pt of §2]

**§431:4-418 Aggregate liability.** No one policy or subscriber as to such policy shall be assessed or be charged with an aggregate of contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year, in excess of the number of times the premium as stated in the policy, computed solely upon premium earned on such policy during that year. [L 1987, c 347, pt of §2]

**§431:4-419 Assessment.** (a) Assessment may be levied from time to time upon the subscribers of a domestic reciprocal insurer, other than as to nonassessable policies, by the attorney upon approval in advance by the subscribers' advisory committee and the commissioner, or by the commissioner in liquidation of the insurer.

(b) Each subscriber's share of a deficiency for which an assessment is made, not exceeding in any event the subscriber's aggregate contingent liability as computed in accordance with section 431:4-418, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned during the period upon all policies subject to assessment.

(c) In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.

(d) No subscriber shall have an offset against any assessment for which the subscriber is liable on account of any claim for unearned premium or losses payable. [L 1987, c 347, pt of §2]

**§431:4-420 Time limit for assessment.** Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for, and shall pay the subscriber's share of any assessment, as computed and limited in accordance with this part if:

(1) While the subscriber's policy is in force or within one year after its termination, the subscriber is notified by either the attorney or the commissioner of the attorney's or the commissioner's intentions to levy such assessment, or

(2) If an action to have a receiver, conservator, rehabilitator, or liquidator of the insurer appointed is

commenced pursuant to article 15 while the subscriber's policy is in force or within one year after its termination. [L 1987, c 347, pt of §2]

**Revision Note**

Subsection designation deleted.

**§431:4-421 Nonassessable policies.** (a) If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum paid-up capital stock and surplus required of a domestic stock insurer authorized to transact like classes of insurance, upon application of the attorney and as approved by the subscribers' advisory committee, the commissioner shall issue the commissioner's certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this State, and to omit provisions imposing contingent liability of subscribers under its policies then in force in this State, and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this State for so long as the surplus remains unimpaired.

(b) Upon impairment of the surplus, the commissioner shall forthwith revoke the certificate. No policy shall thereafter be issued or renewed without providing for the contingent assessment liability of subscribers.

(c) The commissioner shall not authorize a domestic reciprocal insurer to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualifies to and does extinguish the liability of all its subscribers and in all such policies for all classes of insurance transacted by it. Except, if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in the state, and need not extinguish the contingent liability applicable to policies theretofore in force in the state. [L 1987, c 347, pt of §2]

**§431:4-422 Contributions of surplus.** The attorney or other parties may advance to the reciprocal insurer funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer, and shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No such withdrawal or repayment shall be made without the advance approval of the commissioner. [L 1987, c 347, pt of §2]

**§431:4-423 Share in savings.** A reciprocal insurer may from time to time return to its subscribers any savings or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks, or policies, or between subscribers, but the distribution may vary as to classes of subscribers, based upon the experience of the subscribers. [L 1987, c 347, pt of §2]

**§431:4-424 Subscriber's share of assets.** Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contributions to

its surplus made as provided in section 431:4-422, and the return of any unused deposits, savings, or credits, shall be distributed to its subscribers who were such within the twelve months prior to such formula as may have been approved by the commissioner. [L 1987, c 347, pt of §2]

**§431:4-425 REPEALED.** L 1989, c 195, §42.

## PART V. REORGANIZATION AND CONVERSION OF DOMESTIC INSURERS

**§431:4-501 Reorganization, merger or consolidation.** (a) A domestic insurer may reorganize, merge or consolidate with another insurer subject to the provisions of this part, and subject to the following conditions:

(1) The plan of reorganization, merger, or consolidation shall be submitted to and be approved by the commissioner in advance of the reorganization, merger, or consolidation.

(2) The commissioner shall not approve any such plan unless the commissioner finds that it is fair, equitable, and consistent with law. If the commissioner fails to approve the plan, the commissioner shall state the commissioner's reasons for such failure in the commissioner's decision.

(3) No director, officer, member, or subscriber of any such insurer, except as is expressly provided by the plan of reorganization, merger, or consolidation, shall receive any fee, commission, other compensation or valuable consideration whatsoever, for in any manner aiding, promoting, or assisting in the reorganization, merger, or consolidation.

(4) Any reorganization, merger, or consolidation as to an incorporated domestic insurer shall in other respects be governed by the general laws of this State relating to business corporations. Except, that as to domestic mutual insurers, approval by two-thirds of its members who vote thereon pursuant to the notice and procedure as was approved by the commissioner shall constitute approval of the reorganization, merger, or consolidation as respects the insurer's members.

(b) Reinsurance of all or substantially all of the insurance in force of a domestic insurer by another insurer shall be deemed a consolidation for the purposes of this part. [L 1987, c 347, pt of §2]

**§431:4-502 Mutualization of stock insurers.** (a) Any domestic stock insurer may become a domestic mutual insurer pursuant to such plan and procedure as are approved by the commissioner in advance of such mutualization.

(b) The commissioner shall not approve any such plan, procedure, or mutualization unless:

(1) It is equitable to both shareholders and policyholders.

(2) It is approved by vote of the holders of not less than three-fourths of the insurer's capital stock having voting rights, and by vote of not less than two-thirds of the insurer's policyholders who vote on such plan, pursuant to such notice and procedure as may be approved by the commissioner; provided that in the case of a life insurer, the right to vote thereon is limited to those policyholders whose policies have face amounts of not less than $1,000 and have been in force one year or more. Such vote may be registered in person, by proxy, or by mail.

(3) Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair value thereof as determined by competent disinterested appraisers.

(4) The plan provides for appraisal and purchase of the shares of any nonconsenting stockholder in

accordance with the laws of this State relating to the sale or exchange of all the assets of a private corporation.

(5) The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective.

(6) Mutualization leaves the insurer with surplus funds reasonably adequate to preserve the security of its policyholders and its ability to continue successfully in business in the states in which it is then authorized, and in the classes of insurance it is then authorized to transact. [L 1987, c 347, pt of §2]

**§431:4-503 Conversion or reinsurance of mutual insurer.** (a) No domestic mutual insurer shall be converted, changed, or reorganized as a stock corporation.

(b) Such an insurer may be wholly reinsured in, its assets transferred to, and its liabilities assumed by another mutual or stock insurer under such terms and conditions as are approved by the commissioner in advance of such reinsurance.

(c) The commissioner shall not approve any such reinsurance agreement which does not determine the amount of and make adequate provision for paying to policyholders of the mutual insurer, reasonable compensation for their equities as owners of the insurer, such compensation to be apportioned to policyholders as identified and in the manner prescribed in section 431:4-326. [L 1987, c 347, pt of §2]

**§431:4-504 Merger or conversion of reciprocal insurer.** (a) A domestic reciprocal insurer, upon affirmative vote of not less than two-thirds of the subscribers who vote upon such merger pursuant to such notice as may be approved by the commissioner and with approval of the commissioner of the terms therefor, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

(b) Every new reciprocal insurer formed by merger shall assume and succeed to all of the obligations and liabilities of the respective merging reciprocal insurers and shall be held liable to pay and discharge all such debts and liabilities and perform such obligations in the same manner as if they had been incurred or contracted by it, but the subscribers of the predecessor reciprocal insurers shall continue subject to all the liabilities, claims, and demands which shall then exist, or which may thereafter accrue against them, or any of them, by reason of any liabilities and obligations incurred by them, or on their behalf as the subscribers before the date of merger.

(c) Such a stock or mutual insurer shall be subject to the same capital requirements and shall have the same rights as a like domestic insurer transacting like classes of insurance.

(d) The commissioner shall not approve:

(1) Any plan for a merger or conversion which is inequitable to subscribers, or

(2) Any plan for a conversion to a stock insurer which does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to the subscriber's interest in the reciprocal insurer, as determined in accordance with section 431:4-424, and a reasonable length of time within which to exercise the right. [L 1987, c 347, pt of §2; am L 1989, c 195, §15]

**[ARTICLE 4A]**

**§431:4A-101 Credit allowed a domestic ceding insurer.** (a) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (b), (c), (d), (e), or (f). Credit shall be allowed under subsection (b) or (c) only as respects cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under subsection (c) or (d) only if the applicable requirements of subsection (g) have been satisfied.

(b) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this State, or is accredited by the commissioner as a reinsurer in this State. To be eligible for accreditation, a reinsurer shall:

(1) File with the commissioner evidence of its submission to this State's jurisdiction;

(2) Submit to this State's authority to examine its books and records;

(3) Be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

(4) File annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(5) Demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than $20,000,000 and its accreditation has not been denied by the commissioner within ninety days after submission of its application.

(c) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance equal to or exceeding those applicable under this article and the assuming insurer or United States branch of an alien assuming insurer:

(1) Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

(2) Submits to the authority of this State to examine its books and records;

provided that paragraph (1) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(d) Credit shall be allowed as follows:

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in section 431:4A-103(b), for the payment of the valid claims of its United States ceding insurers, their assigns and successors in interest. To enable the commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the National Association of

Insurance Commissioners' annual statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the commissioner and bear the expense of examination;

(2) Credit for reinsurance shall not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

(A) The commissioner of the state where the trust is domiciled; or

(B) The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

The form of the trust and any trust amendments shall also be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States.

The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner.

The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustee of the trust shall report to the commissioner in writing the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31;

(3) The following requirements shall apply to these categories of assuming insurers:

(A) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in subparagraph (B);

(B) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty per cent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust;

(C) In the case of a group including incorporated and

individual unincorporated underwriters:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group;

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this article, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(iii) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of United States domiciled ceding insurers of any member of the group for all years of account.

The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group;

(D) In the case of a group of incorporated underwriters under common administration, the group shall:

(i) Have continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation;

(ii) Maintain aggregate policyholders' surplus of at least $10,000,000,000;

(iii) Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of such group;

(iv) Maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and

(v) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner an

annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

(e) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the commissioner as a reinsurer in this State and secures its obligations in accordance with the requirements of this subsection as follows:

(1) To be eligible for certification, the assuming insurer shall:

(A) Be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to paragraph (3);
(B) Maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the rules adopted by the commissioner;
(C) Maintain financial strength ratings from two or more rating agencies deemed acceptable by the rules adopted by the commissioner;
(D) Agree to submit to the jurisdiction of this State, appoint the commissioner as its agent for service of process in this State, and agree to provide security for one hundred per cent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final United States judgment;
(E) Agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis; and
(F) Satisfy any other requirements for certification deemed relevant by the commissioner;

(2) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. To be eligible for certification, in addition to satisfying the requirements of paragraph (1):

(A) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection;
(B) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and
(C) Within ninety days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each

underwriter member of the association;

(3) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in a qualified jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer. In addition:

(A) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner;

(B) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners committee process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under rules adopted by the commissioner;

(C) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners financial regulation standards and accreditation program shall be recognized as qualified jurisdictions; and

(D) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation;

(4) The commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable pursuant to rules adopted by the commissioner. The commissioner shall publish a list of all certified reinsurers and their ratings;

(5) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with its rating, as specified in rules adopted by the commissioner. In addition:

(A) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with section 431:4A-102, or in a multibeneficiary trust in accordance with subsection (d),

except as otherwise provided in this subsection;

(B) If a certified reinsurer maintains a trust to fully secure its obligations subject to subsection (d), and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to subsection (d). It shall be a condition to the grant of certification under this subsection that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account;

(C) The minimum trusteed surplus requirements provided in subsection (d) shall not be applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of $10,000,000;

(D) With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due; and

(E) For purposes of this subsection:

(i) A certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred per cent of its obligations;

(ii) "Terminated" means revoked, suspended, voluntarily surrendered, or placed on inactive status; and

(iii) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, this requirement shall not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended;

(6) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction's certification, and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this State; and

(7) A certified reinsurer that ceases to assume new business in this State may request to maintain its certification in inactive status to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(f) Credit shall be allowed when the reinsurance is ceded to an

assuming insurer not meeting the requirements of subsection (b), (c), (d), or (e), but only with respect to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(g) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this State, the credit permitted by subsections (c) and (d) shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(1) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give the court jurisdiction, and shall abide by the final decision of that court or of any appellate court in the event of an appeal; and

(2) To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

(h) If the assuming insurer does not meet the requirements of subsection (b) or (c), the credit permitted by subsection (d) or (e) shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(1) Notwithstanding any other provisions in the trust instrument to the contrary, if the trust fund is inadequate because it contains an amount less than the amount required by subsection (d)(3), or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of any court of competent jurisdiction in any state of the United States directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund;

(2) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

(3) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

(4) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

(i) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification. In addition:

(1) The commissioner shall give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the commissioner's order after a hearing, unless:

(A) The reinsurer waives its right to a hearing;
(B) The commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary

surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subsection (e)(6); or

(C) The commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(2) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with section 431:4A-102. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subsection (e)(5) or section 431:4A-102.

(j) A ceding insurer shall take steps to:

(1) Manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the commissioner within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceed fifty per cent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, are likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer; and

(2) Diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within thirty days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty per cent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer. [L 1992, c 176, pt of §5; am L 1993, c 321, §11; am L 1994, c 34, §1; am L 2014, c 234, §1]

**§431:4A-102 Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer.** An asset or reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 431:4A-101 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if that security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution as defined in section 431:4A-103(b). This security may be in the form of:

(1) Cash;

(2) Securities listed by the securities valuation office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the securities valuation office, and qualifying as admitted assets;

(3) Clean, irrevocable, and unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in section 431:4A-103, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the

filing date of its annual statement;

(4) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or

(5) Any other form of security acceptable to the commissioner. [L 1992, c 176, pt of §5; am L 2014, c 234, §2]

**[§431:4A-103] Qualified United States financial institutions.** (a) For purposes of section 431:4A-102(3), a "qualified United States financial institution" means an institution that:

(1) Is organized or (in the case of a United States office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

(2) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the commissioner, or the securities valuation office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(b) For purposes of those provisions of this article specifying those institutions that are eligible to act as a fiduciary of a trust, "qualified United States financial institution" means an institution that:

(1) Is organized, or (in the case of a United States branch or agency office of a foreign banking organization) licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(2) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies. [L 1992, c 176, pt of §5]

**[§431:4A-104] Rules.** The commissioner may adopt rules under chapter 91 implementing this article. [L 1992, c 176, pt of §5]

**§431:4A-105 REPEALED.** L 2014, c 234, §3.

## [ARTICLE 4F]
## STATE OF ENTRY FOR ALIEN INSURERS

**[§431:4F-101] Definitions.** As used in this article, unless the context requires otherwise:

"Alien insurer" has the same meaning as set forth in section 431:3-101.

"Trusteed assets" mean the assets in a trust account required by section 431:4F-104.

"Trusteed surplus" means the aggregate value of the insurer's general state deposits and trusteed assets deposited with a trustee in compliance with section 431:4F-105, plus accrued investment income thereon where such interest is collected by the states for trustees, less the aggregate net amount of all of the insurer's reserves and other liabilities in the United States as determined in accordance with section 431:4F-106.

"United States branch" means the business unit through which business is transacted within the United States by an alien insurer and the assets and liabilities of the insurer within the United States pertaining to such business. [L 2004, c 120, pt of §2]

**[§431:4F-102] Scope.** This article applies to a United States branch using this State as a state of entry to transact insurance in the United States. The United States branch shall be subject to all state laws applicable to an insurer domiciled in this State, unless otherwise provided. [L 2004, c 120, pt of §2]

**§431:4F-103 Authorization of entry.** (a) An alien insurer may use this State as a state of entry to transact insurance in the United States through a United States branch by:

(1) Qualifying as an insurer licensed to do business in this State; and

(2) Establishing trust accounts, pursuant to trust agreements approved by the commissioner with a United States financial institution approved by the commissioner, in an amount at least equal to the minimum capital and surplus or authorized control level risk-based capital, whichever is greater, required to be maintained by a domestic insurer licensed for the same kind of insurance.

(b) Before authorizing the entry of a United States branch of any alien insurer through this State, the commissioner shall in addition to the requirements of section 431:4F-105 and any other requirement of this chapter, require the alien insurer to:

(1) Comply with the requirements of section 431:3-212;

(2) Submit an English language translation, as necessary, of any of the documents required in paragraph (1); and

(3) Submit to an examination of the insurer's affairs at its principal office within the United States. [L 2004, c 120, pt of §2; am L 2010, c 116, §1(4)]

**[§431:4F-104] Maintenance of trust account.** The trusteed assets, or the assets of the trust account of an alien insurer, as required by section 431:4F-103, shall at all times be in an amount equal to the United States branch's reserves and other liabilities plus the minimum capital and surplus or authorized control level risk-based capital, whichever is greater, required to be maintained by a domestic insurer licensed to do the same kind of insurance. [L 2004, c 120, pt of §2]

**[§431:4F-105] Requirements for trust agreement.** (a) The terms of the trust agreement required by section 431:4F-103 shall be set forth in a deed of trust. The deed of trust and all subsequent amendments shall be authenticated in a form and manner as the commissioner may prescribe and shall not be effective unless approved by the commissioner upon a finding that:

(1) A deed of trust or its amendments are sufficient in form and in conformity with law;

(2) The trustee or trustees are eligible as such; and

(3) The deed of trust is adequate to protect the interests of the beneficiaries of the trust.

(b) If at any time after reasonable notice and hearing, the commissioner finds that the requisites for the approval no longer exist, the commissioner may withdraw approval.

(c) The commissioner may approve modifications of, or variations in any deed of trust, which in the commissioner's judgment are not prejudicial to the interests of the people of this State or policyholders and creditors in the United States, of the United States branch.

(d) The deed of trust shall contain provisions that:

(1) Vest legal title to trusteed assets in the trustee or trustees, and their lawfully appointed successors;

(2) Require that all assets deposited in the trust shall be continuously kept within Hawaii;

(3) Provide for substitution of a new trustee or trustees in case of a vacancy by death, resignation, or otherwise, subject to the approval of the commissioner;

(4) Require that the trustee or trustees shall continuously maintain a record at all times sufficient to identify the assets of such fund;

(5) Require that the trusteed assets shall consist of cash or investments, or both, as permitted by article 6 for investment of the funds of domestic insurers and accrued interest thereon if collectable by the trustee;

(6) Require that the trust shall be for the exclusive benefit, security, and protection of the policyholders, or policyholders and creditors in the United States, of the United States branch;

(7) Require that the trust shall be maintained as long as there is any outstanding liability of the alien insurer arising out of its insurance transactions in the United States; and

(8) Provide, in substance, that no withdrawals of assets, other than income as specified in subsection (e) shall be made or permitted by the trustee or trustees without the approval of the commissioner except to:

(A) Make deposits required by law in any state for the security or benefit of all policyholders, or policyholders and creditors in the United States, of the United States branch;

(B) Substitute other assets permitted by law and at least equal in value and quality to those withdrawn, upon the specific written direction of the United States branch manager when duly empowered and acting pursuant to either general or specific written authority previously given or delegated by the board of directors; or

(C) Transfer such assets to an official liquidator or rehabilitator pursuant to an order of a court of competent jurisdiction.

(e) The deed of trust may provide that income, earnings, dividends, or interest accumulations of the assets of the fund may be paid over to

the United States branch manager of the United States branch upon request; provided that the total trusteed assets shall not be less than the amount required to be maintained pursuant to section 431:4F-104.

(f) Upon withdrawal of trusteed assets deposited in another state in which the insurer is authorized to do business, it shall be sufficient if the deed of trust requires similar written approval of the insurance supervising official of that state in lieu of approval of the commissioner; provided that the total trusteed assets shall not be less than the amount required to be maintained pursuant to section 431:4F-104. In all such cases, the United States branch shall notify the commissioner in writing of the nature and extent of the withdrawal.

(g) The commissioner may:

(1) Make examinations of the trusteed assets of any authorized United States branch at the insurer's expense; and

(2) Require the trustee or trustees to file a statement, in such form as the commissioner may prescribe, certifying the assets of the trust fund and the amounts thereof.

(h) Refusal or neglect of any trustee to comply with this section shall be grounds for the revocation of the insurer's license or the liquidation of its United States branch. [L 2004, c 120, pt of §2]

**[§431:4F-106] Reporting requirements for United States branches of alien insurers.** (a) In addition to other requirements of the insurance code, every authorized United States branch shall complete and file the report required of a domestic insurer in article 3, including:

(1) Annual and quarterly statements of the business transacted within the United States and the assets held by or for it within the United States for the protection of policyholders and creditors within the United States, and of the liabilities incurred against such assets. The forms shall not contain any statement in regard to its assets and business elsewhere. The statements shall be in the same format required of an insurer domiciled in Hawaii and licensed to write the same kinds of insurance; and

(2) A statement of trusteed surplus, in such form as the commissioner may prescribe, as of the end of the same period covered by the statement filed pursuant to paragraph (1). In determining the net amount of the United States branch's liabilities in the United States to be reported in the statement of trusteed surplus, the United States branch shall make adjustments to total liabilities reported on the accompanying annual or quarterly statement as follows:

(A) Add back liabilities used to offset admitted assets reported in the accompanying quarterly or annual statement; and

(B) Deduct:

(i) Unearned premiums on agent's balances or uncollected premiums not more than ninety days past due not exceeding unearned premium reserves carried thereon;

(ii) Reinsurance on losses with authorized insurers, less unpaid reinsurance premiums;

(iii) Reinsurance recoverables on paid losses from unauthorized insurers that are included as assets in the annual or quarterly statement; but only to the extent a liability for such unauthorized recoverables is included in the liabilities report in the trusteed surplus statement;

(iv) Special state deposits held for the exclusive benefit

of policyholders, or policyholders and creditors, of any particular state not exceeding net liabilities reported for that state;

(v) Secured accrued retrospective premiums;

(vi) If a life insurer, the amount of its policy loans to policyholders within the United States, not exceeding the amount of legal reserve required on each such policy;

(vii) If a life insurer, the net amount of uncollected and deferred premiums; and

(viii) Any other non-trusteed asset that the commissioner determines secures liabilities in a substantially similar manner; and

(C) Provide any additional information that the commissioner may require relating to the total business or assets, or any portion thereof, of the alien insurer.

(b) The annual statement and trusteed surplus statement shall be signed and verified by the United States branch manager, attorney-in-fact, or a duly empowered assistant United States branch manager, of the United States branch. The items of securities and other property held under trust deeds shall be certified in the trusteed surplus statement by the United States trustee or trustees.

(c) Every report on examination of a United States branch shall include a trusteed surplus statement as of the date of examination in addition to the general statement of the financial condition of the United States branch. [L 2004, c 120, pt of §2]

**[§431:4F-107] Additional requirements for United States branch license.** (a) Before issuing any new or renewal license to any United States branch, the commissioner may require satisfactory proof, either in the alien insurer's charter or by an agreement evidenced by a duly certified resolution of its board of directors, or otherwise as the commissioner may require, that the insurer will not engage in any insurance business in contravention of this section or not authorized by its charter.

(b) The commissioner shall issue a renewal license to any United States branch if satisfied, by such proof as required, that the insurer is not delinquent with respect to any requirement imposed by this chapter and that its continuance in business in this State will not be hazardous or prejudicial to the best interests of the people of this State.

(c) No United States branch shall be licensed to do any kind of insurance business in this State, or any combination of kinds of insurance business, that are not permitted to be done by domestic insurers licensed under this chapter. No United States branch shall be authorized to do an insurance business in this State if it does anywhere within the United States any kind of business other than an insurance business and the business necessarily or properly incidental to the kind or kinds of insurance business that it is authorized to do in this State.

(d) Except as otherwise specifically provided, no United States branch, entering through this State or another state, shall be or continue to be authorized to do an insurance business in this State if it fails to comply substantially with any requirement or limitation of this chapter, applicable to similar domestic insurers hereafter organized, which in the judgment of the commissioner is reasonably necessary to protect the interest of the policyholders.

(e) No United States branch that, outside of this State, does any kind or combination of kinds of insurance business not permitted to be done in this State by similar domestic insurers hereafter organized, shall be or continue to be authorized to do an insurance business in this State, unless in the judgment of the commissioner the doing of that kind or combination of kinds of insurance business will not be prejudicial to the best interests of the people of this State.

(f) No United States branch shall be or continue to be authorized to do an insurance business in this State if it fails to keep full and correct entries of its transactions, which shall at all times be open to the inspection of persons invested by law with the rights of inspection and be maintained in its principal office within this State. [L 2004, c 120, pt of §2]

**[§431:4F-108] Authority of commissioner.** Whenever it appears to the commissioner from any annual statement, quarterly statement, trusteed surplus statement, or any other report that a United States branch's trusteed surplus is reduced below minimum capital and surplus or the authorized control level risk-based capital, whichever is greater, required to be maintained by a domestic insurer licensed to transact the same kinds of insurance, the commissioner may proceed against the insurer pursuant to articles 5 and 15 as an insurer whose condition is such that its further transaction of business in the United States will be hazardous to its policyholders, its creditors, or the public in the United States. [L 2004, c 120, pt of §2]

## ARTICLE 5
## FINANCIAL CONDITION

### PART I. STANDARDS

### §431:5-101 Impairment of capital.

(a) (1) A domestic stock insurer's capital stock shall be deemed to be impaired if its qualified assets at any time are less than its liabilities, including its capital stock as a liability.

(2) If a domestic insurer's capital stock is deemed to be impaired, the commissioner shall at once determine the amount of the deficiency and serve notice upon the insurer to cure the deficiency within ninety days after service of such notice.

(b) The insurer may cure the deficiency by assessment of stockholders, by action of its board of directors, or by other lawful means. The deficiency shall be cured:

(1) By the provision of cash or other assets eligible under this code for the investment of the insurer's funds; or

(2) By reduction of the insurer's capital stock to an amount not below the minimum required by either section 431:3-205, section 431:3-207 or section 431:3-208 for the classes of insurance to be thereafter transacted.

(c) Shares as to which such an assessment, made pursuant to this section, is not paid within sixty days after demand, shall be forfeitable and may be cancelled by vote of the directors and new shares issued to

make up the deficiency.

(d) If the deficiency is not cured and proof thereof filed with the commissioner within the ninety-day period, the insurer shall be deemed insolvent and shall be proceeded against as authorized by article 15.

(e) If the deficiency is not cured, the insurer shall not issue or deliver any policy after the expiration of the ninety-day period. Any officer or director who violates or knowingly permits the violation of this provision shall be fined not less than $500 nor more than $10,000 for each violation. [L 1987, c 347, pt of §2]

**§431:5-102 Impairment of surplus.**

(a) (1) A domestic mutual insurer's surplus shall be deemed to be impaired if its qualified assets are less than its liabilities, plus the amount of any surplus required by this code for the classes of insurance authorized to be transacted.

(2) If a domestic mutual insurer's surplus is deemed to be impaired, the commissioner shall at once ascertain the amount of the deficiency and serve notice upon the insurer to cure the deficiency within ninety days after service of such notice.

(b) The insurer shall cure the deficiency in cash or in assets eligible under this code for the investment of the insurer's funds.

(c) If the deficiency is not cured and proof thereof filed with the commissioner within such ninety-day period, the insurer shall be deemed insolvent and shall be proceeded against as authorized by article 15.

(d) If the deficiency is not cured the insurer shall not issue or deliver any policy after the expiration of such ninety-day period. Any officer or director who violates or knowingly permits the violation of this provision shall be fined not less than $500 nor more than $10,000 for each violation. [L 1987, c 347, pt of §2]

**§431:5-103 Impairment of reciprocal's surplus.**

(a) (1) A domestic reciprocal insurer's surplus shall be deemed to be impaired if its qualified assets are at any time insufficient to discharge its liabilities other than any liability on account of funds contributed by the attorney or other parties, and insufficient to maintain the surplus required for the classes of insurance it is authorized to transact.

(2) Upon such impairment of a reciprocal insurer's surplus, its attorney shall forthwith levy an assessment upon subscribers made subject to assessment by the terms of their policies for the amount needed to make up the deficiency.

(3) For the purposes of a determination of impairment of a reciprocal under this section, surplus means the required surplus which corresponds to the paid-up capital stock required of a stock insurer for authority to transact a like class or classes of insurance.

(b) The insurer shall be deemed insolvent and shall be proceeded against as authorized by this code if:

(1) The attorney fails to make the assessment within thirty days after the commissioner orders the attorney to do so; or

(2) The deficiency is not fully made up within sixty days after the date the assessment was made.

(c) If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to limits as provided by this code, as the commissioner determines to be

necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney, but including the reasonable cost of the liquidation. [L 1987, c 347, pt of §2]

## PART II. ASSETS AND LIABILITIES

**§431:5-201 Qualified assets.** In any determination of the financial condition of an insurer, only such assets as are owned by the insurer, and which consist of the following may be used:

(1) Cash in the possession of the insurer or in transit under its control, and the true positive balance of any deposit of the insurer in a solvent bank or trust company;

(2) Investments, securities, properties, and secured loans acquired or held in accordance with article 6, and in connection therewith the following items:

(A) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.
(B) Declared and unpaid dividends on stocks and shares unless the amount has otherwise been allowed as an asset.
(C) Interest due or accrued upon a collateral loan in an amount not to exceed six months' interest thereon.
(D) Interest due or accrued on:
(i) Deposits in solvent banks, trust companies, and financial investment companies; and
(ii) Other assets if such interest is in the judgment of the commissioner a collectible asset.
(E) Interest due or accrued on a mortgage loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; provided that interest due and unpaid for a period in excess of six months shall not be allowed as an asset.
(F) Rent due or accrued on real property if such rent is not in arrears for more than three months, unless the rent is secured by property held in the name of the tenant and conveyed to the insurer as collateral.

(3) Premium notes, policy loans, and other policy assets and liens on policies of life insurance, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(4) The net amount of uncollected and deferred premiums on an effective date item basis and annuity considerations in the case of a life insurer, corresponding to the basis on which reserves are held;

(5) Producer balances or uncollected premiums, other than for life insurance and other receivables, not more than ninety days past due, less commissions payable thereon; provided that the foregoing limitation shall not apply to premiums and other receivables payable directly or indirectly by the United States government or any of its instrumentalities;

(6) Installment premiums other than life insurance premiums, in accordance with rules adopted by the commissioner consistent with practice formulated or adopted by the National Association of Insurance Commissioners;

(7) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon and unless otherwise required by rules adopted by the commissioner;

(8) (A) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer not disqualified to take such reinsurance under this code; or

(B) So much of reinsurance recoverable from such reinsurer as does not exceed the liabilities carried by the ceding insurer for amounts withheld under a reinsurance treaty with such reinsurer as security for the payment of obligations thereunder if such funds are held subject to withdrawal by, and under the control of, the ceding insurer in the case of a reinsurer disqualified under this code;

(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(10) Deposits or equities recoverable from underwriting associations and reinsurance funds, or from any suspended banking institution, to the extent deemed by the commissioner available for the payment of losses and claims and at values to be determined by the commissioner;

(11) Electronic data hardware;

(12) Other assets not inconsistent with the foregoing provisions, deemed by the commissioner available for the payment of losses and claims; and

(13) All assets, whether or not consistent with the provisions of this code, as may be allowed pursuant to the annual statement form provided for in section 431:3-301. [L 1987, c 347, pt of §2; am L 2002, c 155, §11]

**§431:5-202 Assets not allowed.** In addition to assets excluded under section 431:5-201, the following shall not be allowed as assets in any determination of the financial condition of an insurer:

(1) Trade names, agency plants, other like intangible assets, and any receivable without adequate documentation;

(2) Positive goodwill from all sources in excess of ten per cent of capital and surplus adjusted to exclude electronic data processing equipment and operating system software and net deferred tax assets;

(3) Prepaid or deferred charges for expenses and commissions paid by the insurer except the unaccrued portion of taxes paid prior to due date, on real property acquired or used pursuant to section 431:6-311;

(4) Advances to officers, employees, agents, and other persons on personal security only;

(5) Stock of the insurer, owned by it, or any equity therein or loans secured thereby, or any proportionate interest in such stock through the ownership by the insurer of an interest in another firm, corporation or business unit;

(6) Furniture, furnishings, fixtures, electronic data software, safes, vehicles, library, stationery, literature, and supplies; except such personal property:

(A) The insurer is permitted to hold pursuant to section 431:6-311(e)(5);

(B) Acquired through enforcement of rights arising from security agreements acquired pursuant to section 431:6-310; or

(C) Reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch

office, and similar purposes; and

(7) The amount, if any, by which the aggregate book value of investments, as carried in the ledger assets of the insurer, exceeds the aggregate value thereof as determined under this code. [L 1987, c 347, pt of §2; am L 2004, c 122, §17]

**§431:5-203 Liabilities.** In any determination of the financial condition of an insurer, liabilities to be charged against its assets shall include:

(1) The amount of its capital stock outstanding, if any;

(2) The amount, estimated consistent with this article, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expense of adjustment or settlement thereof;

(3) With reference to life and accident and health or sickness insurance, and annuity contracts:

(A) The amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted pursuant to this article which are applicable thereto;
(B) Reserves for accident and health or sickness benefits, for both active and disabled lives;
(C) Reserves for accidental death benefits; and
(D) Any additional reserves which may be required by the commissioner, consistent with practices adopted or approved by the National Association of Insurance Commissioners, on account of such insurances;

(4) With reference to insurance other than those specified in paragraph (3), the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this article;

(5) Taxes, expenses, and other obligations accrued at the date of the statement; and

(6) Any additional reserve set up by the insurer for a specific liability purpose or required by the commissioner consistent with practices adopted or approved by the National Association of Insurance Commissioners. [L 1987, c 347, pt of §2; am L 2003, c 212, §38]

**§431:5-204 Determining financial condition of reciprocal insurers.** In determining the financial condition of a reciprocal insurer, the commissioner shall apply the following rules:

(1) The commissioner shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis.

(2) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposit delinquent for ninety days shall first be charged against the surplus deposits.

(3) The surplus deposits of subscribers shall not be charged as a liability.

(4) All premium deposits delinquent less than ninety days shall be allowed as assets.

(5) An assessment levied upon subscribers and not collected, shall not be allowed as an asset.

(6) The contingent liability of subscribers shall not be allowed as an asset.

(7) The computation of reserves shall be based upon premium deposits other than membership fees, and without any deduction for the compensation of the attorney. [L 1987, c 347, pt of §2]

## PART III. RESERVES AND VALUATION

**§431:5-301 Unearned premium reserve.** (a) Every insurer shall maintain an unearned premium reserve on all policies in force for:

(1) Insurance against loss or damage to property, except as provided in section 431:5-302;

(2) General casualty insurance;

(3) Accident and health or sickness insurance, except as provided in section 431:5-303 and section 431:5-307; and

(4) Surety insurance.

(b) For purposes of this article, "unearned premium reserve" means the portions of the gross premiums in force, less authorized reinsurance.

(c) All reserves may be computed, at the insurer's option, on a monthly or more frequent, pro rata basis.

(d) After adopting any one of the methods for computing such reserve, an insurer shall not change methods without the commissioner's approval. [L 1987, c 347, pt of §2; am L 1997, c 368, §4; am L 2003, c 212, §39]

**§431:5-302 Unearned premium reserve for marine and transportation.** Marine and transportation insurance policy premiums on trip risks not terminated shall be deemed unearned. The commissioner may require the insurer to carry a reserve equal to one hundred per cent on trip risks written during the month ended as of the date of statement, and:

(1) Computed upon a pro rata basis; or

(2) With the commissioner's consent, in accordance with the alternative methods provided in section 431:5-301(c) and section 431:5-301(d). [L 1987, c 347, pt of §2; am L 1997, c 368, §5]

**§431:5-303 Active life reserves and unearned premium reserves for noncancellable disability insurance.** (a) The legal minimum standard for computing the active life reserve, including the unearned premium reserve, of noncancellable disability policies shall be based on conference modification of class III disability experience with interest not to exceed three and one-half per cent a year on the full preliminary term basis.

(b) The tables shall be extended to cover the provisions of such policies on such bases as the commissioner may approve for policies:

(1) With a waiting period of less than three months; or

(2) Providing benefits at ages beyond the limits of conference modification of class III disability experience.

(c) The reserve for losses under noncancellable disability policies shall be based on conference modification of class III disability experience, except that for claims of less than twenty-seven months' duration, the reserve may be taken as equivalent to the prospective claim payments for three and one-half times the elapsed period of disability. In no case shall the reserve be less than the equivalent of seven weeks' claim payments.

(d) The commissioner shall modify the application of the tables and requirements prescribed in this section to policies or to claims arising under policies in accordance with the waiting period contained in such policies and in accordance with any limitation as to the time for which indemnity is payable. [L 1987, c 347, pt of §2]

**§431:5-304 Loss reserves for liability and workers' compensation insurance.** The reserves for outstanding losses and loss expenses under policies of liability insurance and workers' compensation insurance shall be determined in accordance with the applicable basis set forth in the convention annual statement blank of the National Association of Insurance Commissioners. [L 1987, c 347, pt of §2]

**§431:5-305 Increased reserves.** (a) If the commissioner determines that an insurer's unearned premium reserves, however computed, are inadequate, the commissioner may require the insurer to compute such reserves or any part thereof according to such other method or methods as are prescribed in this code.

(b) If the loss reserves, however estimated, are inadequate, the commissioner shall require the insurer to maintain loss reserves in such increased amount as is needed to make them adequate. [L 1987, c 347, pt of §2]

**§431:5-306 Reserve credit for reinsurance.** (a) An insurer may take credit for reserves on risks ceded to a reinsurer to the extent reinsured, except that:

(1) No credit shall be taken on account of reinsurance in any reinsurer not qualified under article 4A or in any reinsurer that has been disapproved by the commissioner; and

(2) No credit shall be allowed, as an asset or as a deduction from liability, to any ceding insurer for reinsurance unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer.

(b) A reinsurance agreement may provide that:

(1) The liquidator, receiver or statutory successor of an insolvent ceding insurer shall be given written notice of the pendency of a claim against the insolvent ceding insurer on the policy or bond reinsured within a reasonable time after the claim is filed in the insolvency proceeding; and

(2) Any assuming insurer may investigate such claim and interpose any defense or defenses which it may deem available to the ceding insurer, its liquidator, receiver, or statutory successor, during the pendency of the claim, in the proceeding where the claim is to be adjudicated, at its own expense.

(c) Subject to court approval, the expense thus incurred by the assuming insurer shall be chargeable against the insolvent ceding insurer as a part of the expense of liquidation to the extent of a proportionate

share of the benefit which may accrue to the ceding insurer solely as a result of the defense undertaken by the assuming insurer.

(d) Where two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose defense to the claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer. [L 1987, c 347, pt of §2; am L 2004, c 122, §18]

**§431:5-307 Standard valuation law; life.** (a) This section shall be known as the standard valuation law.

(b)(1) For policies and contracts issued prior to the operative date of the valuation manual:

(A) The commissioner shall annually value, or cause to be valued, the reserve liabilities, hereinafter called reserves, for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this State issued on or after January 1, 1956, and prior to the operative date of the valuation manual. In calculating the reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction, when the valuation complies with the minimum standard under this section;

(B) Subsections (e) to (n) shall apply to all policies and contracts, as appropriate, subject to this section issued on or after January 1, 1956, and prior to the operative date of the valuation manual; provided that subsections (o) and (p) shall not apply to those policies and contracts;

(C) The minimum standard for the valuation of policies and contracts issued prior to January 1, 1956, shall be that provided by the laws in effect immediately prior to that date;

(2) For policies and contracts issued on or after the operative date of the valuation manual:

(A) The commissioner shall annually value, or cause to be valued, the reserve liabilities, hereinafter called reserves, for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section; and

(B) Subsections (o) and (p) shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(c) For an actuarial opinion prior to the operative date of the

valuation manual:

(1) Every life insurance company doing business in this State shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rules are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with the applicable laws of this State. The commissioner shall define by rules the specifics of this opinion and add any other items deemed to be necessary to its scope;

(2) For actuarial analysis of reserves and assets supporting the reserves:

(A) Every life insurance company, except as exempted by rules, shall also include annually in the opinion required by paragraph (1), an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rules, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts; and

(B) The commissioner may provide by rules for a transition period for establishing any higher reserves that the qualified actuary may deem necessary to render the opinion required by this section;

(3) Each opinion required by paragraph (2) shall be governed by the following:

(A) A memorandum, in form and substance acceptable to the commissioner as specified by rules, shall be prepared to support each actuarial opinion; and

(B) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rules, or if the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by rules, or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurance company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner; and

(4) Every opinion required by paragraph (1) shall be governed by the following:

(A) The opinion shall be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1995;

(B) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rules;

(C) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor

and on any additional standards as the commissioner may prescribe by rules;

(D) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State;

(E) For the purposes of this subsection, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in the regulations adopted by the American Academy of Actuaries;

(F) Except in cases of fraud or wilful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion;

(G) Disciplinary action by the commissioner against the company or the qualified actuary shall be as defined by rules;

(H) Except as provided in subparagraphs (L), (M), and (N), documents, materials, or other information in the possession or control of the insurance division that are part of a memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, shall be confidential by law and privileged, shall not be disclosable under chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties;

(I) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subparagraph (H);

(J) To assist in the performance of the commissioner's duties, the commissioner:

(i) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subparagraph (H) with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities; provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information; and

(ii) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and

its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information;

(K) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this subsection or as a result of sharing as authorized in subparagraph (J);

(L) A memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this subsection or related rules adopted by the commissioner;

(M) The memorandum or other material may otherwise be released by the commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material; and

(N) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(d) For actuarial opinions of reserves after the operative date of the valuation manual:

(1) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this State and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this State. The valuation manual shall prescribe the specifics of this opinion including any items deemed to be necessary to its scope;

(2) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this State and subject to regulation by the commissioner, except as exempted in the valuation manual, also shall annually include in the opinion required by paragraph (1), an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts including but not limited to the benefits under and expenses associated with the policies and contracts;

(3) Each opinion required by this subsection shall be governed by the following provisions:

(A) A memorandum, in form and substance as specified in the

valuation manual and acceptable to the commissioner, shall be prepared to support each actuarial opinion; and

(B) If the company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual, or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual, or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurance company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner; and

(4) Every opinion subject to this subsection shall be governed by the following provisions:

(A) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner;

(B) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual;

(C) The opinion shall apply to all policies and contracts subject to paragraph (2), plus other actuarial liabilities as may be specified in the valuation manual;

(D) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor and on such additional standards as may be prescribed in the valuation manual;

(E) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State;

(F) Except in cases of fraud or wilful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion; and

(G) Disciplinary action by the commissioner against the company or the appointed actuary shall be defined by rules adopted by the commissioner.

(e) Except as otherwise provided in subsections (f), (g), and (n), the minimum standard for the valuation of policies and contracts issued prior to January 1, 1956, shall be that provided by the laws in effect immediately prior to January 1, 1956.

Except as otherwise provided in subsections (f), (g), and (n), the minimum standard for the valuation of all policies and contracts issued on or after January 1, 1956, shall be the commissioner's reserve valuation methods defined in subsections (h), (i), (l), and (n), three and one-half per cent interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after June 1, 1976, four per cent interest for policies issued prior to June 1, 1979, five and one-half per cent interest for single premium life insurance policies, and four and one-half per cent interest for all

other policies issued on or after June 1, 1979, and the following tables:

(1) For ordinary policies of life insurance issued on the standard basis, excluding any disability income and accidental death benefits in the policies: the Commissioners 1941 Standard Ordinary Mortality Table for the policies issued prior to the operative date of section 431:10D-104(e)(6), the Commissioners 1958 Standard Ordinary Mortality Table for the policies issued on or after the operative date of section 431:10D-104(e)(6) and prior to the operative date of section 431:10D-104(e)(8); provided that for any category of the policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than six years younger than the actual age of the insured; and for the policies issued on or after the operative date of section 431:10D-104(e)(8):

(A) The Commissioners 1980 Standard Ordinary Mortality Table;
(B) At the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors;
(C) Any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rules adopted by the commissioner for use in determining the minimum standard of valuation for the policies;

(2) For industrial life insurance policies issued on the standard basis, excluding any disability income and accidental death benefits in the policies: the 1941 Standard Industrial Mortality Table for the policies issued prior to the operative date of section 431:10D-104(e)(7), and for policies issued on or after the operative date of section 431:10D-104(e)(7), the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by rules adopted by the commissioner for use in determining the minimum standard valuation for the policies;

(3) For individual annuity and pure endowment contracts, excluding any disability income and accidental death benefits in the policies: the 1937 Standard Annuity Mortality Table, or at the option of the company, the Annuity Mortality Table for 1949, ultimate, or any modification of either of these tables approved by the commissioner;

(4) For group annuity and pure endowment contracts, excluding any disability income and accidental death benefits in the policies: the Group Annuity Mortality Table for 1951, a modification of the table approved by the commissioner, or at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(5) For total and permanent disability income benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued after December 31, 1965, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rules adopted by the commissioner for use in determining the minimum standard of valuation for those policies; for policies or contracts issued after December 31, 1960, and prior to January 1, 1966, either the tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any table, for active lives, shall be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(6) For accidental death benefits in or supplementary to policies issued after December 31, 1965: the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rules adopted by the commissioner for use in determining the minimum standard of valuation for those policies, for policies issued after December 31, 1960, and prior to January 1, 1966, either that table or, at the option of the company, the Inter-company Double Indemnity Mortality Table. Either table shall be combined with a mortality table for calculating the reserves for life insurance policies; and

(7) For group life insurance, life insurance issued on the substandard basis, and other special benefits: tables approved by the commissioner.

(f) Except as provided in subsection (g), the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this subsection and for annuities and pure endowment contracts purchased on or after the operative date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in subsections (h) and (i) and the following tables and interest rates:

(1) For individual annuity and pure endowment contracts issued prior to June 1, 1979, excluding any disability income and accidental death benefits in the contracts: the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner, and six per cent interest for single premium immediate annuity contracts, and four per cent interest for all other individual annuity and pure endowment contracts;

(2) For individual single premium immediate annuity contracts issued on or after June 1, 1979, excluding any disability income and accidental death benefits in the contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rules adopted by the commissioner for use in determining the minimum standard valuation for these contracts, or any modification of these tables approved by the commissioner, and seven and one-half per cent interest;

(3) For individual annuity and pure endowment contracts issued on or after June 1, 1979, other than single premium immediate annuity contracts, excluding any disability income and accidental death benefits in those contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rules adopted by the commissioner for use in determining the minimum standard of valuation for those contracts, or any modification of these tables approved by the commissioner, and five and one-half per cent interest for single premium deferred annuity and pure endowment contracts and four and one-half per cent interest for all other individual annuity and pure endowment contracts;

(4) For annuities and pure endowment contracts purchased prior to June 1, 1979, under group annuity and pure endowment contracts, excluding any disability income and accidental death benefits purchased under those contracts: the 1971 Group Annuity Mortality Table or any modification of this table approved by the commissioner, and six per cent interest; and

(5) For annuities and pure endowment contracts purchased on or after June 1, 1979, under group annuity and pure endowment contracts, excluding any disability income and accidental death benefits purchased under those contracts: the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rules adopted by the commissioner for use in determining the minimum standard of valuation for the annuities and pure endowment contracts, or any modification of these tables approved by the commissioner, and seven and one-half per cent interest.

After June 1, 1976, any company may file with the commissioner a written notice of its election to comply with this subsection after a specified date before January 1, 1979, which shall be the operative date of this subsection for that company. If a company makes no election, the operative date of this subsection for that company shall be January 1, 1979.

(g)(1) The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this section:

(A) Life insurance policies issued in a particular calendar year, on or after the operative date of section 431:10D-

104(e)(8);

(B) Individual annuity and pure endowment contracts issued in a particular calendar year after December 31, 1982;

(C) Annuities and pure endowment contracts purchased in a particular calendar year after December 31, 1982, under group annuity and pure endowment contracts; and

(D) The net increase, if any, in a particular calendar year after January 1, 1983, in amounts held under guaranteed interest contracts.

(2) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one per cent:

(A) For life insurance,

$$I = .03 + W\ (R_1 - .03) + \frac{W}{2}\ (R_2 - .09);$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W\ (R - .03)$$

where $R_1$ is the lesser of R and .09, $R_2$ is the greater of R and .09, R is the reference interest rate defined in this subsection, and W is the weighting factor defined in this subsection;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (B), the formula for life insurance stated in subparagraph (A) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subparagraph (B) shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subparagraph (B) shall apply; and

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (B) shall apply.

If the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this subsection differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one per cent, the calendar year statutory valuation interest rate for the life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when section 431:10D-104(e)(8) becomes operative;

(3) The weighting factors referred to in the formulas stated in paragraph (2) are given in the following

tables:

(A) Weighting factors for life insurance:

| Guarantee Duration (Years) | Weighting Factors |
|---|---|
| 10 or (less) | .50 |
| More than 10, but not more than 20 | .45 |
| More than 20 | .35 |

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both, which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80; and

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph (B), shall be as specified in the tables below, according to the rules and definitions stated below:

Table I:

For annuities and guaranteed interest contracts valued on an issue year basis:

| Guarantee Duration For Plan Type (Years) | A | B | C |
|---|---|---|---|
| 5 or less: | .80 | .60 | .50 |
| More than 5, but not more than 10: | .75 | .60 | .50 |
| More than 10, but not more than 20: | .65 | .50 | .45 |
| More than 20: | .45 | .35 | .35 |

| Table II: | Plan Type A | B | C |
|---|---|---|---|
| For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in Table I increased by: | .15 | .25 | .05 |

| Table III: | Plan Type A | B | C |
|---|---|---|---|
| For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than | | | |

twelve months beyond the valuation
date, the factors shown in Table I or
derived in
Table II increased by: .05 .05 .05

For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence. Plan type as used in the above tables is defined as follows:

Plan Type A: At any time the policyholder may withdraw funds only: (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; (2) without an adjustment, but in installments over five years or more; (3) as an immediate life annuity; or (4) no withdrawal permitted;

Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only: (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; (2) without an adjustment, but in installments over five years or more; or (3) no withdrawal permitted. At the end of the interest rate guarantee, funds may be withdrawn without adjustment in a single sum or in installments over less than five years;

Plan Type C: The policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or in installments over less than five years either: (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options shall be valued on an issue year basis. As used in this subsection, "issue year basis" means a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and "change in fund basis" means a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund;

(4) The reference interest rate referred to in paragraph (2) shall be defined as follows:

(A) For life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year preceding the year, of the monthly average of composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (B), with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (B), with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.; and

(F) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subparagraph (B), the average over a period of twelve months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.; and

(5) In the event that the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the

National Association of Insurance Commissioners and approved by rules adopted by the commissioner may be substituted.

(h)(1) Except as otherwise provided in subsections (i), (l), and (n), reserves, according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of the future guaranteed benefits provided for by the policies, over the then present value of any future modified net premiums therefor. The modified net premiums for a policy shall be the uniform percentage of the respective contract premiums for the benefits such that the present value, at the date of issue of the policy, of all the modified net premiums shall be equal to the sum of the then present value of the benefits provided for by the policy and the excess of subparagraph (A) over subparagraph (B) as follows:

(A) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due; provided that the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age of issue of the policy; and

(B) A net one-year term premium for the benefits provided for in the first policy year;

(2) For a life insurance policy issued on or after January 1, 1986, for which the contract premium in the first policy year exceeds that of the second year, and for which no comparable additional benefit is provided in the first year for the excess, and that provides an endowment benefit, a cash surrender value, or a combination thereof, in an amount greater than the excess premium, the reserve, according to the commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium, except as otherwise provided in subsection (l), shall be the greater of the reserve as of the policy anniversary calculated pursuant to this paragraph and the reserve as of the policy anniversary calculated as described, but with:

(A) The value defined in paragraph (1) being reduced by fifteen per cent of the amount of the excess first year premium;

(B) All present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;

(C) The policy being assumed to mature on that date as an endowment; and

(D) The cash surrender value provided on that date being considered as an endowment benefit.

In making the above comparison, the mortality and interest bases stated in subsections (e) and (g) shall be used; and

(3) Reserves according to the commissioner's reserve valuation method shall be calculated by a method consistent with the principles of paragraphs (1) and (2) for:

(A) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(B) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a

partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended;

(C) Disability income and accidental death benefits in all policies and contracts; and

(D) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

(i) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability income and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable prior to the end of the respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

(j) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability income and accidental death benefits, issued on or after January 1, 1956, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (h), (i), (l), and (m), and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for those policies. In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by subsections (c) and (d).

(k) With regard to optional reserve calculation:

(1) Reserves for policies and contracts issued prior to January 1, 1956, may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to that date;

(2) Reserves for any category of policies, contracts, or benefits established by the commissioner, issued on or after January 1, 1956, may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for the category than those calculated according to the minimum standard provided herein, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies or contracts; and

(3) A company, which adopts at any time a standard valuation producing greater aggregate reserves than

those calculated according to the minimum standard provided under this section, may adopt a lower standard of valuation with the approval of the commissioner, but not lower than the minimum provided herein; provided that for the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by subsections (c) and (d) shall not be deemed to be the adoption of a higher standard of valuation.

(l) If in any contract year the gross premium charged by a company on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract, but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsections (e) and (g). For a life insurance policy issued on or after January 1, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and that provides an endowment benefit or a cash surrender value, or a combination thereof, in an amount greater than the excess premium, this subsection shall be applied as if the method actually used in calculating the reserve for the policy were the method described in subsection (h), ignoring subsection (h)(2). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (h), including subsection (h)(2) and the minimum reserve calculated in accordance with this subsection.

(m) In the case of any plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (h), (i), and (l), the reserves that are held under the plan shall:

(1) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Be computed by a method that is consistent with the principles of this section, as determined by rules adopted by the commissioner.

(n) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (b)(2). For accident and health insurance contracts issued on or after January 1, 1956, and prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the commissioner by rule.

(o)(1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (b)(2), except as provided under paragraph (5) or (7) of this subsection;

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first

July 1 as of which all of the following have occurred:

(A) The valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote of at least forty-two members, or three-fourths of the members voting, whichever is greater;

(B) The Standard Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five per cent of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements; and

(C) The Standard Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions: the fifty states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico;

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when all of the following have occurred:

(A) The change to the valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote representing:

(i) At least three-fourths of the members of the National Association of Insurance Commissioners voting, but not less than a majority of the total membership; and

(ii) Members of the National Association of Insurance Commissioners representing jurisdictions totaling greater than seventy-five per cent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in clause (i): life, accident and health annual statements; health annual statements; or fraternal annual statements; and

(B) The valuation manual becomes effective pursuant to rules adopted by the commissioner;

(4) The valuation manual shall specify all of the following:

(A) Minimum valuation standards for and definitions of the policies or contracts subject to subsection (b)(2). These minimum valuation standards shall be:

(i) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection (b)(2);

(ii) The commissioner's annuity reserve valuation method for annuity contracts subject to subsection (b)(2); and

(iii) Minimum reserves for all other policies or contracts subject to subsection (b)(2);

(B) Which policies or contracts or types of policies or contracts that are subject to the requirements of a

principle-based valuation in subsection (p)(1) and the minimum valuation standards consistent with those requirements;

(C) For policies and contracts subject to a principle-based valuation under subsection (p):

(i) Requirements for the format of reports to the commissioner under subsection (p)(2)(C) that shall include information necessary to determine if the valuation is appropriate and in compliance with this section;

(ii) Assumptions shall be prescribed for risks over which the company does not have significant control or influence; and

(iii) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(D) For policies not subject to a principle-based valuation under subsection (p), the minimum valuation standard shall either:

(i) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(ii) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(E) Other requirements including but not limited to those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(F) The data and form of the data required under subsection (q), with whom the data shall be submitted, and may specify other requirements including data analyses and reporting of analyses;

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this section, then the company shall, with respect to these requirements, comply with minimum valuation standards prescribed by the commissioner by rule;

(6) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The commissioner may rely upon the opinion, regarding provisions contained within this section, of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this paragraph, "engage" includes employment and contracting; and

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary to comply with the requirements of the valuation manual or this section, and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted pursuant to this chapter.

(p)(1) A company shall establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(A) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, the valuation shall reflect conditions appropriately adverse to quantify the tail risk;

(B) Incorporate assumptions, risk analysis methods and financial models, and management techniques that are consistent with, but not necessarily identical to, those used within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(C) Incorporate assumptions that are prescribed in the valuation manual, or for assumptions that are not prescribed, the assumptions shall:

(i) Be established using the company's available experience, to the extent it is relevant and statistically credible; or

(ii) To the extent that company data is not available, relevant, or statistically credible, be established using other relevant, statistically credible experience; and

(D) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty, the larger the margin and resulting reserve;

(2) A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

(A) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(B) Provide to the commissioner and to the company's board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. These controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year; and

(C) Develop and file with the commissioner, upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual; and

(3) A principle-based valuation may include a prescribed formulaic reserve component.

(q) On or after the operative date of the valuation manual, a company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(r)(1) With respect to privilege for, and confidentiality of, confidential information:

(A) Except as provided in this subsection, a company's

confidential information is confidential by law and privileged, and shall not be disclosable under chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided that the commissioner may use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties;

(B) Neither the commissioner nor any person who received confidential information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential information;

(C) To assist in the performance of the commissioner's duties, the commissioner may share confidential information:

(i) With other state, federal, and international regulatory agencies and with the National Association of Insurance Commissioners and its affiliates and subsidiaries; and

(ii) In the case of confidential information specified in paragraph (3)(A)(i) and (iv) only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with the state, federal, and international law enforcement officials in the case of this clause and clause (i); provided that the recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of the documents, materials, data, and other information in the same manner and to the same extent as required for the commissioner;

(D) The commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information;

(E) The commissioner may enter into agreements governing the sharing and use of information consistent with this paragraph;

(F) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the commissioner under this subsection or as a result of sharing as authorized in subparagraph (C); and

(G) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this paragraph shall be available and enforced in any proceeding in, and in any

court of, this State;

(2) Notwithstanding paragraph (1), any confidential information specified in paragraph (3)(A)(i) and (iv):

(A) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsections (c) and (d) or principle-based valuation report developed under subsection (p)(2)(C) by reason of an action required by this section or by rules adopted hereunder;

(B) May otherwise be released by the commissioner with the written consent of the company; and

(C) Once any portion of a memorandum in support of an opinion submitted under subsections (c) and (d) or a principle-based valuation report developed under subsection (p)(2)(C) is cited by the company in its marketing, is publicly volunteered to or before a governmental agency other than a state insurance department, or is released by the company to the news media, all portions of the memorandum or report shall no longer be confidential; and

(3) For purposes of this section:

(A) "Confidential information" means:

(i) A memorandum in support of an opinion submitted under subsections (c) and (d) and any other documents, materials, and other information, including but not limited to all working papers and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such memorandum;

(ii) All documents, materials, and other information, including but not limited to all working papers and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in the course of an examination made under subsection (o)(6); provided that if an examination report or other material prepared in connection with an examination made under section 431:2-302 is not held as private and confidential information under section 431:2-305, an examination report or other material prepared in connection with an examination made under subsection (o)(6) shall not be "confidential information" to the same extent as if the examination report or other material had been prepared under section 431:2-305;

(iii) Any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under subsection (p)(2)(B) evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including but not limited to all working papers and copies thereof, created, produced, or obtained by, or disclosed to the commissioner or any other person in connection with such reports, documents, materials,

and other information;

(iv) Any principle-based valuation report developed under subsection (p)(2)(C) and any other documents, materials, and other information, including but not limited to all working papers and copies thereof, created, produced, or obtained by, or disclosed to the commissioner or any other person in connection with the report; and

(v) Any documents, materials, data, and other information submitted by a company under subsection (q) (collectively, "experience data") and any other documents, materials, data, and other information, including but not limited to all working papers and copies thereof, created or produced in connection with the experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any "experience data", the "experience materials") and any other documents, materials, data, and other information, including but not limited to all working papers and copies thereof, created, produced, or obtained by, or disclosed to the commissioner or any other person in connection with the experience materials; and

(B) "Regulatory agency", "law enforcement agency", and "National Association of Insurance Commissioners" include but shall not be limited to their employees, agents, consultants, and contractors.

(s) The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this State from the requirements of subsection (o); provided that:

(1) The commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(2) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the commissioner and adopted by rule.

For any company granted an exemption under this subsection, subsections (c) to (n) shall be applicable. With respect to any company applying this exemption, any reference to subsection (o) found in subsections (c) to (n) shall not be applicable.

(t) As used in this section, the following definitions shall apply on or after the operative date of the valuation manual:

"Accident and health insurance" means a contract that incorporates morbidity risk and provides protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

"Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (d).

"Company" means an entity that:

(1) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this State and has at least one such policy in force or on claim; or

(2) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or

deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this State.

"Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

"Life insurance" means a contract that incorporates mortality risk, including an annuity and a pure endowment contract, and as may be specified in the valuation manual.

"Policyholder behavior" means any action that a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section including but not limited to lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract, but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

"Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (p) as specified in the valuation manual.

"Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing the statement and who meets the requirements specified in the valuation manual.

"Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

"Valuation manual" means the manual of valuation instructions adopted by the National Association of Insurance Commissioners as specified in this section or as subsequently amended. [L 1987, c 347, pt of §2; am L 1994, c 190, §§3, 10; am L 1995, c 61, §2 as superseded by c 232, §4; am L 1999, c 302, §9 as superseded by c 128, §2; am L 2003, c 212, §40; am L 2014, c 234, §4; am L 2015, c 63, §5]

**§431:5-308 Valuation of bonds.** (a) All bonds or other evidences of debt having a fixed term and rate held by any insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

(1) If purchased at par, at the par value.

(2) If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at the earliest date callable at par or maturing at par and so as to yield in the meantime the effective rate of interest at which the purchase was made; or in lieu of such method, according to such accepted method of valuation as is approved by the commissioner.

(3) Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase plus actual brokerage, transfer, postage, or express charges paid in the acquisition of such securities.

(4) Unless otherwise provided by a valuation established or approved by the National Association of Insurance Commissioners, no such security shall be carried at above call price for the entire issue during any period within which the security may be so called.

(b) The commissioner shall have full discretion in determining the method of calculating values according to the rules set forth in this section, not inconsistent with any such methods then currently formulated or approved by the National Association of Insurance Commissioners. [L 1987, c 347, pt of §2]

**§431:5-309 Valuation of other securities.** (a) Any security, other than a security covered by section 431:5-308, is required to be valued at its market value or, if there is no market, at its value as fixed by an impartial appraiser, all consistent with any current method for the valuation of any such security formulated or approved by the National Association of Insurance Commissioners.

(b) Preferred or guaranteed stock or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the commissioner and in accordance with such method of computation as the commissioner may approve.

(c) The stock of a subsidiary of an insurer acquired after January 1, 1956, shall be valued on the basis of the value of only such of the assets of the subsidiary as would constitute lawful investments for the insurer if acquired or held directly by the insurer. [L 1987, c 347, pt of §2]

**§431:5-310 Valuation of property.** (a) Real property acquired pursuant to a mortgage loan or a contract for a deed, in the absence of a recent appraisal deemed by the commissioner to be reliable, shall not be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of the acquisition, with accrued interest thereon for not in excess of eighteen months, together with any taxes and expenses paid or incurred in connection with the acquisition, the cost of improvements thereafter made by the insurer, and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.

(b) Other real property held by an insurer shall not be valued at any amount in excess of fair value.

(c) Personal property acquired pursuant to security agreements made under section 431:6-310 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition together with taxes and expenses incurred in connection with the acquisition, or the fair value of the property, whichever amount is the lesser. [L 1987, c 347, pt of §2]

**§431:5-311 Valuation of purchase money mortgages.** Purchase money mortgages on real property referred to in section 431:5-310 shall be valued in an amount not exceeding the acquisition cost of the real property covered thereby or ninety per cent of the fair value of the real property, whichever is less. [L 1987, c 347, pt of §2]

## PART IV. RULES

**[§431:5-401] Rules.** The commissioner may adopt rules under chapter 91 implementing this article. [L 1995, c 232, §5]

## ARTICLE 6

## PART I. GENERAL PROVISIONS

**§431:6-101 Definitions pertaining to investments.** (a) For purposes of this article:

"Cash" includes cash equivalents.

"Cash equivalents" means highly-rated and highly-liquid investments or securities with a remaining term of ninety days or less and rated in the highest short-term category by a nationally recognized statistical rating organization recognized by the SVO. Cash equivalents include government money market mutual funds and class one money market mutual funds defined by the Purposes and Procedures Manual of the SVO, or its successor publication.

"Fixed charges" means interest on funded and unfunded debt, amortization of debt discount, and rentals for leased properties.

"Institution" means corporations, joint-stock associations, and business trusts.

"Net earnings available for fixed charges" means net income after deducting operating and maintenance expenses, taxes other than federal and state income taxes, depreciation, and depletion, but excluding extraordinary nonrecurring items of income or expense appearing in the regular financial statements of such institution.

"Obligation" means bonds, debentures, notes, or other evidence of indebtedness.

"Surplus as regards to policyholders" means the excess of the insurer's admitted assets over its liabilities.

"SVO" means the Securities Valuation Office of the National Association of Insurance Commissioners.

"Value" means fair value. Market value is the best evidence of fair value.

(b) If net earnings are determined in reliance upon consolidated earnings statements of parent and subsidiary institutions:

(1) The net earnings shall be determined after provision for income taxes of subsidiaries and after proper allowance for minority stock interest, if any, and

(2) The required coverage of fixed charges shall be computed on a basis including fixed charges and preferred dividends of subsidiaries other than those payable by the subsidiaries to the parent corporation or to any other of the subsidiaries.

Except that if the minority common stock interest in the subsidiary corporation is substantial, the fixed charges and preferred dividends may be apportioned in accordance with regulations prescribed by the commissioner. [L 1987, c 347, pt of §2; am L 2008, c 142, §1]

**§431:6-102 Merged, reorganized institutions.** In applying the earnings test set forth in section 431:6-101 to any such institution, whether or not in legal existence during the whole of such five years next preceding the date of investment by the insurer, which has at any time during the five-year period acquired substantially all of the assets of any other institution or institutions by purchase, merger, consolidation, or otherwise, or has been reorganized pursuant to the bankruptcy law, the earnings of the predecessor or constituent institutions, or of the institution so reorganized, available for the interest and dividends for such portion of the five-year period as may have preceded the acquisition, or the reorganization, may be included in

the earnings of the issuing, assuming, or guaranteeing institution for such portion of such period as may be determined in accordance with adjusted or pro forma consolidated earnings statements covering such portion of such period and giving effect to all stock or shares outstanding, and all fixed charges existing, immediately after the acquisition, or the reorganization. [L 1987, c 347, pt of §2]

**§431:6-103 Eligible investments; scope.** (a) This article shall apply to domestic insurers only. Insurers shall invest in or loan their funds on the security of, and shall hold as assets, only eligible investments as prescribed in this article.

(b) The eligibility of an investment shall be determined as of the date of its making or acquisition.

(c) Any limitation based upon the amount of the insurer's assets or surplus shall relate to assets or surplus as shown by the insurer's annual statement as of December 31 preceding date of investment. [L 1987, c 347, pt of §2; am L 2008, c 142, §2]

**§431:6-104 General qualifications.** (a) Notwithstanding the provisions of section 431:6-321, no security or other investment shall be eligible for purchase or acquisition under this article unless it is interest bearing or interest accruing or income paying, is not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit, the interest or income accruing thereon; except, that it may acquire real property and non-dividend paying securities as provided in this article. An insurer's aggregate investment in non-dividend paying securities shall not exceed the greater of twenty-five per cent of its admitted assets or fifty per cent of its surplus as regards to policyholders as defined in section 431:6-101.

(b) No security shall be eligible for purchase at a price above its fair value.

(c) No provision of this article shall prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets, or if acquired pursuant to a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investments so acquired which are not otherwise eligible under this article shall be disposed of pursuant to section 431:6-403 if personal property or securities, or pursuant to section 431:6-312 if real property. [L 1987, c 347, pt of §2; am L 2008, c 142, §3]

**§431:6-105 General limitations.** Except as otherwise expressly limited, an insurer shall not have at any time any combination of investments in or loans upon the security of the obligations, property, and securities of any one person aggregating an amount exceeding ten per cent of the insurer's assets. This section shall not apply to investments in, or loans upon the security of general obligations of the government of the United States or of any state of the United States, nor to investments in foreign securities pursuant to section 431:6-313(a), nor include policy loans made pursuant to section 431:6-314. [L 1987, c 347, pt of §2]

**§431:6-106 Record of investments.** (a) As to each investment or loan of the funds of a domestic insurer, a written record in permanent

form showing the authorization thereof shall be made and signed by an officer of the insurer or by the chairperson of the committee authorizing the investment or loan.

(b) Investment records which document the security transactions are to be maintained in the insurer's principal office in this State. [L 1987, c 347, pt of §2; gen ch 1993]

## PART II. MANDATORY PROVISIONS

**§431:6-201 Required investments for capital and reserves.** (a) An insurer shall invest and keep invested its funds aggregating in amounts, if a stock insurer, not less than sixty per cent of its minimum required capital, or if a mutual or reciprocal insurer, not less than sixty per cent of its required minimum surplus, in cash or investments eligible in accordance with section 431:6-301 (public obligations), and in mortgage loans on real property, pursuant to section 431:6-306.

(b) In addition to the investments required by subsection (a), an insurer shall maintain an amount aggregating not less than one hundred per cent of its reserves required by this code, in the following assets: cash, premiums in course of collection, reinsurance recoverable on paid losses, or investments eligible in accordance with this article, including interest and dividends receivable on the investments. [L 1987, c 347, pt of §2 as superseded by c 348, §10; am L 2008, c 142, §4]

## PART III. PERMITTED INVESTMENTS

**§431:6-301 Public obligations.** (a) An insurer may invest any of its funds in bonds or other evidences of debt, not in default as to principal or interest, which are valid and legally authorized obligations issued, assumed, or guaranteed by the United States or by any state thereof or by any possession of the United States or by any county, city, town, village, municipality, or district therein or by any political subdivision thereof or by any civil division or public instrumentality of one or more of the foregoing, if, by statutory or other legal requirements applicable thereto, such obligations are payable, as to both principal and interest:

(1) From taxes levied or required to be levied upon all taxable property or all taxable income within the jurisdiction of the governmental unit, or

(2) From adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment, but not including any obligation payable solely out of special assessments on properties benefited by local improvements unless adequate security is evidenced by the ratio of assessment to the value of the property or the obligation is additionally secured by an adequate guaranty fund required by law.

(b) In addition to the foregoing, an insurer may invest any of its funds in obligations issued or guaranteed by the Inter-American Development Bank, the International Bank for Reconstruction and Development, the Asian Development Bank or the African Development Bank. [L 1987, c 347, pt of §2; am L 1989, c 195, §16]

**§431:6-302 Corporate obligations.** An insurer may invest any of its funds in obligations other than those eligible for investment under section 431:6-306 if they are:

(1) Issued, assumed, or guaranteed by any solvent institution created or existing under the laws of the United States or of any state, or district thereof; and

(2) Filed with the SVO or are considered "filing exempt" by the Purposes and Procedures Manual of the SVO, or its successor publication. [L 1987, c 347, pt of §2; am L 2008, c 142, §5]

**§431:6-303 Preferred or guaranteed stocks or shares.** An insurer may invest any of its funds, in an aggregate amount not exceeding fifteen per cent of its assets, in preferred or guaranteed stocks or shares, other than common stocks, of solvent institutions existing under the laws of the United States or of any state, district, or territory thereof, if all of the prior obligations and prior preferred stocks, if any, of the institution at the date of acquisition by the insurer are:

(1) Eligible as investments under this article; and

(2) Filed with the SVO or are considered "filing exempt" by the Purposes and Procedures Manual of the SVO, or its successor publication. [L 1987, c 347, pt of §2; am L 2008, c 142, §6]

**§431:6-304 Trustees or receivers obligations.** An insurer may invest any of its funds, in an aggregate amount not exceeding two per cent of its assets, in certificates, notes or other obligations issued by trustees or receivers of institutions existing under the laws of the United States or of any state, district or territory thereof, which, or the assets of which, are being administered under the direction of any court having jurisdiction, if the obligation is adequately secured as to principal and interest. [L 1987, c 347, pt of §2]

**§431:6-305 Equipment trust obligations.** An insurer may invest any of its funds, in an aggregate amount not exceeding ten per cent of its assets, in equipment trust obligations or certificates which are adequately secured, or in other adequately secured instruments evidencing an interest in transportation equipment wholly or in part within the United States and the right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of such transportation equipment. [L 1987, c 347, pt of §2]

**§431:6-306 Mortgage loans and contracts.** An insurer may invest any of its funds in:

(1) (A) Bonds or evidences of debt which are secured by first mortgages or deeds of trust on real property located in the United States or Guam which meet either of the following requirements:
(i) Improved, unencumbered real property; or
(ii) Unimproved, unencumbered real property, only where the real property is to be improved, and the bond or evidence of debt is secured by a first mortgage or deed of trust on the real property and the improvement to be made thereon.

(B) Security interests in connection therewith pursuant to section 431:6-310;

(C) The seller's equity in an agreement of sale in any such

property, covering the entire balance due on a bona fide sale of such property, in an amount not to exceed $15,000 or the amount permissible under section 431:6-105, whichever is greater, in any one such agreement of sale, nor in any amount in excess of the following percentages of the actual sale price or fair value of the property, whichever is the smaller:

(i) If a dwelling primarily designed for single family occupancy and occupied by the purchaser under such contract, seventy-five per cent,

(ii) In all other cases, sixty-six and two-thirds per cent.

(2) Purchase money mortgages or like securities received by it upon the sale or exchange of real property acquired pursuant to section 431:6-311.

(3) Evidences of debt secured by mortgage or trust deed guaranteed or insured by an agency of the United States.

(4) Evidences of debt secured by first mortgages or deeds of trust upon leasehold estates, running for a term of not less than five years beyond the maturity of the loan as made or extended, in improved real property, otherwise unencumbered, and if the mortgagee is entitled to be subrogated to all the rights under the leasehold. [L 1987, c 347, pt of §2 as superseded by c 348, §11; am L 1988, c 330, §4]

**§431:6-307 Mortgage loan limited by property value.** (a) No mortgage loan or investment therein upon any one parcel of real property shall exceed in amount at the time of acquisition:

(1) Eighty per cent of the fair value of the property if the property is a dwelling house primarily intended for occupancy by one family, and the loan is required to be amortized within not more than thirty years by payment of installments thereon, at regular intervals not less frequent than every three months; or

(2) Seventy-five per cent of the fair value of the property in all other cases.

(b) The extent to which a mortgage loan made under section 431:6-306(3) is guaranteed or insured by an agency of the United States, may be deducted before application of the limitations in subsection (a). [L 1987, c 347, pt of §2]

**§431:6-308 Encumbrance defined.** (a) Real property shall not be deemed to be encumbered within the meaning of section 431:6-306 by reason of the existence of instruments reserving mineral, oil, timber, or similar rights, rights of way, sewer rights, rights in walls, nor by reason of any liens for taxes or assessments not yet due, or on account of liens not delinquent for community recreational facilities or for the maintenance of community facilities, nor by reason of building restrictions or other restrictive covenants common to the community in which the property is located, nor by liens for service and maintenance of water rights where not delinquent, nor when such real property is subject to lease under which rents or profits are reserved to the owner if in any event the security for the loan or investment is a first lien upon the real property.

(b) If under any of the exceptions set forth in subsection (a) there is any sum owing but not due or delinquent, the total amount of such sum shall be deducted from the amount which otherwise might be

loaned on the property.

The value of any mineral, oil, timber, or similar right reserved shall not be included in the fair value of the property. [L 1987, c 347, pt of §2]

**§431:6-309 Appraisal; insurance; limit.** (a) The fair value of property shall be determined by appraisal by a competent appraiser at the time of the making or acquiring of a mortgage loan or investing in a contract for the deed thereon.

(b) Buildings and other improvements located on the mortgaged premises shall be kept insured for the benefit of the mortgagee against loss or damage from fire in an amount not less than the unpaid balance of the obligation, or the insurable value of the property, whichever is the lesser.

(c) An insurer shall not make or acquire a loan or loans upon the security of any one parcel of real property in an aggregate amount in excess of $250,000 or more than the amount permissible under section 431:6-105, whichever is the greater. [L 1987, c 347, pt of §2 as superseded by c 348, §12]

**§431:6-310 Security agreements.** (a) In connection with a mortgage loan on the security of real property designed and used primarily for residential purposes only acquired pursuant to section 431:6-306, an insurer may loan or invest an amount not exceeding twenty per cent of the amount loaned or invested in the real property mortgage, on the security of a security agreement for a term of not more than five years representing a first and prior lien, except for taxes not then delinquent, on personal property constituting durable equipment owned by the mortgagor and kept and used in the mortgaged premises.

(b) The term durable equipment shall include only mechanical refrigerators, mechanical laundering machines, heating and cooking stoves and ranges, mechanical kitchen aids, vacuum cleaners, and fire extinguishing devices; and in addition, in the case of apartment houses and hotels, room furniture and furnishings.

(c) Prior to acquisition of a security agreement, items of property to be included shall be separately appraised by a competent appraiser and the fair market value thereof determined. No such security agreement shall exceed in amount the same ratio of loan to the value of the property as is applicable to the companion mortgage loan on the real property. [L 1987, c 347, pt of §2; am L 2004, c 122, §19]

**§431:6-311 Real property owned.** (a) An insurer other than a life insurer may own and invest, or have invested in its home office and branch office buildings, any of its funds in an aggregate amount not to exceed twenty per cent of its admitted assets unless approved by the commissioner, or if a mutual or reciprocal insurer, not to exceed twenty per cent of its admitted assets nor an amount as would reduce its surplus, exclusive of such investment, below the minimum required surplus for the class, or combination of classes, of insurance authorized, unless approved by the commissioner. A life insurer may own and invest, or have invested in its home office building and branch office buildings, any of its funds in an aggregate amount not to exceed twenty per cent of its admitted assets, or fifty per cent of the excess of its admitted assets over its liabilities, other than capital stock if a stock life insurer, whichever is the lesser amount. The home office or branch office

buildings may be constructed upon leasehold estates. However, if a life insurer has been licensed less than five years, a prior approval from the commissioner shall be required before investment may be made in home office or branch office buildings.

(b) An insurer may invest any of its funds, in an aggregate amount not exceeding ten per cent of its assets, in real property acquired for the production of income under the following terms and conditions:

(1) The investment in any single parcel of real estate shall not exceed five per cent of its admitted assets;

(2) The investment shall produce sufficient income to amortize any loan secured by a mortgage on the real property;

(3) If any improvements exist on or are to be constructed on the real property for lease to lessees, the improvements shall remain on the property during the period of the lease, with provisions when the improvements are put upon the property at the cost of the lessee that at the termination of the lease the ownership of the improvements, free of liens, shall vest in the owner of the real estate; and

(4) During the term of the lease the tenant shall pay all taxes and assessments levied on or against the real estate, including improvements, shall keep and maintain the improvements in good repair, and shall provide and maintain for the benefit of the lessor fire insurance on the improvements in an amount at least equal to the insurable value of the improvements, or at least equal to the amount invested by the lessor in the real estate, whichever is less.

(c) An insurer may invest any of its funds, in an aggregate amount not exceeding thirty per cent of its assets in real property including the realty set forth in subsections (a) and (b), for realty acquired for the purpose of leasing the same to any person for a period of not less than twenty years, or in real property already leased for an unexpired period of not less than fifteen years of an original period of not less than twenty years, under the following terms and conditions:

(1) The lessee, at the lessee's own cost, shall erect, or have already erected, thereon free of liens a building or other improvements costing an amount at least equal to the value of the real estate exclusive of improvements; but if the lease be entered into simultaneously with the purchase of the real estate, the lessor may agree to erect the improvements on the real estate;

(2) The improvements shall remain on the property during the period of the lease, with provisions when the improvements are put upon the property at the cost of the lessee that at the termination of the lease the ownership of the improvements, free of liens, shall vest in the owner of the real estate;

(3) The lessee, during the term of the lease, or the unexpired period of the lease if the property is bought subject to the lease, shall pay to the owner of the real estate rent in an amount as will enable the owner to amortize the investment at or before the normal termination of the lease, or at or before the end of fifty years should the lease, or the unexpired period of the lease, be for a longer period than fifty years; and

(4) During the term of the lease the tenant shall pay all taxes and assessments levied on or against the real estate, including improvements, shall keep and maintain the improvements in good repair, and shall provide and maintain for the benefit of the lessor fire insurance on the improvements in an amount at least equal to the insurable value of the improvements, or at least equal to the amount invested by the lessor in the real estate, whichever is less.

(d) Real property acquired pursuant to subsection (c) shall not be treated as an investment unless and until the required improvements have been constructed and the lease agreement entered into, and the amount to which the real property shall be treated as an investment shall not exceed the amount actually invested reduced each year in the amounts as will suffice to amortize completely the investment at the normal

termination of the lease or at the end of fifty years should the term of the lease, or the unexpired period of the lease, be for a longer period than fifty years.

(e) An insurer may own real property acquired in satisfaction or on account of loans, mortgages, liens, judgments, or other debts previously owing to the insurer in the course of its business, and may invest or have invested in an aggregate amount not exceeding three per cent of its assets in other real property, and in the repair, alteration, furnishing, or improvement thereof, as follows only:

(1) Other real property requisite for its accommodation in the convenient transaction of its business if approved by the commissioner;

(2) Real property acquired by gift or devise;

(3) Real property acquired in exchange for real property owned by it. If necessary in order to consummate an exchange, the insurer may put up cash in an amount not to exceed twenty per cent of the fair value of its real property to be so exchanged, in addition to the property;

(4) Real property acquired through a lawful merger or consolidation with it of another insurer and not required for the purposes specified in subsection (a) and subsection (c)(1); or

(5) Upon approval of the commissioner, in real property and equipment incident to real property, requisite or desirable for the protection or enhancement of the value of other real property owned by the insurer. [L 1987, c 347, pt of §2 as superseded by c 348, §13; am L 1996, c 65, §1]

**§431:6-312 Time limit for disposal.** (a) Real property acquired by an insurer pursuant to section 431:6-311(e)(1) shall be disposed of within three years after it has ceased being necessary for the use of the insurer in the transaction of its business. Real property acquired by an insurer pursuant to such loans, mortgages, liens, judgments, or other debts, or pursuant to paragraphs (2), (3), (4), and (5) of section 431:6-311(e) shall be disposed of within three years after date of acquisition. The time for any such disposal shall be extended by the commissioner for a definite additional period or periods upon application and reasonable showing that forced sale of the property would be against the best interests of the insurer.

(b) Any such real property held by the insurer without the commissioner's consent beyond the time permitted for its disposal shall not be carried or allowed as an asset. [L 1987, c 347, pt of §2; am L 2004, c 122, §20]

**§431:6-313 Foreign securities.** (a) An insurer authorized to transact insurance in a foreign country may invest any of its funds, in an aggregate amount not exceeding its deposit and reserve obligations incurred in such country, in securities of or in such country possessing characteristics and of a quality similar to those required pursuant to this article for investments in the United States.

(b) An insurer may invest any of its funds, in an aggregate amount not exceeding fifteen per cent of its assets, in addition to any amount permitted pursuant to subsection (a), in obligations of the governments of the Dominion of Canada, or of Canadian provinces, or municipalities, and in obligations of Canadian corporations, which have not been in default during the five years next preceding date of acquisition, and which are otherwise of equal quality to like United States public or

corporate securities as prescribed in this article.

(c) In addition to investments permitted under subsections (a) and (b), an insurer may acquire foreign investments, including American Depository Receipts, or engage in investment practices with persons of or in foreign jurisdictions of substantially the same types as those permitted under this article; provided that:

(1) The aggregate amount of foreign investments then held by the insurer under this subsection shall not exceed twenty per cent of its admitted assets; and

(2) The aggregate amount of foreign investments then held by the insurer under this subsection in a single foreign jurisdiction shall not exceed ten per cent of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or three per cent of its admitted assets as to any other foreign jurisdiction.

(d) Investments acquired under this section shall be aggregated with investments of the same types made under all other sections of this article, and in a similar manner, for the purposes of determining compliance with limitations, if any, contained in the other sections. [L 1987, c 347, pt of §2; am L 2008, c 142, §7]

**§431:6-314 Policy loans.** An insurer may loan upon a life insurance policy, as collateral security, any sum not exceeding the cash surrender value of the policy. [L 1987, c 347, pt of §2]

**§431:6-315 Banks, savings and loan associations, credit unions, and financial services loan companies.** (a) An insurer may invest or deposit any of its funds in checking or savings accounts, under separate certificates of deposit, or in any other form in solvent banks or trust companies.

(b) An insurer may invest any of its funds in shares or savings accounts in solvent savings and loan associations that are insured by the Federal Deposit Insurance Corporation.

(c) An insurer may deposit any of its funds in shares or share draft accounts in solvent state chartered credit unions or federally chartered credit unions.

(d) An insurer may invest or deposit any of its funds in savings accounts, in certificates of deposit, or in any other form in solvent financial services loan companies that are insured by the Federal Deposit Insurance Corporation. [L 1987, c 347, pt of §2; am L 1993, c 107, §2]

**§431:6-316 Insurance stocks.** (a) An insurer other than a life insurer may invest a portion of its surplus funds in an aggregate amount not exceeding fifty per cent of its surplus over its capital stock and other liabilities, or thirty-five per cent of its capital funds, whichever is greater, in the stocks of other insurers organized and existing under the laws of the states of the United States. Indirect or proportionate interests in insurance stocks held by an insurer through any intermediate subsidiary or subsidiaries shall be included in applying the limitations provided in subsections (a), (b) and (c).

(b) A life insurer may invest in such insurance stocks in an aggregate amount not exceeding the smaller of the following amounts: Five per cent of its assets or twenty-five per cent of its surplus over its capital stock and other liabilities, or of surplus over its required minimum surplus if a mutual life insurer.

(c) No such insurance stock shall be eligible as an investment

unless it meets the qualifications for stocks of other corporations as set forth in section 431:6-317.

(d) The limitations on investment in insurance stocks set forth in this article shall not apply to stocks acquired under a plan for merger of the insurers which has been approved by the commissioner or to shares received as stock dividends upon shares already owned. [L 1987, c 347, pt of §2]

**§431:6-317 Common stocks.** (a) To meet the requirements under section 431:6-201, an insurer may invest any of its funds in common shares of stock that are filed with the SVO or are considered "filing exempt" by the Purposes and Procedures Manual of the SVO, or its successor publication; provided that an insurer's amount of investment in common stocks and in non-dividend paying stocks made pursuant to this section and in common trust funds, mutual funds, and exchange traded funds made pursuant to section 431:6-322 shall not exceed the greater of twenty-five per cent of its admitted assets or one hundred per cent of its surplus as regards to policyholders as defined in section 431:6-101.

(b) An insurer may invest any of its funds in common shares of stock in solvent United States corporations after satisfying the requirements under section 431:6-201.

(c) An insurer's aggregate amount of investment in non-dividend paying stocks shall be subject to the limitations in section 431:6-104. [L 1987, c 347, pt of §2; am L 2008, c 142, §8; am L 2009, c 77, §4]

**§431:6-318 Collateral loans.** An insurer is permitted to loan its funds upon the pledge of securities or evidences of debt eligible for investment under this article. As at date made, no such loan shall exceed in amount ninety per cent of the fair value of the collateral pledged, except that loans upon pledge of United States government bonds may be equal to the fair value of the bonds pledged and that loans on life insurance policies may equal the cash surrender value of the policy as provided in section 431:6-314. The amount so loaned shall be included in the maximum percentage of funds permitted to be invested in the kinds of securities for evidences of debt pledged or permitted by section 431:6-105. [L 1987, c 347, pt of §2]

**§431:6-319 Miscellaneous investments.** (a) An insurer may loan or invest its funds in an aggregate amount not exceeding the lesser of the following sums: Five per cent of its assets or fifty per cent of its surplus over its capital and other liabilities, or, if a mutual or reciprocal insurer, fifty per cent of its surplus over the minimum required surplus, in kinds of loans or investments not otherwise specifically made eligible for investment and not specifically prohibited or made ineligible by this or other provisions of this article.

(b) No such loan or investment shall be represented by:

(1) Any item described in section 431:5-202;

(2) Any loan or investment of a kind specifically made eligible under any other provision of this code; or

(3) Any loan, investment, or assets theretofore acquired or held by the insurer under any other category of loans or investments.

(c) No one investment or loan shall exceed the amount specified in subsection (a) or one per cent of insurer's assets, whichever is the lesser.

(d) The insurer shall keep a separate record of all investments acquired under this section. [L 1987, c 347, pt of §2]

**§431:6-320 Special consent investments.** Upon approval of the commissioner and in compliance with section 431:6-104, an insurer may make any investment or kind of investment or exchange of assets otherwise prohibited or not eligible under this article. The commissioner's order of approval, if granted, shall specify whether any part of the investment may be credited to required minimum capital or surplus investment, or to investment of reserves. [L 1987, c 347, pt of §2]

**§431:6-321 Hedging transactions.** (a) A domestic insurer may effect or maintain bona fide hedging transactions pertaining to securities otherwise eligible for investment under this part including, but not limited to:

(1) Financial futures contracts, warrants, options, calls, and other rights to purchase, and

(2) Puts and other rights to require another person to purchase the securities.

(b) The contracts, options, calls, puts, and rights shall be traded on a commodity exchange regulated under the Commodity Exchange Act, as amended, on a securities exchange, or on an over-the-counter market regulated under the Securities Exchange Act of 1934, as amended.

(c) For purposes of this section, a bona fide hedging transaction means a purchase or sale of a contract, warrant, option, call, put, or right entered into for the purpose of:

(1) Minimizing interest rate risks in respect to interest obligations on insurance policies or contracts supported by securities held by the insurer, or

(2) Offsetting changes in the market values or yield rates of securities held by the insurer. [L 1987, c 349, §3]

**§431:6-322 Common trust funds; mutual funds; and exchange traded funds.** (a) For purposes of this section:

"Common trust funds" means a fund maintained by a bank exclusively for the collective investment and reinvestment of moneys contributed by the bank in its capacity as a trustee, executor, administrator, guardian, or custodian of accounts as defined in section 584 of the Internal Revenue Code of 1986, as amended.

"Exchange traded fund" means a security that tracks an index, commodity, or basket of assets similar to an index fund, is registered with the federal Securities and Exchange Commission under the Investment Company Act of 1940, as amended, and is traded on a public exchange.

"Mutual funds" means an investment company that is registered with the federal Securities and Exchange Commission under the Investment Company Act of 1940 (15 United States Code section 80a-1, et seq.), as amended.

(b) To meet the requirements under section 431:6-201, an insurer may invest in common trust funds, mutual funds, and exchange traded

funds; provided that an insurer's amount of investment made pursuant to this section and in common stocks made pursuant to section 431:6-317(a) shall not exceed the greater of twenty-five per cent of its admitted assets or one hundred per cent of its surplus as regards to policyholders as defined in section 431:6-101. This limitation shall not apply to investments approved on the "Mutual Funds List" from the Purposes and Procedures Manual of the SVO, or its successor publication.

(c) An insurer may invest any of its funds in common trust funds, mutual funds, and exchange traded funds after satisfying the requirements of section 431:6-201. [L 1987, c 349, §4; am L 2008, c 142, §9; am L 2009, c 11, §5 and c 77, §5]

**§431:6-323 Separate accounts.** (a) A life insurer, after adoption of a resolution by its board of directors and certification thereof to the commissioner, may allocate to one or more separate accounts, in accordance with the terms of a written agreement or a contract on a variable basis, amounts which are paid to the insurer, in connection with a pension, retirement or profit sharing plan, or in connection with a contract on a variable basis, whether on an individual or group basis, and which amounts are to be applied to purchase retirement benefits in fixed or in variable dollar amounts, or both, or to provide benefits in accordance with a contract on a variable basis.

The income, if any, and gains or losses realized or unrealized on each account may be credited to or charged against the amount allocated to the account in accordance with the agreement, without regard to the other income, gains or losses of the insurer. The commissioner may prescribe reasonable limitations on charges against and permissible deductions from the investment experience credited to life insurance contracts on a variable basis. Notwithstanding any other provision in the insurer's articles of incorporation or in this code, the amounts allocated to the accounts and accumulations thereon may be invested and reinvested in any class of loans and investments specified in the agreement, or, with respect to life insurance contracts on a variable basis, as prescribed by the commissioner, and the loans and investments shall not be considered in applying any limitation in this article. The commissioner, with respect to separate accounts for life insurance on a variable basis, may establish reasonable standards for procedures to be used in changing investment policy and provisions to safeguard the rights of insured persons and beneficiaries.

(b) Contract on a variable basis means a contract issued by an insurer providing for the dollar amount of benefits or other contractual payments or values thereunder to vary so as to reflect investment results of a segregated portfolio of investments or of a designated account in which amounts received in connection with the contract have been placed and other contracts as may be approved by the commissioner.

(c) Notwithstanding any other provision of law, a life insurer, if necessary to comply with the Investment Company Act of 1940, with respect to any account or any portion thereof, may:

(1) Exercise the voting rights of the stock or shares or interest in accordance with instructions from the persons having the beneficial interests in the account ratably according to their respective interests in the account, or

(2) Establish a committee for the account, the members of which may be directors or officers or other employees of the insurer, persons having no relationship to the insurer, or any combination thereof, who may be elected to membership by the vote of the persons having the beneficial interests in the account ratably

according to their respective interests in the account. The committee alone, in conjunction with others, or by delegation to the insurer or any other person, as investment manager or investment adviser, may authorize purchases and sales of investments for the account if, as long as the life insurer or any subsidiary or affiliate of the life insurer is the investment manager or investment adviser of the account, the investments of the account are eligible under this section. If compliance with the Investment Company Act of 1940 involves only a portion of the account, the insurer may establish a committee for only that portion, and its members may be elected by the vote of the persons having the beneficial interests in the portion. A committee for only a portion of the account may be given the further power to require the subdivision of the account into two accounts so that the portion of the account with respect to which the committee is acting shall constitute a separate account. If the committee so requires, the insurer shall segregate, from the account being so subdivided, a portion of each asset held with respect to the reserve liabilities of the account. That portion shall be in the same proportion to the total of the asset as the reserve liability for the portion of the account with respect to which the committee is acting bears to the total reserve liability of the account; and notwithstanding any other provision of law, the assets so segregated shall be transferred to a separate account with respect to which the committee shall act.

(d) The investments and liabilities of the account shall at all times be clearly identifiable and distinguishable from the other investments and liabilities of the insurer. A sale, transfer, or exchange of investments shall not be made between any of the separate accounts or between any other investment account of the company and one or more of the separate accounts, except for the purpose of:

(1) Conducting the business of the account in accordance with subsections (a) and (c); or

(2) Making adjustments necessitated by the contract for mortality experience adjustment, and then only if the transfers are made by a transfer of cash or by a transfer of securities having a valuation that can readily be determined in the marketplace. The commissioner may require for domestic life insurers that a transfer of cash or investments from a separate account or accounts to the company be approved in advance of the transfer. The commissioner may prescribe reasonable limitations on charges against and permissible deductions from separate accounts for life insurance contracts on a variable basis.

(e) As used in this section, Investment Company Act of 1940 means the Act of Congress approved August 22, 1940, entitled Investment Company Act of 1940 as amended from time to time, or any similar statute enacted in substitution therefor.

(f) The commissioner may adopt rules pursuant to chapter 91. [L 1987, c 349, §5; am L 2004, c 122, §21]

**§431:6-324 Subsidiaries.** (a) Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries subject to the limitations of this section.

(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under all other sections of this article, a domestic insurer also may do one or more of the following:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten per cent of the insurer's assets or fifty per cent of the insurer's surplus as regards policyholders. However, after the investments, the insurer's surplus as regards policyholders shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, investments in domestic or foreign insurance subsidiaries shall be excluded, and there shall be included:

(A) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a

subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary, whether represented by the purchase of capital stock or issuance of other securities; and

(B) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;

(2) If the insurer's total liabilities, as calculated for National Association of Insurance Commissioners' annual statement purposes, are less than ten per cent of assets, invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries. However, after the investment the insurer's surplus as regards policyholders, considering the investment as if it were a disallowed asset, shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs;

(3) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries; provided that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in paragraph (1) or in this article applicable to the insurer. For the purpose of this subsection, the total investment of the insurer shall include:

(A) Any direct investment by the insurer in an asset; and

(B) The insurer's proportionate share of any investment of an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership of the subsidiary;

(4) With the approval of the commissioner, invest any amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after the investment, the insurer's surplus as regards policyholders shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs; or

(5) Invest any amount in the common stock, preferred stock, debt obligations, or other securities of any subsidiary exclusively engaged in holding title to, or holding title to and managing or developing real or personal property, if after considering as a disallowed asset so much of the investment as is represented by subsidiary assets, which if held directly by the insurer would be considered as a disallowed asset, the insurer's surplus as regards policyholders shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(c) Investments in common stock, preferred stock, debt obligations, or other securities of subsidiaries made pursuant to subsection (b) shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this article applicable to the investment of insurers.

(d) Whether any investment pursuant to subsection (b) meets the applicable requirements is to be determined immediately after the investment is made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the date they were made.

(e) If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three years from the time of the cessation of control or within such further times as the commissioner may prescribe, unless at any time after the investment has been made, the investment has met the requirements for investment under any other section of this article, and the insurer has notified the commissioner thereof.

(f) In addition to the above subsection, any insurer acquiring or disposing of any subsidiary, must also comply with article 11 of this code. [L 1987, c 349, §6; am L 1993, c 205, §10; am L 2004, c 122, §22]

## PART IV. PROHIBITED INVESTMENTS AND LIMITATIONS

**§431:6-401 Prohibited investments.** In addition to investments excluded under other provisions of this article, an insurer shall not, except with the commissioner's approval in advance, invest in or loan its funds upon the security of, or hold:

(1) Issued shares of its own capital stock, except for the purpose of mutualization in accordance with section 431:4-502.

(2) Any investment or loan ineligible under section 431:6-105.

(3) Securities issued by an insolvent corporation.

(4) Any investment or security which is found by the commissioner to be designed to evade any prohibition of this article. [L 1987, c 347, pt of §2]

**§431:6-402 Securities underwriting; agreements to withhold or to repurchase.** No insurer shall:

(1) Participate in the underwriting of the marketing of securities in advance of their issuance or enter into any transaction for such underwriting for the account of such insurer jointly with any other person; or

(2) Enter into any agreement to withhold from sale any of its property, or to repurchase any property sold by it. [L 1987, c 347, pt of §2]

**§431:6-403 Disposal of ineligible property and securities.** (a) Any personal property or securities lawfully acquired by an insurer, which it could not otherwise have invested in or loaned its funds upon at the time of the acquisition, shall be disposed of by the insurer within three years from date of acquisition, unless within such period the security has attained the standard for eligibility. The commissioner, upon application and reasonable showing that forced sale of any such property or security would be against the best interests of the insurer, may extend the disposal period for an additional reasonable time.

(b) While any such property or security remains so ineligible, it shall not be allowed as an asset of the insurer.

(c) Any ineligible property or security acquired contrary to this article by an insurer shall be disposed of forthwith; for failure so to do within sixty days after order of the commissioner requiring such disposal, the commissioner may revoke or suspend the insurer's certificate of authority.

(d) For the purposes of subsection (c), an investment otherwise eligible shall not be deemed ineligible for the reason that it is in excess of the amount permitted under this article to be invested in the category of investments to which it belongs; any such excess investment shall be disposed of within the time prescribed in subsection (a). [L 1987, c 347, pt of §2]

**§431:6-404 Authorization of investments.** No investment, loan, sale, or exchange, except a loan upon a life insurance policy, shall be made by any domestic insurer unless authorized or approved by its board of directors or by a committee charged by the board of directors, or the bylaws with the duty of making such investment, loan, sale, or exchange. The minutes of any such committee shall be recorded and reports shall be submitted to the board of directors for approval or disapproval. [L 1987, c 347, pt of §2]

## PART V. INVESTMENT OF FOREIGN AND ALIEN INSURERS

**§431:6-501 Investments of foreign, alien insurers.** The investments of a foreign or alien insurer shall be as permitted by the laws of its domicile, but shall be of a quality substantially as high as those required by this article for similar funds of like domestic insurers. [L 1987, c 347, pt of §2]

## [PART VI. INVESTMENT POOLS]

**§431:6-601 Insurer investment pools.** (a) For purposes of this section:

"Business entity" means a corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund trust, or other similar form of business organization, whether organized for-profit or not-for-profit.

"Class one money market mutual funds" means a mutual fund that at all times qualifies for investment using the bond class one reserve factor under the Purposes and Procedures of the SVO or any successor publication.

"Government money market mutual fund" means a money market mutual fund that at all times:

(1) Invests only in obligations issued, guaranteed, or insured by the government of the United States or collateralized repurchase agreements composed of these obligations; and

(2) Qualifies for investment without a reserve under the Purposes and Procedures of the SVO or any successor publication.

"Money market mutual fund" means a mutual fund that meets the conditions of 17 Code of Federal Regulations part 270.2a-7, under the Investment Company Act of 1940 (15 United States Code section 80a-1 et seq.), as amended, or renumbered.

"Obligation" means a bond, note, debenture, trust certificate, including equipment certificate, production payment, negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, loan secured by financing net leases and other evidence of indebtedness for the payment of money (or participation, certificates, or other evidence of an interest in any of the foregoing), whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

"Qualified bank" means a national bank, state bank, or trust company that at all times is no less than adequately capitalized as determined by the standards adopted by the United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System.

"Repurchase transaction" means a transaction in which an insurer

purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

"Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

"Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loans, securities, or equivalent securities to the insurer, either within a specified period of time or upon demand.

(b) An insurer may acquire investments in investment pools that:

(1) Invest only in:

(A) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally-recognized statistical rating organization recognized by the SVO and have:

(i) A remaining maturity of three hundred ninety-seven days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding three hundred ninety-seven days; or

(ii) A remaining maturity of three years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate or commercial paper) and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(B) Government money market mutual funds or class one money market mutual funds; or

(C) Securities lending, repurchase, and reverse repurchase transactions that meet all the requirements of section 431:6-318; or

(2) Invest only in investments which an insurer may acquire under this article, if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this article.

(c) For an investment in an investment pool to be qualified under this article, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed, or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur an indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of this article; or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from or invested in any one business entity under this section to exceed ten per cent of the total assets of the investment pool.

(d) The limitations of sections 431:6-105 and 431:6-402 shall not apply to an insurer's investment in an investment pool; however, an insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section:

(1) In any one investment pool would exceed ten per cent of its admitted assets;

(2) In all investment pools investing in investments permitted under subsection (b)(2) would exceed twenty-five per cent of its admitted assets; or

(3) In all investment pools would exceed thirty-five per cent of its admitted assets.

(e) For an investment in an investment pool to be qualified under this section, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2) Be the insurer, an affiliated insurer, or a business entity affiliated with the insurer, a qualified bank, a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. §80a-1 et seq.), as amended, or, in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact, or in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:

(A) The cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;
(B) A complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date (if any), and other appropriate designations); and
(C) Other records that on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement shall:

(A) State and recognize the claims and rights of each participant;
(B) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and
(C) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

(f) The pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under subsection (b)(1), the insurer and its subsidiaries, affiliates, or any pension or profit sharing plan of the insurer, its subsidiaries and affiliates or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, at all times, shall hold one hundred per

cent of the interests in the investment pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) Each participant owns an undivided interest in the underlying assets of the investment pool; and
(B) The underlying assets of the investment pool are held solely for the benefit of each participant;

(4) A participant, or in the event of the participant's insolvency, bankruptcy, or receivership, its trustee, receiver, or other successor-in-interest, may withdraw all or any portion of its investment from the pool under the terms of the pooling agreement;

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter not to exceed five business days. Distributions under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(A) In cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;
(B) In kind, a pro rata share of each underlying asset; or
(C) In a combination of cash and in kind distributions, a pro rata share in each underlying asset; and

(6) The pool manager shall make the records of the investment pool available for inspection by the commissioner.

(g) The investment pool authorized under these provisions shall be a business entity.

(h) Transactions between the pool and its participants shall not be subject to section 431:11-106. Investment activities of pools and transactions between pools and participants shall be reported annually in the registration statement required by section 431:11-105. [L 1997, c 233, pt of §1; am L 2004, c 122, §23; am L 2008, c 142, §10]

**[§431:6-602] Securities lending, repurchase, reverse repurchase, and dollar roll; investment pools.** (a) For purposes of this section, "business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy, or other similar form of business organization, whether organized for-profit or not-for-profit.

(b) This section is applicable to investment pools under section 431:6-601.

(c) An insurer may enter into securities lending, repurchase, reverse repurchase, and dollar roll transactions with business entities, subject to the requirements of this section.

(d) The board of directors shall adopt a written plan which shall include at least the following:

(1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

(2) Operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(3) The extent to which the insurer may engage in these transactions.

(e) The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer, if the agent is a qualified business entity, and if the agreement:

(1) Requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(2) Prohibits securities lending transactions under the agreement with the agent or its affiliates.

(f) Cash received in a transaction under this section shall be invested in accordance with section 431:6-601, and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. For so long as the transaction remains outstanding, the insurer, its agent, or custodian shall maintain acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the commissioner.

(g) In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date, at least equal to one hundred two per cent of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals one hundred two per cent of the market value of the loaned securities.

(h) In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five per cent of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five per cent of the market value of the securities so transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals ninety-five per cent of the market value of the transferred securities.

(i) In a dollar roll transaction, the insurer shall receive cash in the amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

(j) In a repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to one hundred two per cent of the purchase price paid by the insurer for the securities. If at any time the market value of the

acceptable collateral is less than one hundred per cent of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals one hundred two per cent of the purchase price. Securities acquired by an insurer in a repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged. [L 1997, c 233, pt of §1]

## ARTICLE 7
## FEES, TAXES AND DEPOSITS

### PART I. FEES

**§431:7-101 Fees.** (a) The commissioner shall collect, in advance, the following fees:

(1) Certificate of authority:

(A). Application for a certificate of authority...$900
(B). Issuance of certificate of authority .....$600

(2) Organization of domestic insurers and affiliated corporations:

(A). Application for a solicitation permit..... $1,500
(B). Issuance of solicitation permit..... $150

(3) Producer's license:

(A). Issuance, regular license..... $50
(B). Issuance, temporary license..... $50

(4) Nonresident producer's license: Issuance..... $75

(5) Independent adjuster's license: Issuance..... $75

(6) Public adjuster's license: Issuance..... $75

(7) Claims adjuster's limited license: Issuance..... $75

(8) Independent bill reviewer's license:

Issuance..... $80

(9) Limited producer's license: Issuance..... $60

(10) Managing general agent's license: Issuance..... $75

(11) Reinsurance intermediary's license:

Issuance..... $75

(12) Surplus lines broker's license: Issuance.... $150

(13) Service contract provider's registration:

Issuance..... $75

(14) Approved course provider certificate:

Issuance..... $100

(15) Approved continuing education course certificate: Issuance. $30

(16) Vehicle protection product warrantor's registration: Issuance..... $75

(17) Criminal history record check; fingerprinting: For each criminal history record check and fingerprinting check, a fee to be established by the commissioner.

(18) Limited line motor vehicle rental company producer's license: Issuance.. $1,000

(19) Legal service plan certificate of authority:

Issuance before July 1, 2014 $1,000

Issuance on or after July 1, 2014..... $500

(20) Life settlement provider's license:

Issuance before July 1, 2014 $150

Issuance on or after July 1, 2014..... $75

(21) Life settlement broker's license:

Issuance before July 1, 2014 $150

Issuance on or after July 1, 2014..... $75

(22) Examination for license: For each examination, a fee to be established by the commissioner.

(b) The fees for services of the department of commerce and consumer affairs subsequent to the issuance of a certificate of authority, license, or other certificate are as follows:

(1) $600 per year for all services (including extension of the certificate of authority) for an authorized insurer;

(2) $50 per year for all services (including extension of the license) for a regularly licensed producer;

(3) $75 per year for all services (including extension of the license) for a regularly licensed nonresident producer;

(4) $45 per year for all services (including extension of the license) for a regularly licensed independent adjuster;

(5) $45 per year for all services (including extension of the license) for a regularly licensed public adjuster;

(6) $45 per year for all services (including extension of the license) for a claims adjuster's limited license;

(7) $60 per year for all services (including extension of the license) for a regularly licensed independent bill reviewer;

(8) $45 per year for all services (including extension of the license) for a producer's limited license;

(9) $75 per year for all services (including extension of the license) for a regularly licensed managing general agent;

(10) $75 per year for all services (including extension of the license) for a regularly licensed reinsurance intermediary;

(11) $45 per year for all services (including extension of the license) for a licensed surplus lines broker;

(12) $75 per year for all services (including renewal of registration) for a service contract provider;

(13) $65 per year for all services (including extension of the certificate) for an approved course provider;

(14) $20 per year for all services (including extension of the certificate) for an approved continuing education course;

(15) $75 per year for all services (including renewal of registration) for a vehicle protection product warrantor;

(16) A fee to be established by the commissioner for each criminal history record check and fingerprinting;

(17) $600 per year for all services (including extension of the license) for a regularly licensed limited line motor vehicle rental company producer;

(18) $1,000 per year for all services provided before July 1, 2014, (including extension of the certificate) for an authorized legal service plan;

(19) $500 per year for all services provided on or after July 1, 2014, (including extension of the certificate) for an authorized legal service plan;

(20) $1,200 per year for all services (including extension of the license) for a regularly licensed life settlement provider; and

(21) $150 per year for all services (including extension of the license) for a regularly licensed life settlement broker.

The services referred to in paragraphs (1) to (21) shall not include services in connection with examinations, investigations, hearings, appeals, and deposits with a depository other than the department of commerce and consumer affairs.

(c) The commissioner shall notify the holder of a certificate of authority issued under article 3 by written notice at least thirty days prior to the extension date of the certificate of authority, license, or other certificate. If the fee is not paid before or on the extension date, the fee shall be increased by a penalty in the amount of fifty per cent of the fee. The commissioner shall provide notice in writing of the delinquency of extension and the imposition of the authorized penalty. If the fee and the penalty are not paid within thirty days immediately following the date of notice of delinquency, the commissioner may revoke, suspend, or inactivate the certificate of authority, license, or other certificate, and may not reissue, remove the suspension of, or reactivate the certificate of authority, license, or other certificate until the fee and penalty have been paid.

(d) Failure to pay the fee before or on the extension date for a license or other certificate issued under article 9 or 9A shall cause the automatic inactivation of the license or certificate effective as of the extension date.

(e) All fees and penalties shall be deposited to the credit of the compliance resolution fund. [L 1987, c 347, pt of §2; am L 1993, c 205, §11; am L 1997, c 234, §1; am L 1999, c 163, §3; am L 2000, c 221, §4 and c 288, §5; am L 2001, c 128, §1; am L 2002, c 39, §11, c 155, §12, and c

237, §2; am L 2004, c 122, §24; am L 2007, c 214, §1; am L 2008, c 177, §§2, 7; am L 2009, c 11, §18 and c 77, §§15, 20; am L 2010, c 59, §§4, 5, 7(3); am L 2011, c 81, §4 and c 186, §8; am L 2012, c 256, §2; am L 2015, c 63, §6]

**Cross References**

Service contract providers, see chapter 481X.

## PART II. TAXES

**§431:7-201 Annual and monthly tax statements.** *[Section effective until December 31, 2016. For section effective January 1, 2017, see below.]* (a) Each authorized insurer shall file with the commissioner annually, on or before March 1 in each year, a statement signed by a duly authorized person on its behalf, setting forth the total business transacted, and the amount of gross premiums reported by the insurer, pursuant to section 431:7-202, during the year ending on the preceding December 31, from all risks or property resident, situated, or located within this State, together with such other information as may be required by the commissioner to determine the taxability of premiums. The term "gross premiums" as used in this part shall not include consideration paid for annuities.

(b) Each authorized insurer shall file with the commissioner monthly, on or before the twentieth day of the calendar month following the month in which the taxes accrue, a statement signed by a duly authorized person on its behalf, setting forth the total business transacted and the amount of gross premiums reported by the insurer, pursuant to section 431:7-202, during the month from all risks or property resident, situated, or located within this State, together with other information as may be required by the commissioner to determine the taxability of premiums.

(c) Any insurer failing or refusing to file the annual tax statement on or before March 1, or the monthly statement on or before the twentieth day of the calendar month following the month in which the taxes accrue, shall be liable for a fine in an amount not less than $100 and not more than $500 for each day of delinquency. [L 1987, c 347, pt of §2; am L 1995, c 232, §13; am L 1998, c 202, §1; am L 2003, c 212, §41; am L 2010, c 22, §10]

**§431:7-201 Annual and monthly tax statements.** *[Section effective January 1, 2017. For section effective until December 31, 2016, see above.]* (a) Each authorized insurer shall electronically file with the commissioner annually, on or before March 1 in each year, a statement signed by a duly authorized person on its behalf, setting forth the total business transacted, and the amount of gross premiums reported by the insurer, pursuant to section 431:7-202, during the year ending on the preceding December 31, from all risks or property resident, situated, or located within this State, together with such other information as may be required by the commissioner to determine the taxability of premiums. The term "gross premiums" as used in this part shall not include consideration paid for annuities.

(b) Each authorized insurer shall electronically file with the commissioner monthly, on or before the twentieth day of the calendar month following the month in which the taxes accrue, a statement signed

by a duly authorized person on its behalf, setting forth the total business transacted and the amount of gross premiums reported by the insurer, pursuant to section 431:7-202, during the month from all risks or property resident, situated, or located within this State, together with other information as may be required by the commissioner to determine the taxability of premiums.

(c) Any insurer failing or refusing to electronically file the annual tax statement on or before March 1, or the monthly statement on or before the twentieth day of the calendar month following the month in which the taxes accrue, shall be liable for a fine in an amount not less than $100 and not more than $500 for each day of delinquency. [L 1987, c 347, pt of §2; am L 1995, c 232, §13; am L 1998, c 202, §1; am L 2003, c 212, §41; am L 2010, c 22, §10; am L 2016, c 141, §3]

**§431:7-202 Taxation.** (a) Each authorized insurer, except with respect to all life insurance contracts, ocean marine insurance contracts, and real property title insurance contracts, shall pay to the director of finance through the commissioner a tax of 4.265 per cent on the gross premiums written from all risks or property resident, situated, or located within this State, during the year ending on the preceding December 31, less return premiums (but not including dividends paid or credited to policyholders), and less any reinsurance accepted (the tax upon such business being payable by the direct writing insurer).

All premiums written, procured, or received in the State shall be presumed to have been from risks or property resident, situated, or located within the State. This presumption may be rebutted as to any premium:

(1) By showing that it has been properly allocated or apportioned and reported as a taxable premium of another state or other appropriate taxing authority; or

(2) By facts as to the residence, situation, or location of the risks or property, conclusively showing the nontaxability of the premium.

(b) Each authorized insurer, with respect to life insurance contracts, shall pay to the director of finance through the commissioner a tax of 2.75 per cent on the gross premiums received from all risks resident within this State, during the year ending on the preceding December 31, less return premiums, dividends paid or credited to policyholders, and reinsurance accepted (the tax upon such business being payable by the direct writing insurer).

The tax also shall apply to premiums for insurance written on individuals residing outside the State unless the direct writing insurer shall show the payment of a comparable tax to another appropriate taxing authority. Such showing may be required as to any premium written, procured, or received in the State.

(c) Each authorized insurer shall, with respect to all ocean marine insurance contracts written within the State, during the year ending on the preceding December 31, pay to the director of finance through the commissioner a tax of .8775 per cent on its gross underwriting profit. The gross underwriting profit shall be ascertained by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance ceded) on such ocean marine insurance contracts, the net losses paid (i.e., gross losses paid less salvage and recoveries on reinsurance ceded) during such year under such contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit

shall not include, for computation of the tax prescribed by this subsection, the amount refunded, or paid as participation dividends, by such insurer to the holders of such contracts.

(d) Each authorized insurer, with respect to real property title insurance contracts written on real property situated within this State during the year ending on the preceding December 31, shall pay to the director of finance through the commissioner a tax of 4.265 per cent of the amount of the risk premium actually received by the authorized insurer for the provision of such insurance. The amount of the risk premium received by the authorized insurer for the provision of real property title insurance shall be an amount equal to the amount actually received by the authorized insurer solely for the provision of real property title insurance coverage in accordance with the underwriting agreement or contract between the authorized insurer and the underwritten title company.

(e) No return premium shall be deductible unless the original gross premium, or an adjustment thereof, in an amount equal to or in excess of the return premium, has been concurrently or previously reported as taxable under this section or a prior similar law of the State.

(f) *[Subsection effective until December 31, 2016. For subsection effective January 1, 2017, see below.]* The taxes imposed by subsections (a), (b), (c), and (d) shall be paid monthly. The monthly tax shall be due and payable on or before the twentieth day of the calendar month following the month in which it accrues, coinciding with the filing of the statement provided for in section 431:7-201.

In addition to the monthly tax and monthly tax statement, the annual tax shall be due and payable on or before March 1 coinciding with the filing of the statement provided for in section 431:7-201.

All amounts paid under this subsection, other than fines, shall be allowed as a credit on the annual tax imposed by subsections (a), (b), (c), and (d).

If the total amount of installment payments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of the annual tax and be allowed as a refund under section 431:7-203.

Any insurer failing or refusing to pay the required taxes above stated when due and payable shall be liable for a fine of $500 or ten per cent of the tax due, whichever is greater; plus interest at a rate of twelve per cent per annum on the delinquent taxes. The taxes may be collected by distraint, or the taxes, fine, and interest may be recovered by an action to be instituted by the commissioner in the name of this State, in any court of competent jurisdiction. The commissioner may suspend the certificate of authority of the delinquent insurer until the taxes, fine, and interest, should any be imposed, are fully paid.

(f) *[Subsection effective January 1, 2017. For subsection effective until December 31, 2016, see above.]* The taxes imposed by subsections (a), (b), (c), and (d) shall be paid monthly. The monthly tax shall be due and payable by electronic payment via the Automated Clearing House debit or credit payment system on or before the twentieth day of the calendar month following the month in which it accrues, coinciding with the filing of the statement provided for in section 431:7-201.

In addition to the monthly tax and monthly tax statement, the annual tax shall be due and payable by electronic payment via the Automated Clearing House debit or credit payment system on or before March 1 coinciding with the filing of the statement provided for in section 431:7-201.

All amounts paid under this subsection, other than fines, shall be allowed as a credit on the annual tax imposed by subsections (a), (b), (c), and (d).

If the total amount of installment payments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of the annual tax and be allowed as a refund under section 431:7-203.

Any insurer failing or refusing to pay the required taxes above stated when due and payable shall be liable for a fine of $500 or ten per cent of the tax due, whichever is greater; plus interest at a rate of twelve per cent per annum on the delinquent taxes. The taxes may be collected by distraint, or the taxes, fine, and interest may be recovered by an action to be instituted by the commissioner in the name of this State, in any court of competent jurisdiction. The commissioner may suspend the certificate of authority of the delinquent insurer until the taxes, fine, and interest, should any be imposed, are fully paid.

As used in this subsection, "Automated Clearing House debit or credit payment system" means the network for the interbank clearing of electronic payments for participating depository financial institutions.

(g) In establishing the prepayment amount of an insurer who has acquired the business of another insurer, the amount of tax liability of the acquiring insurer for the preceding calendar year shall be deemed to include the amount of tax liability of the acquired insurer for that year. [L 1987, c 347, pt of §2; am L 1992, c 236, §6; am L 1994, c 160, §1; am L 1995, c 232, §14; am L 1998, c 202, §2; am L 2003, c 212, §42; am L 2010, c 22, §11; am L 2016, c 141, §4]

**Case Notes**

Cited: 676 F. Supp. 2d 1006 (2009).

**[§431:7-202.5] Additions to taxes for noncompliance or evasion; interest on underpayments and overpayments.** The provisions of section 231-39 shall apply to taxes under this article. [L 1992, c 236, §2]

**§431:7-203 Administrative refunds.** (a) If any person has paid to the commissioner any tax, fee, or other charge in error or in excess of that which the person is lawfully obligated to pay under this code, the commissioner, upon written request made by the person to the commissioner within the time set forth in section 431:7-204.6, shall authorize a refund thereof out of the compliance resolution fund, except that a tax refund shall be payable out of the general fund, by submitting a voucher therefor to the comptroller subject to the following limitations:

(1) No recourse may be had except under section 40-35 or by appeal for refunds of taxes paid pursuant to an assessment by the commissioner; provided that if the assessment by the commissioner contains clerical errors, transposition of figures, typographical errors, and errors in calculation or if there is an illegal or erroneous assessment because the assessment is not in accordance with this code, the refund procedures in subsection (a) shall apply; and

(2) No refund or overpayment credit shall be made unless the original payment of the tax was due to the law having been interpreted or applied with respect to the taxpayer concerned differently than with respect to taxpayers generally.

As to all tax payments for which a refund or credit is not authorized

by this subsection (including, without prejudice to the generality of the foregoing, cases of unconstitutionality), the remedies provided by appeal or under section 40-35 are exclusive.

(b) Where a taxpayer is entitled to a refund, the taxpayer, at the taxpayer's election, may apply the amount of the refund as an overpayment credit to taxes subsequently accruing under this code.

(c) This subsection shall apply to a refund for an overpayment of tax.

(1) If the tax return as filed by a taxpayer shows the amount already paid, whether or not on the basis of installments, exceeds the amount determined to be the correct amount of the tax due, and the taxpayer requests a refund of the overpayment, the amount of overpayment together with interest, if any, shall be refunded in the manner provided in subsection (a). The interest shall be allowed and paid at the rate of two-thirds of one per cent for each calendar month or fraction thereof, beginning with the first calendar day after the due date of the return or, if the return is filed after the prescribed due date, the first month following the month the return is received, and continuing until the date that the commissioner approves the refund voucher. If the commissioner approves the refund voucher within ninety days from the due date or the date the return is received, whichever is later, and the comptroller of the State sends the taxpayer a refund warrant within forty-five days from the date of the commissioner's approval, no interest on the overpayment will be allowed or paid. However, if either the commissioner or the comptroller exceeds the time allowed herein, interest will be computed from the first calendar day after the due date of the return or from the first month following the month the return is received by the commissioner if the return is filed after the prescribed due date, until the date that the comptroller sends the refund warrant to the taxpayer.

(2) If any overpayment of taxes results or arises from

(A) The taxpayer filing an amended return, or from

(B) A determination made by the commissioner and such overpayment is not shown on the original return as filed by the taxpayer, interest on the overpayment shall be allowed and paid from the first calendar day after the due date of the original return or, if the original return is filed after the prescribed due date, the first month following the month the return is received, to the date that the commissioner signs the refund voucher. If the comptroller does not send the refund warrant to the taxpayer within forty-five days after the commissioner's approval, interest will continue until the date that the comptroller sends the refund warrant to the taxpayer.

(3) In the case of credit, interest shall be allowed and paid from the first calendar day after the due date of the return, the first month following the month the return is received by the commissioner, or the date of payment, whichever is later, to the date the credit is taken; provided that the commissioner may make a refund of any credit to a taxpayer where the taxpayer has no underpayment against which to apply the credit. [L 1987, c 347, pt of §2; am L 1992, c 236, §7; am L 1999, c 163, §15; am L 2000, c 162, §1 and c 182, §6; am L 2002, c 39, §12]

## Case Notes

As agencies may not pass upon the constitutionality of statutes, had insurers initially brought a claim under this section, insurance commissioner, as an administrative officer, would have been powerless to declare fees imposed on insurers pursuant to this section unconstitutional or to provide a refund on that basis; thus, as there were no remedies for insurers' constitutional claims under this section, circuit court did not lack subject matter jurisdiction by virtue of insurers' failure to exhaust their administrative remedies under this

section. 120 H. 51, 201 P.3d 564 (2008).

Where subsection (a) did not establish a true available administrative remedy for challenging the constitutionality of the insurance division's assessments against insurers, trial court did not err in rejecting State's failure-to-exhaust defense. 117 H. 454 (App.), 184 P.3d 769 (2008).

**§431:7-204 In lieu provision.** As to insurers, the taxes and fees imposed by section 431:7-201 to section 431:7-204, and the fees imposed by this code, when paid shall be in settlement of and in lieu of all demands for taxes, licenses, or fees of every character imposed by the laws of this State, the ordinances or other laws, rules, or regulations of any county of this State, except:

(1) As expressly otherwise provided;

(2) Taxes on real property;

(3) Taxes on the purchase, use, or ownership of tangible personal property; and

(4) Taxes on gross income, gross proceeds, gross rental, or gross rental proceeds under chapter 237 or 237D.

Nothing in this section shall be deemed to exempt insurers from liability for withholding taxes payable by their employees and paying the same to the proper collection officers, or from keeping such records, and making such returns and reports, as may be required in the case of other persons enjoying tax exemption. [L 1987, c 347, pt of §2; am L 1991, c 286, §4]

**§431:7-204.5 Appeals.** Notwithstanding section 431:2-308, any person aggrieved by any assessment of the tax for any month or any year may appeal from the assessment in the manner and within the time and in all other respects as provided in section 235-114. [L 1992, c 236, §3; am L 2004, c 123, §12]

**Note**

The 2004 amendment applies to tax appeals filed on or after July 1, 2004. L 2004, c 123, §14.

**§431:7-204.6 Limitation period for assessment, levy, collection, or refund.** (a) The amount of insurance taxes imposed by this chapter shall be assessed or levied within three years after the annual return was filed, or within three years of the due date prescribed for the filing of the return, whichever is later, and no proceeding in court without assessment for the collection of any taxes shall be begun after the expiration of the period. Where the assessment of the tax imposed by this chapter has been made within the period of limitation applicable thereto, the tax may be collected by levy or by a proceeding in court under chapter 231; provided that the levy is made or the proceeding was begun within fifteen years after the assessment of the tax. For any tax that has been assessed prior to July 1, 2009, the levy or proceeding shall be barred after June 30, 2024.

Notwithstanding any other provision to the contrary in this section,

the limitation on collection after assessment in this section shall be suspended for the period:

(1) The taxpayer agrees to suspend the period;

(2) The assets of the taxpayer are in control or custody of a court in any proceeding before any court of the United States or any state, and for six months thereafter;

(3) An offer in compromise under section 231-3(10) is pending; and

(4) During which the taxpayer is outside the State if the period of absence is for a continuous period of at least six months; provided that if at the time of the taxpayer's return to the State the period of limitations on collection after assessment would expire before the expiration of six months from the date of the taxpayer's return, the period shall not expire before the expiration of the six months.

In the case of a false or fraudulent return with intent to evade the insurance taxes, or of a failure to file the annual return, the insurance taxes may be assessed or levied at any time; provided that the burden of proof with respect to the issues of falsity or fraud and intent to evade tax shall be upon the State.

(b) In the case of a false or fraudulent return with intent to evade tax, or of a failure to file the annual return, the tax may be assessed or levied at any time.

(c) Where, before the expiration of the period prescribed in subsection (a) or (d), both the commissioner and the taxpayer have consented in writing to the assessment or levy of the tax after the date fixed by subsection (a) or the credit or refund of the tax after the date fixed by subsection (d), the tax may be assessed or levied, or the overpayment, if any, may be credited or refunded, at any time prior to the expiration of the period agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

(d) No credit or refund shall be allowed for any tax imposed by this chapter, unless a claim for such credit or refund shall be filed as follows:

(1) If an annual return is timely filed, or is filed within three years after the date prescribed for filing the annual return, then the credit or refund shall be claimed within three years after the date the annual return was filed or the date prescribed for filing the annual return, whichever is later.

(2) If an annual return is not filed, or is filed more than three years after the date prescribed for filing the annual return, a claim for credit or refund shall be filed within:

(A) Three years after payment of the tax; or

(B) Three years after the date prescribed for the filing of the annual return, whichever is later.

Paragraphs (1) and (2) are mutually exclusive. The limitation shall not apply to a credit or refund pursuant to an appeal provided for by section 431:7-204.5, or to a payment under protest as provided in section 40-35. [L 1992, c 236, §4; am L 2009, c 166, §14]

**Note**

Applicability of L 2009, c 166. L 2009, c 166, §27.

**§431:7-205 Reports to department of taxation.** The commissioner

shall promptly report to the department of taxation all amounts of taxes collected under section 431:7-201 to section 431:7-204 and section 431:8-315 and all amounts of refunds of such taxes made under section 431:7-203. [L 1987, c 347, pt of §2]

**§431:7-206 Domestic company credit for retaliatory taxes paid other states.** If by the laws of any state other than this State, or by the action of any public official of another state, any insurer or company, as defined in section 431:1-202, organized or domiciled in this State, shall be required to pay taxes for the privilege of doing business in the other state, and the amounts are imposed or assessed so that the taxes which are or would be imposed against Hawaii domestic insurance companies are greater than those taxes required of insurers organized or domiciled in the other state, to the extent the amounts are legally due to the other states, an insurer or company organized or domiciled in this State may claim a credit against the tax payable pursuant to this article of a sum not to exceed one hundred per cent of the amount. The credit shall not be greater than the tax payable pursuant to this article during the taxable year. All claims for the tax credit under this section, including any amended claims, shall be filed on or before the end of the twelfth month following the close of the taxable year for which the credit may be claimed. Failure to comply with the foregoing provision shall constitute a waiver of the right to claim the credit. [L 1987, c 348, §14; am L 2009, c 77, §6]

**§431:7-207 Tax credit to facilitate regulatory oversight.** (a) Each authorized insurer that meets the requirements of subsection (b) may claim a tax credit under this section against the tax imposed by section 431:7-202(a) or (b) for the taxable year for which the credit is properly claimed. The tax credit shall be an amount equal to one per cent of the premiums taxed by section 431:7-202(a) and (b).

(b) An insurer may claim the credit only if, at all times during the taxable year, the insurer:

(1) Maintains in Hawaii books and records required by the commissioner sufficient to conduct the examination authorized by section 431:2-302;

(2) Employs in Hawaii personnel knowledgeable about the insurer's financial operations and who are authorized to represent the insurer in all matters pertaining to examination; and

(3) Maintains in Hawaii a customer service center with employees authorized to promptly adjust, settle, and pay claims and to promptly answer all questions from customers regarding their insurance policies.

(c) The commissioner shall prepare the forms necessary to claim a credit under this section, may require proof of the claim for the tax credit, and may adopt rules pursuant to chapter 91.

(d) All claims for the tax credit under this section, including any amended claims, must be filed on or before the end of the twelfth month following the close of the taxable year for which the credit may be claimed. Failure to comply with the foregoing provision shall constitute a waiver of the right to claim the credit.

(e) The tax credit allowed by subsection (a) may be claimed on the interim returns required by section [431:7-202(f)]. [L 1992, c 236, §5; am L 1994, c 160, §2]

**[§431:7-208] Low-income housing, insurance premium tax credit.** The low-income housing tax credit provided under section 235-110.8 shall be operative for this chapter and may be claimed against the tax imposed under section 431:7-202. [L 1999, c 24, §1]

**§431:7-209 High technology business investment tax credit.** (a) The high technology business investment tax credit provided under section 235-110.9 shall be operative for this chapter on July 1, 1999.

(b) For investments made on or after May 1, 2009, this section shall be subject to section 235-109.5. [L 1999, c 178, §27; am L 2009, c 178, §7]

**Revision Note**

"July 1, 1999" substituted for "the effective date of this Act".

The 2009 amendment applies to investments made, renovation costs incurred, or eligible depreciable tangible property placed in service on or after May 1, 2009. L 2009, c 178, §10.

## PART III. DEPOSITS

**§431:7-301 Deposits of insurers.** (a) The director of finance shall accept, when made through the commissioner, deposits of securities or funds by insurers as follows:

(1) Deposits in amount as required to be made as prerequisite to a certificate of authority to transact insurance in this State.

(2) Deposits of insurers in amount as required to be made by the laws of other states as prerequisites for authority to transact insurance in such other states.

(3) Deposits in other additional amounts permitted to be made by this part.

(b) This part shall apply to the deposits listed in this section unless expressly inconsistent with the provisions of article 3 of this code, in which case the provisions of article 3 shall prevail. [L 1987, c 347, pt of §2; am L 1989, c 207, §5]

**§431:7-302 Purpose of deposit.** Each deposit shall be held by the director of finance in trust for the protection of all policyholders, obligees, or creditors in the United States of the insurer making it. [L 1987, c 347, pt of §2]

**§431:7-303 Securities eligible for deposit.** All deposits shall consist of cash or other assets comprised of securities which are eligible for the investment of the funds of insurers under section 431:6-301 representing public obligations, and section 431:6-302 representing corporate obligations. [L 1987, c 347, pt of §2; am L 1989, c 195, §17]

**§431:7-304 Record and receipt.** (a) The director of finance shall keep a record in permanent form of all such funds and securities.

(b) The director of finance shall deliver to the insurer a receipt

for all funds and securities so deposited by it. [L 1987, c 347, pt of §2]

**§431:7-305 Transfer of securities.** (a) No transfer of any funds or security so held on deposit, whether voluntary or by operation of law, shall be valid unless approved in writing by the commissioner and countersigned by the director of finance or by the director's authorized deputy or agent, or unless expressly provided elsewhere in this code.

(b) A statement of each such transfer shall be entered on the records of the director, showing the name of the insurer from whose deposit the transfer is made, the name of the transferee, the par value of securities having par value, and the asset value of other securities as at last recent valuation. [L 1987, c 347, pt of §2]

**§431:7-306 Director may designate depositary.** At the request of an insurer, the director of finance may designate any solvent trust company or other solvent financial institution having trust powers, domiciled in the United States, as the director's depositary to receive and hold any such deposit. Any deposit so held shall be at the expense of the insurer. [L 1987, c 347, pt of §2]

**§431:7-307 Responsibility for deposits.** This State shall be responsible for the safekeeping and return of all funds and securities deposited pursuant to section 431:7-301 to section [431:7-311] with the director of finance. The insurer shall be responsible for the safekeeping and return of all funds and securities deposited pursuant to section 431:7-306. [L 1987, c 347, pt of §2]

**§431:7-308 Dividends and substitutions.** While solvent and complying with this part, an insurer shall be entitled:

(1) To collect and receive interest and dividends accruing on the securities so held on deposit for its account, and

(2) From time to time to exchange and substitute for any of such securities, other securities eligible for deposit and of at least equal value. [L 1987, c 347, pt of §2]

**§431:7-309 Release of deposit.** (a) Any required deposit or portion thereof shall be released in these instances only:

(1) Upon extinguishment of all liabilities or portion thereof, of the insurer for the security of which the deposit is held, by reinsurance contract or otherwise.

(2) If any such deposit or portion thereof is no longer required under this part.

(3) Upon proper order of a court of competent jurisdiction the deposit or portion thereof shall be released to the receiver, conservator, rehabilitator, or liquidator of the insurer for whose account the deposit is held.

(b) No such release shall be made except on application to and written order of the commissioner made upon proof satisfactory to the commissioner of the existence of one of such grounds therefor. The commissioner shall not have any personal liability for any such release of any deposit or part thereof so made by the commissioner in good faith.

(c) All releases of deposits or any part thereof shall be made to the person then entitled thereto upon proof of title satisfactory to the commissioner. [L 1987, c 347, pt of §2]

**§431:7-310 Voluntary excess deposit.** An insurer may deposit and maintain on deposit with the director of finance through the commissioner funds and eligible securities in amount exceeding its required deposit under this part by not more than $100,000 for the purpose of absorbing fluctuations in the value of securities held in its required deposit, and to facilitate the exchange and substitution of such required securities. During the solvency of the insurer, any such excess deposit, or any part thereof, shall be released to it upon its request. During the insolvency of the insurer, such excess deposit shall be released only as provided in section 431:7-309. [L 1987, c 347, pt of §2]

**§431:7-311 Not subject to levy.** No judgment creditor or other claimant of an insurer shall levy upon any deposit held pursuant to this article or upon any part hereof. [L 1987, c 347, pt of §2]

## ARTICLE 8
## UNAUTHORIZED INSURERS AND SURPLUS LINES

### Cross References

Insurance policies issued to construction professionals, see §431:1-217.

### PART I. GENERAL PROVISIONS

**§431:8-101 Scope.** This article shall apply to the placement of insurance in insurers not authorized to transact insurance in the state in which the subject resident is located or in which the insurance contract will be performed. [L 1987, c 347, pt of §2; am L 2011, c 68, §4]

**§431:8-102 Definitions.** As used in this article:

"Approved continuing education course" means a course approved by the commissioner following receipt of recommendations from insurance professionals.

"Approved course provider" means an individual or entity that is approved to offer continuing education courses pursuant to article 9A.

"Authorized insurer" means an insurer holding a valid certificate of authority to transact an insurance business in the state in which the subject resident is located or in which the insurance contract will be performed.

"Business entity" means an association, corporation, individual, limited liability company, limited liability partnership, partnership, person, or other legal entity.

"Credit hour" means the value assigned to an approved continuing education course that is equivalent to at least fifty minutes of classroom instruction.

"Exempt commercial purchaser" means any person purchasing commercial

insurance which, at the time of placement, employs or retains a qualified risk manager to negotiate insurance coverage; and has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding twelve months. The person shall possess a net worth in excess of $20,000,000; generate annual revenues in excess of $50,000,000; employ more than five hundred full-time or full-time equivalent employees per individual insured or be a member of an affiliated group employing more than 1,000 employees in the aggregate; be a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30,000,000; or be a municipality with a population in excess of 50,000 persons. Effective January 1, 2015, and every five years thereafter, the amount of net worth, annual revenues, and budgeted expenditures shall be adjusted to reflect the percentage change for that five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the federal Department of Labor.

"Home state" means, with respect to an insured, the state in which an insured maintains the insured's principal place of business or, in the case of an individual, the state in which the individual maintains the individual's principal residence; provided that if one hundred per cent of the insured risk is located out of the state where the insured maintains the insured's principal place of business or the state where the individual maintains the principal residence, the home state shall be the state where the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

"Home state" means, with respect to an insured, the state in which an insured maintains the insured's principal place of business or, in the case of a surplus lines broker, the state in which the surplus lines broker maintains the surplus lines broker's principal residence or principal place of business and is licensed to act as a surplus lines broker; provided that if one hundred per cent of the insured risk is located out of the state where the insured maintains the insured's principal place of business or the state where the individual maintains the principal residence, the home state shall be the state where the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

"Home state of affiliated group" means the home state of the member of the affiliated group that has the largest percentage of premium attributed to it under an insurance contract that has more than one insured from the affiliated group listed as named insureds on a single unauthorized insurance contract.

"Home state of group insurance" means the home state of the group policyholder who pays one hundred per cent of the premium from the policyholder's own funds. When the group policyholder does not pay one hundred per cent of the premium from the policyholder's own funds, the term "home state of group insurance" means the home state of the group member.

"Inactive" means that the authority of a license issued by the commissioner is not in effect.

"Independently procured insurance" means insurance obtained by an insured directly from an unauthorized insurer as permitted by the laws of the insured's home state.

"Individual" means a natural person or a business entity.

"License" means a document issued by the commissioner authorizing a person to act as a surplus lines broker as specified in the document. The license itself shall not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurer.

"Licensee" means a surplus lines broker licensed under this article.

"Multi-state risk" means a risk covered by an unauthorized insurer with insured exposures in more than one state.

"Principal place of business" means, with respect to determining the home state of the insured:

(1) The state where the insured maintains the insured's headquarters and where the insured's high-level officers direct, control, and coordinate the business activities;

(2) If the insured's high-level officers direct, control, and coordinate the business activities in more than one state, the state in which the greatest percentage of the insured's taxable premium for that insurance contract is allocated; or

(3) If the insured maintains the insured's headquarters or the insured's high-level officers direct, control, and coordinate the business activities outside any state, the state in which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

"Principal residence" means, with respect to determining the home state of the individual insured:

(1) The state where the individual insured resides for the greatest number of days during a calendar year; or

(2) If the insured's principal residence is located outside any state, the state in which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

"Single state risk" means a risk with insured exposures in only one state.

"Surplus lines broker" means any person licensed under section 431:8-310 to place insurance on risks resident, located, or to be performed in this State with unauthorized insurers.

"Surplus lines insurance" means any property and casualty insurance on risks procured from or placed with an unauthorized insurer under the laws of the insured's home state. Surplus lines insurance, when this State is the home state of the insured, shall be in accordance with part III of this article.

"Unauthorized insurer" means an insurer not holding a valid certificate of authority to transact an insurance business in the state in which the subject resident is located or in which the insurance contract will be performed. [L 1987, c 347, pt of §2; am L 1989, c 195, §18; am L 2002, c 155, §13; am L 2011, c 68, §5; am L 2011, c 68, §5; am L 2012, c 66, §3]

## PART II. UNAUTHORIZED INSURERS

**§431:8-201 Transacting insurance business without certificate of authority prohibited.** It shall be unlawful for any insurer to transact an insurance business in this State, as defined in section 431:1-215, without a certificate of authority; provided that this section shall not apply to:

(1) The lawful transaction of surplus lines insurance;

(2) The lawful transaction of reinsurance by insurers;

(3) Transactions in this State involving a policy lawfully solicited, written, and delivered outside of this

State covering only subjects of insurance not resident, located, or expressly to be performed in this State at the time of issuance, and subsequent to the issuance of the policy;

(4) Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses;

(5) Transactions in this State involving group life and group accident and health or sickness or blanket accident and health or sickness insurance or group annuities where the master policy of the groups was lawfully issued in and delivered pursuant to the laws of a state in which the insurer was authorized to do an insurance business;

(6) Transactions in this State involving any policy of insurance or annuity contract issued prior to July 1, 1988;

(7) Transactions in this State involving ocean marine insurance; and

(8) Transactions of contracts of insurance for property and casualty multi-state risks; provided that the producer is licensed to sell, solicit, or negotiate that insurance in the home state of the insured. [L 1987, c 347, pt of §2; am L 1989, c 195, §19; am L 2003, c 212, §43; am L 2011, c 68, §6]

**§431:8-202 Acting for or aiding unauthorized insurer prohibited.** (a) No person shall directly or indirectly act as producer for, or otherwise represent or aid on behalf of another, any unauthorized insurer in the solicitation, negotiation, procurement, or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist an unauthorized insurer in the transaction of an insurance business.

(b) This section does not apply to:

(1) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this State; and

(2) The property and operation of aircraft engaged in interstate or foreign commerce. [L 1987, c 347, pt of §2; am L 1989, c 195, §20; am L 2002, c 155, §14; am L 2006, c 154, §4]

**§431:8-203 Validity of contracts illegally effectuated.** A contract of insurance effectuated by an unauthorized insurer in violation of this article shall be voidable except at the instance of the insurer. [L 1987, c 347, pt of §2]

**§431:8-204 Liability of person assisting unauthorized insurer.** In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of such insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of such insurance contract and who knew or should have known the transaction was illegal shall be liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of the insurance contract. [L 1987, c 347, pt of §2]

**§431:8-205 Insurance independently procured; duty to report and pay tax.** (a) Nothing in this part shall prohibit a person from

independently procuring, continuing, or renewing insurance from an insurer which is not authorized to transact insurance in this State.

(b) Each insured who in this State, before July 1, 2011, procures, continues, or renews surplus lines insurance on a risk located or to be performed in whole in this State, other than insurance procured through a surplus lines broker pursuant to part III of this article shall file within sixty days after the date the insurance was procured, continued, or renewed, a written report with the commissioner. Each insured who in this State, after June 30, 2011, procures, continues, or renews surplus lines insurance for which this State is the home state of the insured, other than insurance procured through a surplus lines broker pursuant to part III of this article shall file within forty-five days after the end of the calendar quarter in which the insurance was procured, continued, or renewed, a written report with the commissioner. The report shall be on forms prescribed by the commissioner, showing:

(1) The name and address of the insured or insureds;

(2) The name and address of the insurer;

(3) The subject of the insurance;

(4) A general description of the coverage;

(5) The itemized amount of premiums, taxes, and fees currently charged for each state;

(6) The policy number, effective date of the policy, and home state of the insured; and

(7) Other additional, pertinent information requested by the commissioner.

(c) Gross premiums charged for the surplus lines insurance allocable to this State, less any return premiums, are subject to a tax at the rate of 4.68 per cent. At the time of filing the report required in subsection (b) for insurance procured, continued, or renewed before July 1, 2011, the insured shall pay the tax to the commissioner. At the time of filing the report required in subsection (b) for insurance procured, continued, or renewed after June 30, 2011, if this State is the home state of the insured, the insured shall pay the tax and fees of this State and all other states to the director of finance, through the commissioner. If this State is not the home state of the insured, the insured shall pay the tax and fees of this State to the home state of the insured.

As used in this subsection, "gross premiums" means the amount of the policy or coverage premium charged by the insurer in consideration for the insurance contract. Any charges for policy, survey, inspection, service, or similar fees or other charges added by the broker shall not be considered part of gross premiums.

(d) If an independently procured policy covers risks or exposures only partially located or to be performed in this State, the tax payable shall be computed on the portion of the premium properly attributable to the risks or exposures located or to be performed in this State.

(e) Delinquent taxes shall bear interest at the rate of ten per cent per annum.

(f) This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify, any provision of section 431:8-202 or any other provision of this code.

(g) This section shall not apply to life insurance, accident and health or sickness insurance, or annuities. [L 1987, c 348, §15; am L

1989, c 195, §21; am L 2003, c 212, §44; am L 2006, c 154, §5; am L 2011, c 68, §7]

**§431:8-206 Commissioner may enjoin unauthorized insurers.** Whenever the commissioner believes, from evidence satisfactory to the commissioner, that any insurer is violating or about to violate the provisions of section 431:8-201, the commissioner may bring an action in accordance with the commissioner's injunctive authority under article 2. [L 1987, c 347, pt of §2]

**§431:8-207 Legal process against unauthorized insurer; how service of process made.** (a) Any act of transacting an insurance business in this State by any unauthorized insurer is equivalent to and shall constitute an irrevocable appointment by such insurer, binding upon the insurer, the insurer's personal representative, or successor in interest if a corporation, of the commissioner or the commissioner's successor in office, to be the true and lawful attorney of the insurer upon whom may be served all lawful process in any action, suit, or proceeding in any court by the commissioner or by the State or others, and upon whom may be served any notice, order, pleading, or process in any proceeding before the commissioner, and which arises out of transacting an insurance business in this State by such insurer. Any act of transacting an insurance business in this State by any unauthorized insurer shall be acknowledgement of its agreement that such service of process is of the same legal force and validity as personal service of process in this State upon the insurer.

(b) Service of process in an action or proceeding shall be made in accordance with section 431:2-206. Service is sufficient if:

(1) Notice of service and a copy of the court process or the notice, order, pleading, or process in the administrative proceeding are sent within ten days by registered mail by the plaintiff or the plaintiff's attorney in the court proceeding, or by the commissioner in the administrative proceeding, to the defendant or defendant's agent or representative at the defendant's last known principal place of business;

(2) The defendant's receipt, or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in a court proceeding, or of the commissioner in an administrative proceeding, are filed with the clerk of the court in which the proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant is required to appear or respond, or within any further time as the court or commissioner may allow.

(c) No plaintiff shall be entitled to a judgment or a determination by default in any court or administrative proceeding in which process is served under this section until the expiration of forty days from the date of filing of the affidavit of compliance.

(d) Nothing in this section shall limit or affect the right to serve any process, notice, order, or demand upon any person or insurer in any other manner now or hereafter permitted by law. [L 1987, c 347, pt of §2; am L 2006, c 154, §6]

**§431:8-208 Defense of action by unauthorized insurer; bond.** (a) Before any unauthorized insurer files or causes to be filed any pleading in any court action, suit, or proceeding, or any notice, order, pleading, or process in an administrative proceeding before the commissioner,

instituted against such person or insurer by service made as provided in section 431:8-207, such insurer shall either:

(1) Deposit with the clerk of the court in which such action, suit, or proceeding is pending, or with the commissioner in administrative proceedings, cash or securities, or file a bond with good and sufficient sureties to be approved by the court or commissioner, in an amount fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in such action or administrative proceeding, or

(2) Procure a certificate of authority to transact insurance in this State.

(b) The commissioner, in any administrative proceeding in which service is made as provided in section 431:8-207, may in the commissioner's discretion order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (a) and to defend such action.

(c) Nothing in subsection (a) shall be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service made in the manner provided in section 431:8-207 on the ground that the unauthorized insurer has not transacted any insurance business in this State. [L 1987, c 347, pt of §2; am L 2003, c 212, §45; am L 2004, c 122, §25]

**§431:8-209 Attorney's fees.** In an action against an unauthorized insurer upon a contract of insurance issued or delivered to a person in this State, if the insurer has failed for thirty days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that the refusal was vexatious and without reasonable cause, the court may allow to the plaintiff reasonable attorney's fees and include the fees in any judgment that may be rendered in the action. The fee shall not exceed twelve and one-half per cent of the amount that the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall the fee be less than $25. Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause. [L 1987, c 347, pt of §2; am L 2006, c 154, §7]

**§431:8-210 Advertising prohibited.** (a) No publication published in this State, or radio or television broadcaster, or any other agency or means for the dissemination of information operated or located in this State shall publish, broadcast, or otherwise disseminate within this State, advertising for or on behalf of any insurer not then authorized to transact insurance in this State.

(b) This section does not apply to publications published in this State principally for circulation in the continental United States, wherein advertising by or on behalf of an unauthorized insurer is not directed expressly toward residents or subjects of insurance in this State. [L 1987, c 347, pt of §2]

**§431:8-211 Penalties.** (a) Any person, other than an insured, who represents or aids an unauthorized insurer in violation of this part may be subject to a fine not in excess of $1,000.

(b) Any unauthorized insurer who transacts any unauthorized act of an insurance business as set forth in this part may be fined not more

than $10,000. [L 1987, c 347, pt of §2; am L 1989, c 207, §6; am L 2006, c 154, §8]

## PART III. SURPLUS LINES INSURANCE

§431:8-300 Exemptions from surplus lines law. This part shall not apply to reinsurance or to the following insurance when placed by a licensed producer of this State:

(1) Ocean marine insurance;

(2) Insurance on subjects located, resident, or to be performed wholly outside this State, or on vehicles or aircraft owned and principally garaged outside this State; or

(3) Insurance of aircraft or cargo of such aircraft, or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of such aircraft. [L 1989, c 195, §2; am L 2002, c 155, §15]

**§431:8-301 Insurance placed with unauthorized insurer permitted.** (a) In addition to section 431:8-205, insurance may be procured from an unauthorized insurer; provided that:

(1) The insurance is procured through a surplus lines broker licensed in the insured's home state;

(2) The full amount or kind of insurance cannot be obtained from insurers who are authorized to do business in this State; provided that a diligent search is made among the insurers who are authorized to transact and are actually writing the particular kind and class of insurance in this State each time the insurance is placed or renewed;

(3) The surplus lines insurance procured is in addition to or in excess of the amount and coverage which can be procured from the authorized insurers; and

(4) The insurance is not procured at a rate lower than the lowest rate that is generally acceptable to authorized insurers transacting that kind of business and providing insurance affording substantially the same protection.

(b) A surplus lines broker is not required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from authorized insurers when the broker is seeking to procure or place unauthorized insurance for an exempt commercial purchaser; provided that:

(1) The broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that the insurance may or may not be available from the admitted market which may provide greater protection with more regulatory oversight; and

(2) The exempt commercial purchaser has subsequently requested in writing for the broker to procure or place the insurance from an unauthorized insurer. [L 1987, c 347, pt of §2; am L 2011, c 68, §8]

### Revision Note

Subsection designation deleted.

**§431:8-302 Surplus lines insurers.** (a) No surplus lines broker shall, either knowingly or without reasonable investigation of the financial condition and general reputation of the insurer, place insurance with a financially unsound insurer or with an insurer engaging in an unfair practice.

(b) A surplus lines broker may place surplus lines insurance only with insurers who are authorized to write that type of insurance in the insurer's domiciliary state.

(c) A surplus lines broker shall not place coverage with an unauthorized insurer unless, at the time of placement, the surplus lines broker has determined that:

(1) The unauthorized insurer has capital and surplus or its equivalent under the laws of its domiciliary state that equal the greater of the minimum capital requirement of this State or a minimum of $15,000,000; provided that:

(A) Minimum capital requirements may be satisfied by the insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner;

(B) A finding of acceptability pursuant to subparagraph (A) shall be based upon factors such as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry; and

(C) The commissioner shall not make an affirmative finding of acceptability pursuant to subparagraph (A) if the unauthorized insurer's capital and surplus is less than $4,500,000; or

(2) For an insurer not domiciled in the United States or its territories, the insurer shall be listed on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department; provided that:

(A) If an alien insurer is not in the Quarterly Listing of Alien Insurers, the surplus lines broker shall maintain in the broker's office evidence of the financial responsibility of the insurer; and

(B) Evidence satisfactory to the commissioner that the insurer maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System in an amount of not less than $5,400,000 consisting of cash, securities, letters of credit, or of investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of authorized insurers writing like kinds of insurance in this State, for the protection of all its policyholders in the United States, shall constitute prima facie evidence of the financial responsibility of the insurer.

(d) The commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to unauthorized insurers domiciled in another state. [L 1987,

c 347, pt of §2; am L 1993, c 205, §12; am L 2000, c 182, §7; am L 2011, c 68, §9]

**§§431:8-303, 304 REPEALED.** L 1989, c 207, §16.

**§431:8-305 Evidence of insurance; changes; penalties.** (a) Upon placing surplus lines insurance, the surplus lines broker shall as soon as reasonably possible deliver to the insured the policy or, if the policy is not available, the surplus lines broker's certificate, cover note, binder, or other evidence of insurance. Any confirmation of insurance shall be executed by the surplus lines broker and shall show:

(1) The policy number, effective date, home state, and a description and location of the subject of the insurance;

(2) A general description of the coverages, including any material limitations other than those in standard forms;

(3) The premium and rate charged, itemized by each state;

(4) The taxes and fees to be collected from the insured, itemized by each state;

(5) The name and address of the insured;

(6) The name and address of the insurer;

(7) If the direct risk is assumed by more than one insurer, the certificate shall state the name and address and proportion of the entire direct risk assumed by each insurer; and

(8) The name of the surplus lines broker and such broker's license number.

(b) No surplus lines broker shall issue or deliver any evidence of insurance or purport to insure, or represent that insurance has or will be written by any unauthorized insurer, unless the broker has authority from the insurer to cause the risk to be insured, or has received information from the insurer in the regular course of business that such insurance has been granted.

(c) If after delivery of the evidence of insurance there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the original evidence of insurance, the surplus lines broker shall as soon as reasonably possible issue and deliver to the insured a substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurer's responsibility thereunder.

(d) As soon as reasonably possible after the placement of any such insurance, the surplus lines broker shall procure from the insurer its policy or, if not available, a certificate of insurance and deliver it to the insured to replace any evidence of insurance initially issued to the insured.

(e) Any surplus lines broker who fails to comply with the requirements of this section shall be subject to the penalties provided in section 431:8-320. [L 1987, c 347, pt of §2; am L 2011, c 68, §10]

**§431:8-306 Signature of broker and special endorsement of surplus lines policy.** Every insurance contract procured and delivered as a surplus lines coverage pursuant to this part, including any evidence of insurance other than a policy, shall:

(1) Bear the name and address of the surplus lines broker who procured it, and

(2) Have stamped or written conspicuously upon the first page of the contract the following:

"This insurance contract is issued by an insurer which is not licensed by the State of Hawaii and is not subject to its regulation or examination. If the insurer is found insolvent, claims under this contract are not covered by any guaranty fund of the State of Hawaii." [L 1987, c 347, pt of §2]

**§431:8-307 Broker's duty to notify insured.** No contract of insurance placed by a surplus lines broker under this part and no premium charged therefor shall be due and payable until the surplus lines broker, when business is originated by a surplus lines broker, or the producer, when business is referred to a surplus lines broker from a licensed producer, has notified the insured in writing that:

(1) The insurer with which the surplus lines broker placed the insurance is not licensed by this State and is not subject to its supervision; and

(2) In the event of the insolvency of the surplus lines insurer, losses will not be paid by any of the State's insurance guaranty funds.

A copy of the notice shall be maintained by the broker with the records of the contract and available for examination.

Nothing in this section shall nullify any agreement by any insurer to provide insurance. [L 1987, c 347, pt of §2; am L 2002, c 155, §16; am L 2003, c 212, §46]

**§431:8-308 Surplus lines insurance valid.** Insurance contracts procured as surplus lines coverage from unauthorized insurers shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers. [L 1987, c 347, pt of §2]

**§431:8-309 Effect of payment to surplus lines broker.** Payment of a premium to a surplus lines broker acting for a person other than the surplus lines broker in negotiating, continuing, or reviewing any policy of insurance under this part shall be deemed to be payment to the insurer, notwithstanding whatever conditions or stipulations may be inserted in the policy or contract. [L 1987, c 347, pt of §2]

**§431:8-310 Surplus lines broker license required; application and qualifications for license.** (a) No person shall procure any contract of surplus lines insurance with an unauthorized insurer unless the person is licensed as a surplus lines broker.

(b) A person applying for a surplus lines broker license shall apply to the commissioner on the uniform application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, accurate, and complete to the best of the applicant's knowledge and belief. Before approving the

application, the commissioner shall find that the applicant:

(1) Is at least eighteen years of age;

(2) Has not committed any act that is a ground for a licensure sanction set forth in section 431:8-317;

(3) Has paid the applicable fees set forth in section 431:7-101;

(4) Has passed, within the two years immediately preceding the date of the application or issuance of the license, whichever is later, the applicable examination; and

(5) Has submitted a full set of fingerprints, including a scanned file from a hard copy fingerprint, for the commissioner to obtain and receive national and state criminal history records checks from the Federal Bureau of Investigation and the Hawaii criminal justice data center, pursuant to section 846-2.7.

(c) The commissioner may require any documents reasonably necessary to verify the information contained in an application.

(d) The commissioner shall issue a surplus lines broker license to any producer licensed under article 9A, except producers licensed under section 431:9A-107(a)(1), (2), or (5), when the producer has:

(1) Remitted the annual license fee to the commissioner as provided in article 7; and

(2) Submitted a completed license application on a form furnished by the commissioner.

(e) A surplus lines broker license shall be inactivated if the licensee fails to pay any required fee or penalty. A surplus lines broker who allows the surplus lines broker's license to become inactive for nonpayment of the renewal fee may reinstate that license without the necessity of a written examination; provided that the surplus lines broker:

(1) Pays the fee and a penalty in the amount of fifty per cent of the then unpaid fees within twenty-four months from the inactivation date; and

(2) Is in compliance with all requirements of chapter 431.

The license shall automatically expire if the surplus lines broker does not reinstate the surplus lines broker's license within the twenty-four month period.

(f) Business entities shall be eligible to be surplus lines brokers, upon meeting the following conditions:

(1) The business entity licensee shall list individuals within the business entity who have satisfied all requirements of this part to become surplus lines brokers;

(2) Only those individuals listed on the business entity's license shall transact surplus lines business; and

(3) A natural person licensed as a surplus lines broker shall be identified as the business entity's designated representative.

(g) Licensing procedure, duration, and related matters shall be governed by article 7. [L 1987, c 347, pt of §2; am L 1993, c 205, §13; am L 2002, c 155, §17; am L 2004, c 122, §26; am L 2006, c 154, §9; am L 2009, c 77, §7; am L 2012, c 66, §4]

§431:8-311 Compensation. A licensed surplus lines broker may

accept and place surplus lines business from any producer licensed in this State for the class of insurance involved, and may compensate the producer therefor. [L 1987, c 347, pt of §2; am L 2002, c 155, §18]

**§431:8-312 Records of surplus lines broker.** (a) Each licensed surplus lines broker shall keep in the broker's office in this State a full and true record of each surplus lines contract placed by the broker including a copy of the policy, certificate, cover note, or other evidence of insurance including, as applicable:

(1) Amount of the insurance and perils insured;

(2) Brief description of the property insured and its location;

(3) Gross premium, taxes, and fees charged, itemized by each state;

(4) Any return premium, taxes, and fees paid, itemized by each state;

(5) Rate of premium charged upon the several items of property;

(6) Effective date of the contract and its terms;

(7) Name, address, and home state of the insured;

(8) Name and address of the insurer;

(9) Amount of tax and other sums to be collected from the insured, itemized by each state; and

(10) Any additional information required by the commissioner.

(b) For each contract of insurance placed by a surplus lines broker, the broker shall maintain a written statement as to the diligent efforts by the surplus lines broker or the producer to place the insurance with authorized insurers.

(c) The record of each contract shall be kept open at all reasonable times to examination by the commissioner without notice for a period not less than five years following the termination of the contract. [L 1987, c 347, pt of §2; am L 1989, c 207, §7; am L 2002, c 155, §19; am L 2011, c 68, §11]

**§431:8-313 Surplus lines broker's reports to commissioner.** (a) Each surplus lines broker shall file with the commissioner on or before March 15, 2011, a verified statement of all surplus lines insurance transacted during 2010. Each surplus lines broker shall file with the commissioner on or before September 15, 2011, a verified statement of all surplus lines insurance transacted after December 31, 2010, and before July 1, 2011. After June 30, 2011, each surplus lines broker shall file with the commissioner within forty-five days of the end of each calendar quarter a verified statement of all surplus lines insurance transacted during the calendar quarter as follows:

(1) The statement for the quarter ending March 31 shall be filed on or before May 15;

(2) The statement for the quarter ending June 30 shall be filed on or before August 15;

(3) The statement for the quarter ending September 30 shall be filed on or before November 15; and

(4) The statement for the quarter ending December 31 shall be filed on or before February 15.

(b) The statement shall be on forms as prescribed and furnished by the commissioner and shall show:

(1) Gross amount of premiums for each kind of insurance transacted;

(2) Aggregate gross premiums charged, itemized by each state;

(3) Aggregate of returned premiums paid to insureds, itemized by each state;

(4) Aggregate of net premiums and fees, itemized by each state;

(5) Amount of aggregate remitted taxes and fees, itemized by each state; and

(6) Additional information as required by the commissioner. [L 1987, c 347, pt of §2; am L 2003, c 212, §47; am L 2011, c 68, §12]

**§431:8-314 Surplus lines advisory organizations.** (a) An advisory surplus lines organization of surplus lines brokers may be formed to:

(1) Facilitate and encourage compliance by its members with the laws of this State and the rules and regulations of the commissioner relative to surplus lines insurance;

(2) Provide means for the examination, which shall remain confidential, of all surplus lines coverage written by its members to determine whether such coverages comply with such laws and regulations;

(3) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market; and

(4) Receive and disseminate to its members information relative to surplus lines coverages.

(b) Every such advisory organization shall file with the commissioner:

(1) A copy of its constitution, its articles of agreement or association or its certificate of incorporation;

(2) A copy of its bylaws, rules and regulations governing its activities;

(3) A current list of its members;

(4) The name and address of its authorized resident agent upon whom notices or orders of the commissioner or processes issued at the commissioner's direction may be served, and

(5) An agreement that the commissioner may examine such advisory organization in accordance with the provisions of subsection (c).

(c) The commissioner shall, at least once in every five years, make or cause to be made an examination of each such advisory organization. The reasonable cost of any such examination shall be paid by the advisory organization upon presentation to it by the commissioner of a detailed account of each cost. The officers, managers, agents, and employees of such advisory organization may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. The commissioner shall furnish two copies of the examination report to the advisory organization examined

and shall notify such organization that it may, within twenty days thereof, request a hearing on the report or on any facts or recommendations therein. If the commissioner finds such advisory organization or any of its members to be in violation of this part, the commissioner may issue an order requiring the discontinuance of such violation. [L 1987, c 347, pt of §2]

**§431:8-315 Tax on surplus lines.** (a) On or before March 15, 2011, each surplus lines broker shall pay to the director of finance, through the commissioner, a premium tax on surplus lines insurance transacted by the broker during 2010. On or before September 15, 2011, each surplus lines broker shall pay to the director of finance, through the commissioner, a premium tax on surplus lines insurance transacted by the broker after December 31, 2010, and before July 1, 2011. After June 30, 2011, within forty-five days after the end of each calendar quarter, each surplus lines broker shall pay to the director of finance, through the commissioner, a premium tax on surplus lines insurance transacted by the broker during the calendar quarter for insurance for which this State is the home state of the insured. The tax rate shall be in the amount of 4.68 per cent of gross premiums, less return premiums, on surplus lines insurance allocated to this State. The tax rate and fees of other states shall be applied to the gross premiums, less return premiums, allocated to those states.

As used in this subsection, "gross premiums" means the amount of the policy or coverage premium charged by the insurer in consideration for the insurance contract. Any charges for policy, survey, inspection, service, or similar fees or other charges added by the broker shall not be considered part of gross premiums.

(b) The commissioner shall collect the taxes and fees on independently procured surplus lines insurance and from surplus lines licensees and disburse to the other states the funds earned by each state; provided that the other state has a reciprocal allocation and disbursement procedure for the benefit of this State. To the extent that other states, where portions of the properties, risks, or exposures reside, have failed to establish a reciprocal allocation and disbursement procedure with this State, the net premium tax collected shall be retained by this State.

(c) If a surplus lines policy covers risks or exposures only partially resident in this State, the tax payable shall be computed upon the proportion of the premium which is properly allocable to the risks or exposures located in this State. The taxes and fees payable to this State on policies that cover risks and exposures only partially resident in this State shall be remitted on the quarterly schedule established by subsection (a) to the home state of the insured for disbursement to this State.

(d) The tax on any portion of the premium unearned at the termination of the insurance contract shall be returned to the policyholder.

(e) The commissioner may:

(1) Enter into a cooperative agreement, reciprocal agreement, or compact with other states to facilitate and provide for the collection, allocation, and disbursement of premium taxes attributable to the placement of surplus lines insurance;

(2) Provide for uniform methods of allocation and reporting among surplus lines insurance risk classifications;

(3) Conform to the requirements of the federal Nonadmitted and Reinsurance Reform Act of 2010;

(4) Share information among states relating to surplus lines insurance premium taxes; and

(5) Utilize a method adopted in cooperation with other states to allocate risk and compute the tax due on the portion of premium attributable to each risk classification and to each state where properties, risks, or exposures are located.

The commissioner shall assess the insured for the cost of the cooperative agreement, reciprocal agreement, or compact to collect and distribute the premium taxes. Upon application of the insured, the commissioner shall refund the insured for excess payments of taxes received by the State that are the result of the statewide tax rate. [L 1987, c 347, pt of §2; am L 2003, c 212, §48; am L 2006, c 154, §10; am L 2011, c 68, §13]

**Revision Note**

The paragraph defining "gross premiums" was moved from subsection (b) to subsection (a) pursuant to §23G-15.

**§431:8-316 Penalty for failure to file statement or remit tax.**

(a) If any surplus lines broker fails to:

(1) File statements required by section 431:8-313; or

(2) Pay the premium tax required by section 431:8-315 when the tax is due,

the surplus lines broker may be liable for a fine of up to $25 for each day of delinquency.

(b) The commissioner may:

(1) Collect the premium tax required by section 431:8-315 by distraint;

(2) Recover the premium tax required by section 431:8-315 and fine for failure to pay the premium tax by instituting an action in any court of competent jurisdiction; or

(3) Recover the fine for failure to file the statements required by section 431:8-313 by instituting an action in any court of competent jurisdiction. [L 1987, c 347, pt of §2; am L 2003, c 212, §49; am L 2006, c 154, §11; am L 2011, c 68, §14]

**§431:8-317 License denial, nonrenewal, suspension, or revocation.**

(a) The commissioner may deny, place on probation, suspend, revoke, or refuse to issue or renew any surplus lines broker's license and may levy a civil penalty in accordance with articles 2 and 3, or any combination of these actions, for any cause specified in any other provision of this chapter, or for any of the following causes:

(1) Failure to file statements required by section 431:8-313 or to pay the tax required by section 431:8-315;

(2) Failure to keep records or to allow the commissioner to examine the surplus lines broker's records as provided in this article;

(3) Removal of office accounts and records from this State during the period in which the accounts are required to be maintained under this article;

(4) Any of the causes for which a producer's license may be suspended or revoked under article 9A;

(5) Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner;

(6) Wilful violation or knowing participation in the violation of any provision of this code;

(7) Obtaining or attempting to obtain a license under this chapter through wilful misrepresentation or fraud, or failure to pass any examination required by section 431:8-324;

(8) Misappropriation, conversion to the licensee's own use, or illegally withholding moneys required to be held in a fiduciary capacity;

(9) Material misrepresentation with intent to deceive of the terms or effect of any insurance contract, or engagement or intent to engage in any fraudulent transaction;

(10) Commission of any unfair practice or fraud as defined in article 13;

(11) Conduct of affairs under a license issued pursuant to this chapter in a manner that causes injury and loss to the public;

(12) The issuance or purported issuance of any binder as to any insurer named in the binder if the licensee is not authorized to bind the insurer; or

(13) Dealing or attempting to deal with insurance or exercising powers relative to insurance outside the scope of the licensee's license.

(b) The license of any business entity may be denied, placed on probation, suspended, revoked, not issued, or not renewed for any of the causes applicable to any individual designated in the license to exercise the business entities' powers.

(c) The holder of any license which has been revoked or suspended shall surrender the license certificate to the commissioner at the commissioner's request.

(d) The procedures provided in article 9A for the suspension or revocation of producer licenses shall apply to suspension or revocation of a surplus lines broker's license.

(e) No broker whose license has been revoked shall again be licensed as a broker within one year thereafter, nor until any fines or delinquent taxes owing by the broker have been paid. [L 1987, c 347, pt of §2; am L 1989, c 195, §22; am L 2002, c 155, §20; am L 2003, c 212, §50; am L 2006, c 154, §12; am L 2011, c 68, §15; am L 2012, c 66, §5]

**§431:8-318 Examination of surplus lines broker's accounts and records.** Whenever deemed necessary the commissioner may examine the records and accounts of any surplus lines broker to determine whether the broker is conducting business in accordance with the requirements of this article. [L 1987, c 347, pt of §2; am L 2003, c 212, §51]

**§431:8-319 Actions against surplus lines insurer; service of process.** (a) A surplus lines insurer may be sued upon any cause of action arising in this State under any surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus

lines broker pursuant to the procedure provided in part II of this article. Any such policy issued by the surplus lines broker shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process.

(b) Each insurer assuming a surplus lines insurance in this State shall be deemed thereby to have subjected itself to this article.

(c) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers. [L 1987, c 347, pt of §2]

**§431:8-320 Penalties.** (a) Any surplus lines broker who in this State represents or aids an unauthorized insurer in violation of this article may be fined not more than $1,000.

(b) In addition to any other penalty provided for in this part or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provisions of this article shall be liable to a penalty not exceeding $1,000 for the first offense, and not exceeding $2,000 for each succeeding offense.

(c) The above penalties are not exclusive remedies, penalties may also be assessed under article 13. [L 1987, c 347, pt of §2]

**[§431:8-321] Nonresident licensing.** (a) Except as provided in section 431:8-317, a nonresident applicant shall receive a nonresident surplus lines broker license if:

(1) The applicant is currently licensed and is in good standing as a resident surplus lines broker in the applicant's home state;

(2) The applicant has submitted the proper request for licensure and has paid the fees required by section 431:7-101;

(3) The applicant has submitted or transmitted to the commissioner the application for licensure that the applicant submitted to the applicant's home state, or in lieu of the same, a completed uniform application; and

(4) The applicant's home state awards nonresident surplus lines broker licenses to residents of this State on the same basis.

(b) The commissioner may verify the surplus lines broker's licensing status through the producer database maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries.

(c) A nonresident surplus lines broker who moves from one state to another state or a resident surplus lines broker who moves from this State to another state shall file a change of address with the commissioner and shall provide certification from the new resident state within thirty days of the change of legal residence. No fee or license application shall be required. Failure to timely inform the commissioner of a change in address shall result in a penalty pursuant to section 431:2-203. [L 2012, c 66, pt of §1]

**[§431:8-322] Reciprocity.** (a) The commissioner shall waive any requirements for a nonresident surplus lines broker license applicant with a valid license from the applicant's home state, except for the

requirements imposed by section 431:8-321, if the applicant's home state awards nonresident surplus lines broker licenses to residents of this State on the same basis.

(b) A nonresident surplus lines broker's satisfaction of the surplus lines broker's home state's continuing education requirements for licensed surplus lines brokers shall constitute satisfaction of this State's continuing education requirements if the nonresident surplus lines broker's home state recognizes the satisfaction of its continuing education requirements imposed upon surplus lines brokers from this State on the same basis. [L 2012, c 66, pt of §1]

**[§431:8-323] Exemption from examination.** (a) Subject to section 431:8-322, an individual who applies for a nonresident surplus lines broker license in this State who was previously licensed to sell surplus lines insurance in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was licensed in good standing in that state, or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, indicate that the surplus lines broker's license is or was in good standing.

(b) A person licensed as a surplus lines broker in another state who moves to this State and makes application within ninety days of establishing legal residence to become a resident licensee pursuant to section 431:8-310, shall not be required to satisfy the prelicensing educational components and examination otherwise required to obtain any line of authority previously held in the prior state, provided that the commissioner may impose these or other requirements by rule. [L 2012, c 66, pt of §1]

**[§431:8-324] Surplus lines broker license examination.** (a) An applicant for a surplus lines broker license shall pass a written examination unless exempt pursuant to section 431:8-323. The examination shall test the knowledge of the applicant concerning property, marine and transportation, vehicle, general casualty, and surety insurance, the duties and responsibilities of a surplus lines broker, and the insurance laws and rules of this State.

(b) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting fees pursuant to section 431:7-101. The fees collected shall be nonrefundable.

(c) An applicant who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being scheduled for another examination.

(d) An applicant's examination scores shall be valid for two years from the date of the examination. [L 2012, c 66, pt of §1]

**[§431:8-325] Scope of examination.** (a) The commissioner shall

prescribe each examination, and each examination shall be of reasonably sufficient scope to test the applicant's knowledge relative to property, marine and transportation, vehicle, general casualty, and surety insurance, that may be dealt with under the license applied for, the duties and responsibilities relating thereto, and the laws of this State that are applicable to the licensee.

(b) The commissioner shall prepare and make available to surplus lines brokers a printed manual specifying in general terms the subjects that may be covered in any examination for a surplus lines broker license. [L 2012, c 66, pt of §1]

**[§431:8-326] Time of examinations.** (a) The commissioner shall give examinations within this State at times and places as may reasonably serve the convenience of both the commissioner and applicants.

(b) The commissioner may require a waiting period of not more than six months before giving a new examination to an applicant who has failed to pass two previous examinations for a surplus brokers license. [L 2012, c 66, pt of §1]

**[§431:8-327] Prerequisites for license renewal.** (a) To qualify for a license renewal, a licensee shall:

(1) During the twenty-four months preceding a license renewal, complete the required number of credit hours specified in subsection (b) in approved continuing education courses; and

(2) Pay the fees as required under section 431:7-101.

(b) The required number of credit hours in approved continuing education courses shall be as follows:

(1) For a licensee authorized to sell surplus lines insurance but who does not hold a producer license, the requisite number of credit hours shall be twenty-four credit hours, consisting of twenty-one credit hours relating to property, marine and transportation, vehicle, general casualty, or surety insurance, and three credit hours relating to ethics training or relating to the insurance laws and rules.

For a licensee who also holds a producer license to sell life or accident and health or sickness lines of insurance pursuant to article 9A, the total requisite number of credit hours shall be twenty-four credit hours, consisting of:

(A) Ten credit hours relating to life or accident and health or sickness insurance;
(B) Eleven credit hours relating to property, marine and transportation, vehicle, general casualty, or surety insurance; and
(C) Three credit hours relating to ethics training or to insurance laws and rules.

For purposes of this section, ethics training shall include but not be limited to the topics of fiduciary responsibility, commingling of funds, payment and acceptance of commissions, unfair claims practices, policy replacement considerations, and conflicts of interest.

(c) Continuing education equivalents, as determined and approved by the commissioner, may include the teaching of continuing education courses and holding certain professional designations, but shall not include the use of carryover credit hours earned in excess of the

required hours in any two-year renewal cycle.

(d) Unless an extension of time has been granted in advance by the commissioner, a licensee's failure to satisfy all of the continuing education requirements by the renewal date shall result in that licensee's license being automatically placed on an inactive status. To reactivate a license, the licensee shall submit proof to the commissioner that the requisite number of credit hours has been completed and the licensee shall pay any required fees and penalties.

(e) After a licensee completes an approved continuing education course, the approved course provider shall issue to the licensee a certificate of completion in a form approved by the commissioner that certifies that the licensee has successfully completed the course. Both the licensee and a person authorized to sign on behalf of the approved course provider shall sign the certificate of completion. The approved course provider shall electronically submit the certificate of completion to the commissioner within fifteen days of course completion.

(f) This section shall not apply to a licensee granted an exemption by the commissioner from this section pursuant to section 431:8-322.

(g) The commissioner may grant an extension of time to meet the requirements of this section to a licensee on extended active military duty for a period of time equal to the number of days the licensee was on active military duty, provided there are no federal laws mandating an extension of time in a specified situation.

(h) A licensee need not retake the surplus lines broker license examination provided that all renewal requirements in this section are met or reactivation occurs within two years of the date of inactivation. [L 2012, c 66, pt of §1]

**[§431:8-328] Continuing education recordkeeping.** (a) Licensees shall maintain their own continuing education records and shall keep these records for four years after completion of an approved continuing education course.

(b) Approved course providers shall maintain attendance records for five years to permit the commissioner to verify the attendance and course completion of all licensees enrolled in an approved course. Approved course providers shall make their records available at all times to the commissioner. [L 2012, c 66, pt of §1]

**[§431:8-329] Commissioner's authority to grant waiver.** Upon receiving a written request and a showing of good cause, the commissioner may grant a waiver of any requirement of an insurance law or rule as applied to an applicant or a producer. [L 2012, c 66, pt of §1]

## ARTICLE 9
## LICENSING OF ADJUSTERS AND BILL REVIEWERS

### Note

Article heading amended by L 2000, c 288, §2; L 2003, c 212, §52.

### Case Notes

Where management company for foreign insurer authorized to do business in Hawaii did not hold a general agent, subagent, or solicitor license under this article (1993), it could not have been legally appointed as either a general agent, subagent, or solicitor of insurer; thus it did not qualify as a "general agent", "subagent", or "solicitor" as defined by this chapter (1993), did not fall within the parameters of the category described by §237-13(7) and was thus subject to a general excise tax rate of four per cent pursuant to §237-13(6). 115 H. 180, 166 P.3d 353 (2007).

## PART I. GENERAL PROVISIONS

### Case Notes

Where management company for foreign insurer authorized to do business in Hawaii did not hold a general agent, subagent, or solicitor license under this article (1993), it could not have been legally appointed as either a general agent, subagent, or solicitor of insurer; thus it did not qualify as a "general agent", "subagent", or "solicitor" as defined by this chapter (1993), did not fall within the parameters of the category described by §237-13(7) and was thus subject to a general excise tax rate of four per cent pursuant to §237-13(6). 115 H. 180, 166 P.3d 353 (2007).

**§431:9-101 Scope.** This article shall govern the qualifications and procedures for granting licenses to all insurance adjusters and independent bill reviewers. [L 1987, c 347, pt of §2; am L 2000, c 288, §6; am L 2001, c 216, §7; am L 2006, c 154, §13]

### Cross References

Independent bill reviewers, see §§431:9-241 to 243.

**§§431:9-102 to 104 REPEALED.** L 2001, c 216, §§28 to 30.

**§431:9-105 Definitions.** As used in this article, unless the context otherwise requires:

"Adjuster":

(1) Means any individual who:

(A) Acts solely on behalf of either the insurer or the insured, as an independent contractor or as an employee of an independent contractor; and

(B) Investigates for, reports to, or adjusts for the individual's principal relative to claims arising under insurance contracts; but

(2) Does not include an individual who is:

(A) An attorney at law who adjusts insurance losses from time to time incidental to the practice of the attorney's profession;

(B) An adjuster of marine losses;

(C) A salaried employee of an insurer or salaried employee of an adjusting corporation or an association owned or controlled by an insurer; or

(D) An individual who acts for a self-insurer or for an insured that administers its own group insurance contract.

"Independent adjuster" means an adjuster representing the interests of the insurer.

"Independent bill reviewer":

(1) Means any individual who:

(A) Acts solely on behalf of either the insurer as an independent contractor or as an employee of an independent contractor; and

(B) Reviews or audits billings for medical services; but

(2) Does not include an individual who is:

(A) A salaried employee of an insurer or salaried employee of an adjusting corporation or an association owned or controlled by an insurer; or

(B) A database provider for the insurer.

"Public adjuster" means an adjuster employed by and solely representing the financial interests of the insured named in the policy. [L 1987, c 347, pt of §2; am L 1997, c 83, §2; am L 2000, c 182, §8; am L 2002, c 155, §21; am L 2006, c 154, §14]

## PART II. LICENSING REQUIREMENTS, PROCEDURES AND ENFORCEMENT

### Case Notes

Where management company for foreign insurer authorized to do business in Hawaii did not hold a general agent, subagent, or solicitor license under this article (1993), it could not have been legally appointed as either a general agent, subagent, or solicitor of insurer; thus it did not qualify as a "general agent", "subagent", or "solicitor" as defined by this chapter (1993), did not fall within the parameters of the category described by §237-13(7) and was thus subject to a general excise tax rate of four per cent pursuant to §237-13(6). 115 H. 180, 166 P.3d 353 (2007).

**§431:9-201 License required; exception.** (a) No person engaging in the business of insurance in this State shall act as, be appointed as, or hold oneself out to be an adjuster or independent bill reviewer unless so licensed by this State.

(b) Notwithstanding subsection (a), following a catastrophe in this State, a Hawaii license shall not be required of a nonresident adjuster for the adjustment of losses; provided that:

(1) The common losses suffered that are to be adjusted are a direct result of the catastrophe and shall be so severe that licensed adjusters and licensed independent adjusters who are residents of this State will be unable to adjust the losses within a reasonable time as determined by the commissioner;

(2) The nonresident adjuster provides to the commissioner a certified copy of the adjuster's current license in another state. The other state shall have substantially similar licensing requirements to section 431:9-222; and

(3) Within three working days of the commencement of work by the nonresident adjuster, the insurance company, independent adjusting company, or producer that is using the adjuster shall provide on its letterhead to the commissioner:

(A) The name of the nonresident adjuster;
(B) The nonresident adjuster's Hawaii mailing and business addresses and phone numbers; and
(C) The nonresident adjuster's permanent home and business addresses and phone numbers.

Upon satisfaction of all of these requirements, the nonresident adjuster may be registered with the commissioner and adjust catastrophic losses in this State for up to one hundred twenty days from the date of registration or for a period of time determined by the commissioner, whichever is less.

As used in this subsection, "catastrophe" means insured property losses in Hawaii that result from a sudden, specific, and natural or manmade disaster or phenomenon, as determined by the commissioner.

(c) Any person violating this section shall be assessed a civil penalty not to exceed $5,000 for each factually different violation.

(d) Any person who knowingly violates this section shall be assessed a civil penalty of not less than $1,000 and not more than $10,000 for each violation.

(e) Each repetition of an act that constitutes a violation subject to subsection (c) or (d) shall constitute a separate violation. [L 1987, c 347, pt of §2; am L 1993, c 205, §14; am L 1998, c 203, §1; am L 2000, c 182, §9 and c 288, §7; am L 2001, c 216, §8; am L 2006, c 154, §15]

**§431:9-202 REPEALED.** L 2001, c 216, §31.

**§431:9-203 General qualifications for license.** (a) For the protection of the public, the commissioner shall not issue or extend any license for an adjuster or independent bill reviewer:

(1) Except as provided by this article; or

(2) To any individual less than eighteen years of age.

(b) An applicant for a license under this article shall notify the commissioner of the applicant's legal name and trade name, if applicable. An applicant doing business under any name other than [the] applicant's legal name shall notify the commissioner prior to using the assumed name.

(c) A licensee shall:

(1) Inform the commissioner by any means acceptable to the commissioner of any change of status within thirty days of the change; and

(2) Report any change of status to the business registration division if the licensee is a business entity registered with the department of commerce and consumer affairs pursuant to title 23 or title 23A, or if the licensee has registered a trade name pursuant to part II of chapter 482.

Failure to timely inform the commissioner or business registration division of a change of status shall result in a penalty pursuant to section 431:2-203.

(d) As used in this section, "change of status" includes but shall

not be limited to change of legal name, assumed name, trade name, business address, home address, mailing address, business phone number, business fax number, business electronic mail address, business website address, or home phone number. [L 1987, c 347, pt of §2; am L 2006, c 154, §16; am L 2010, c 116, §1(5); am L 2011, c 43, §14]

**§431:9-204 Applications for license.** (a) Application for an adjuster or independent bill reviewer license shall be made to the commissioner upon forms prescribed and furnished by the commissioner. As a part of or in connection with the application, the applicant shall furnish information including:

(1) The applicant's identity, personal history, experience, business records, and a full set of fingerprints, including a scanned file from a hard copy fingerprint, for the commissioner to obtain and receive national and state criminal history record checks from the Federal Bureau of Investigation and the Hawaii criminal justice data center, pursuant to section 846-2.7; and

(2) Other pertinent facts as the commissioner may reasonably require.

(b) Any person who wilfully misrepresents or omits any fact required to be disclosed in an application filed pursuant to this section shall be liable for penalties as provided by this code. [L 1987, c 347, pt of §2; am L 2009, c 77, §16; am L 2011, c 81, §5]

**§431:9-205 REPEALED.** L 2001, c 216, §32.

**§431:9-206 Examinations for license.** (a) Each applicant for license as an adjuster or independent bill reviewer shall prior to the issuance of any such license, personally take and pass to the satisfaction of the commissioner an examination given by the commissioner as a test of the applicant's qualifications and competence.

(b) This requirement shall not apply to applicants who at any time within the three-year period next preceding date of application held a license in this State which conferred powers comparable to those being applied for.

(c) Applicants who held a license on December 31, 1987, shall not, for the purpose of qualifying for the issuance or extension of such license after January 1, 1988, be required to take an examination. [L 1987, c 347, pt of §2; am L 1993, c 205, §15; am L 1997, c 234, §2; am L 2000, c 288, §8; am L 2001, c 216, §9]

**Cross References**

Qualification for independent bill reviewer's license, see §431:9-243.

**§431:9-207 Scope of examination** (a) Each examination shall be as the commissioner prescribes and shall be of reasonably sufficient scope to test the applicant's knowledge relative to the classes of insurance which may be dealt with under the license applied for, and of the duties and responsibilities of, and the laws of this State applicable to, such licensee.

(b) The commissioner is required to prepare and make available to

insurers and applicants a printed manual specifying in general terms the subjects which may be covered in any examination for a particular license. [L 1987, c 347, pt of §2; am L 2001, c 216, §10]

**§431:9-208 Time of examinations.** (a) The commissioner shall give examinations at such times and places within this State as are reasonably necessary to serve the convenience of both the commissioner and applicants.

(b) The commissioner may require a waiting period of not more than six months before giving a new examination to an applicant who has failed to pass two previous similar examinations. [L 1987, c 347, pt of §2]

**§431:9-209 Advisory board.** The commissioner may, in the commissioner's discretion, appoint a group of individuals, to be known as the advisory board, to make recommendations to the commissioner concerning any matter relating to the examinations provided for by this article. Any individual appointed to the advisory board shall not be entitled to any compensation for the individual's services. The commissioner shall select a group who represents fairly the insurance industry in this State. The commissioner shall decide how long each individual is to serve on the advisory board. [L 1987, c 347, pt of §2]

**§§431:9-210 to 213 REPEALED.** L 2001, c 216, §§33 to 37.

**§431:9-214 REPEALED.** L 2002, c 155, §107.

**§§431:9-215 to 219 REPEALED.** L 2001, c 216, §§38 to 42.

**§431:9-220 REPEALED.** L 2004, c 122, §95.

**§431:9-221 REPEALED.** L 2001, c 216, §43.

**§431:9-222 Qualification for adjuster's license.** (a) To qualify for an adjuster's license, an applicant shall comply with this article and shall:

(1) Be domiciled in this State, or in a state that will permit residents of this State to act as adjusters in the other state;

(2) Have had experience, special education, or training with reference to the handling of loss claims under insurance contracts, of sufficient duration and extent reasonably to make the individual competent to fulfill the responsibilities of an adjuster;

(3) Have successfully passed any examination required under section 431:9-206; and

(4) Have paid the license fees required by section 431:7-101.

(b) In addition to the requirements in subsection (a), an applicant for a public adjuster's license must file the bond required by section 431:9-223. [L 1987, c 347, pt of §2; am L 1997, c 234, §8; am L 2006, c 154, §17]

**§431:9-222.5 Claims adjusters; limited license.** (a) The commissioner may issue a limited license to an adjuster who only adjusts either workers' compensation or crop insurance claims; provided that the adjuster:

(1) Is domiciled in the State of Hawaii, or in a state that permits residents of the State of Hawaii to act as adjusters in that other state;

(2) Has had experience, special education, or training in handling loss claims under workers' compensation or crop insurance contracts of sufficiently reasonable duration and extent to enable an individual to fulfill the responsibilities of an adjuster;

(3) Has a passing grade on the workers' compensation or crop insurance examination pursuant to section 431:9-206 or has a passing grade on an examination approved by the Risk Management Agency of the United States Department of Agriculture; and

(4) Pays the applicable fees.

(b) An adjuster with a limited license issued under this section may extend the license biennially upon successfully passing a reexamination. [L 1995, c 234, §4; am L 2004, c 122, §27; am L 2009, c 77, §8; am L 2010, c 6, §1]

**§431:9-223 Public adjuster's bond.** (a) Prior to the issuance of a license as a public adjuster, the applicant for such license shall file with the commissioner and shall maintain in force while so licensed, a surety bond in favor of this State. The bond shall be executed by an authorized corporate surety approved by the commissioner, in the amount of $10,000. The bond shall be contingent on the accounting by the adjuster to any insured whose claim the adjuster is handling, for moneys or any settlement received in connection with such claim. The bond may be written without an expiration date and total aggregate liability on the bond may be limited to the payment of $10,000.

(b) Any such bond shall remain in force until the surety is released from liability by the commissioner, or until canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel a bond upon sixty days advance notice in writing filed with the commissioner.

(c) During the existence of the license, the licensee may, in lieu of such bond, maintain on deposit with the commissioner a like amount in cash or securities approved by the commissioner. Such deposit shall be held for the same purpose and upon the same conditions as the bond. [L 1987, c 347, pt of §2]

**§431:9-224 Separate licenses.** The commissioner may license an individual as an independent adjuster or as a public adjuster, and separate licenses shall be required for each type of adjuster. An individual may be concurrently licensed under separate licenses as an independent adjuster and as a public adjuster. The full license fee shall be paid for each license. [L 1987, c 347, pt of §2]

**§431:9-225 Form of adjusters' license.** Adjusters' licenses shall

be in such form as the commissioner prescribes. The licenses shall contain:

(1) The name of the adjuster, and the address of the adjuster's place of business;

(2) A statement as to whether the adjuster is so licensed as an independent adjuster or as a public adjuster;

(3) Date of issuance of the license; and

(4) Other statements proper to the purposes of the license. [L 1987, c 347, pt of §2]

**§431:9-226 Powers conferred by an adjuster's license.** (a) An adjuster has authority under the adjuster's license only to investigate for, report to, or adjust for the adjuster's principal only on behalf of the insurers if licensed as an independent adjuster, or only on behalf of insureds if licensed as a public adjuster.

(b) An adjuster licensed concurrently as both an independent and a public adjuster is not permitted to represent both the insurer and the insured in the same transaction. [L 1987, c 347, pt of §2]

§431:9-227 **Adjuster; restrictions.** An adjuster who is a producer is not permitted to adjust or cause the adjustment of any loss where the adjuster's remuneration for the sale of insurance is primarily dependent upon the adjustment of the loss. This section shall not be applicable to any producer whose remuneration for the sale of insurance, on December 31, 1955, was primarily dependent upon the adjustment of losses, or to any producer or an insurer who, on December 31, 1955, was transacting insurance business where the producer's remuneration for the sale of such insurance was primarily dependent upon the adjustment of losses. [L 1987, c 347, pt of §2; am L 1997, c 83, §3; am L 2001, c 216, §12; am L 2002, c 155, §22]

**§431:9-228 Place of business.** (a) The place of business of every licensed adjuster and independent bill reviewer shall be the place where the licensee principally conducts transactions under the licensee's license.

(b) The licensee shall notify the commissioner of any change of business address within thirty days of the change. [L 1987, c 347, pt of §2; am L 1993, c 205, §18; am L 2000, c 288, §9; am L 2001, c 216, §13; am L 2007, c 214, §2; am L 2010, c 116, §1(6)]

**Cross References**

Qualification for independent bill reviewer's license, see §431:9-243.

**§431:9-229 Records of adjuster or independent bill reviewer.** (a) Every adjuster or independent bill reviewer shall keep a record of all transactions consummated under the licensee's license. This record shall be in organized form according to class of insurance and shall include:

(1) If an adjuster, a record of each investigation or adjustment undertaken or consummated, and a statement of any fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment;

(2) If an independent bill reviewer, a record of each bill reviewed and a statement of any fee, commission, or other compensation received or to be received by the independent bill reviewer on account of the bill reviewed; and

(3) Any additional information as shall be customary, or as may reasonably be required by the commissioner.

(b) All such records as to any particular transaction shall be kept in the licensee's office, available and open to the inspection of the commissioner during business hours during the five years, and in the case of workers' compensation claims during the eight years, immediately after the date of the completion of such transaction.

(c) This section shall not apply to life or accident and health or sickness insurance if the records required of such insurance are customarily maintained in the offices of the insurer. [L 1987, c 347, pt of §2; am L 2000, c 288, §10; am L 2001, c 216, §14; am L 2003, c 212, §53]

**§431:9-230 Reporting and accounting for premiums.** (a) Every licensed adjuster shall have the responsibilities of a trustee for all premium and return premium funds received or collected under this article.

(b) The licensee, upon receipt of the funds, shall either:

(1) Remit the premiums (less commissions) and return premiums received or held by the licensee to the insurers or the persons entitled to such funds; or

(2) Maintain the funds at all times in a federally insured account with a bank, savings and loan association, or financial services loan company situated in Hawaii, separate from the licensee's own funds or funds held by the licensee in any other capacity, in an amount at least equal to the premiums (net of commissions) and return premiums received by such licensee and unpaid to the insurers or persons entitled to such funds. Return premiums shall be returned within thirty days, unless directed otherwise in writing by the person entitled to the funds.

The licensee shall not be required to maintain a separate bank account or other account for the funds of each insurer or person entitled to such funds, if and so long as the funds held for the insurer or person entitled to such funds are reasonably ascertainable from the books of account and records of the licensee. Only such additional funds as may be reasonably necessary to pay bank, savings and loan association, or financial services loan company charges may be commingled with the premium funds. In the event the bank, savings and loan association, or financial services loan company account is an interest earning account, such licensee may not retain the interest earned on such funds to the licensee's own use or benefit without the prior written consent of the insurers or person entitled to such funds. A premium trustee account shall be designated on the records of the bank, savings and loan association, or financial services loan company as a "trustee account established pursuant to section 431:9-230, Hawaii Revised Statutes", or words of similar import.

(c) Any such licensee who, not being lawfully entitled to such funds, diverts or appropriates such funds or any portion of them to the licensee's own use, shall be guilty of embezzlement, and shall be punished as provided in the criminal statutes of this State. [L 1987, c 347, pt of §2; am L 1993, c 107, §3; am L 1995, c 232, §15; am L 2001, c 216, §15]

**§431:9-231 REPEALED.** L 2001, c 216, §44.

**§431:9-232 Extension of licenses.** (a) Prior to the extension of a license, each licensee shall annually pay the fee required in section 431:7-101.

(b) A license for an adjuster or independent bill reviewer shall be inactivated if a licensee fails to pay any required fees or penalties.

An adjuster or independent bill reviewer who allows the adjuster's or independent bill reviewer's license to become inactive for nonpayment of the renewal fee may reinstate that license without the necessity of a written examination; provided that the adjuster or independent bill reviewer:

(1) Pays the fee and a penalty in the amount of fifty per cent of the then unpaid fees within twenty-four months from the inactivation date; and

(2) Is in compliance with all requirements of chapter 431.

The license shall automatically expire if the adjuster or independent bill reviewer does not reinstate the license within the twenty-four-month period.

(c) When the commissioner issues or extends a license, the commissioner shall:

(1) Determine the extension date, which is that date prior to which the license must be extended; and

(2) Notify the licensee in writing of the extension date.

The extension date shall be any date not less than one year and not more than three years after the date of the issue or the last extension of the license. [L 1987, c 347, pt of §2; am L 1999, c 163, §4; am L 2002, c 155, §23; am L 2006, c 154, §18]

**§§431:9-233, 234 REPEALED.** L 2001, c 216, §45, 46.

**[§431:9-234.5] Reporting of actions.** (a) A licensee shall report in writing to the commissioner any civil or administrative action taken against the licensee in any jurisdiction or by any governmental agency in the United States within thirty days of the final disposition of the matter.

(b) Within thirty days of arraignment, a licensee shall report in writing to the commissioner any criminal prosecution of the licensee being taken in any jurisdiction.

(c) A report pursuant to this section shall include a copy of the initial complaint or indictment and any and all other relevant legal documents. [L 2010, c 116, §1(2)]

**§431:9-235 Denial, suspension, revocation of licenses.** (a) The commissioner may suspend, revoke, or refuse to extend any license issued under this article for any cause specified in any other provision of this article, or for any of the following causes:

(1) For any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner;

(2) If the licensee wilfully violates or knowingly participates in the violation of any provision of this code;

(3) If the licensee has obtained or attempted to obtain any license issued under this article through wilful misrepresentation or fraud, or has failed to pass any examination required by section 431:9-206;

(4) If the licensee has misappropriated, converted to the licensee's own use, or illegally withheld moneys required to be held in a fiduciary capacity;

(5) If the licensee, with intent to deceive, has materially misrepresented the terms or effect of any insurance contract; or has engaged or is about to engage in any fraudulent transaction;

(6) If the licensee has been guilty of any unfair practice or fraud as defined in article 13;

(7) If in the conduct of the licensee's affairs under the license, the licensee has shown oneself to be a source of injury and loss to the public; or

(8) If the licensee has dealt with, or attempted to deal with, insurance or to exercise powers relative to insurance outside the scope of the licensee's licenses.

(b) The license of any partnership or corporation may be so suspended, revoked, or refused for any of the causes that relate to any individual designated in the license to exercise its powers.

(c) The holder of any license, which has been revoked or suspended, shall surrender the license certificate to the commissioner at the commissioner's request.

(d) The commissioner shall not renew or reinstate, or shall deny, suspend, or revoke any license or application, if the commissioner has received certification from an administering entity pursuant to chapter 436C that the licensee or applicant is in default or breach of any obligation under any student loan, student loan repayment contract, or scholarship contract that financed the licensee's or applicant's education, or has failed to comply with a repayment plan.

The commissioner in receipt of a certification pursuant to chapter 436C shall, as applicable, and without further review or hearing:

(1) Suspend the license;

(2) Deny the application or request for renewal of the license; or

(3) Deny the request for reinstatement of the license,

and unless otherwise provided by law, shall renew, reinstate, or grant the license only upon receipt of an authorization from the administering entity.

(e) The commissioner may suspend, revoke, or refuse to extend any license for any cause specified in this article by an order:

(1) Given to the licensee not fewer than fifteen days prior to the effective date thereof, subject to the right of the licensee to have a hearing as provided in section 431:2-308, and pending that hearing, the license shall be suspended; or

(2) Made after a hearing, conducted as provided in section 431:2-308, effective ten days after the date the order is given to the licensee, subject to the right of the licensee to appeal to the circuit court of the first judicial circuit of this State as provided in chapter 91. [L 1987, c 347, pt of §2; am L 1997, c 233, §4; am L 2002, c 155, §24 and c 226, §6; am L 2003, c 133, §7 and c 212, §54; am L 2006, c 154, §19]

**§431:9-235.5 Suspension or denial of license for noncompliance with support order.** In addition to any other acts or conditions provided by law, the commissioner shall refuse to renew, reinstate, or restore, or shall deny or suspend any license if the commissioner has received certification from the child support enforcement agency pursuant to the terms of section 576D-13 that the licensee or applicant is not in compliance with an order of support or has failed to comply with a subpoena or warrant relating to a paternity or child support proceeding. Unless otherwise provided by law, following receipt of certification pursuant to this section, the commissioner shall renew, reinstate, restore, or grant the license only upon receipt of an authorization from the child support enforcement agency, office of child support hearings, or the family court. Sections 92-17, 431:9-235, 431:9-237, 431:9-238, 431:9-239, and 431:9-240 shall not apply to a refusal to renew, reinstate, or restore a license or to a license suspension or denial pursuant to this section. [L 1997, c 293, §2; am L 2006, c 154, §20]

**§431:9-236 REPEALED.** L 2006, c 154, §47.

**§431:9-237 Duration of suspension.** Every order suspending any license shall specify the period during which suspension will be effective. [L 1987, c 347, pt of §2; am L 2005, c 132, §3]

**§431:9-238 Power to fine.** (a) In addition to or in lieu of suspension, revocation, or refusal to extend any license, after a hearing, the commissioner may levy a fine upon the licensee in an amount not less than $100 and not more than $10,000.

(b) The order levying the fine shall specify the period within which the fine shall be fully paid, and which period shall be not less than thirty nor more than forty-five days from the date of the order.

(c) Upon failure to pay any such fine when due, the commissioner shall revoke the license of the licensee if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the commissioner by the attorney general.

(d) Any fine collected shall be paid by the commissioner to the director of finance for the account of the compliance resolution fund. [L 1987, c 347, pt of §2; am L 1993, c 205, §20; am L 1999, c 163, §15(1); am L 2002, c 39, §13]

**§431:9-239 Reinstatement or relicensing.** The commissioner shall not reinstate the license of or relicense any licensee or former licensee as to whom a license has been suspended, revoked, or extension refused, until:

(1) Any cause for the suspension, revocation, or refusal of such license is no longer existing;

(2) Any fine levied upon the licensee pursuant to section 431:9-238 and section 431:9-240 has been fully paid; and

(3) The commissioner is satisfied that such causes for the suspension, revocation, or refusal of such license will not reoccur in the future. [L 1987, c 347, pt of §2; am L 1995, c 232, §16]

**§431:9-240 Fine in lieu.** (a) Upon the hearing of an appeal from an order suspending, revoking, or refusing to extend any license issued under this article, the court may impose a fine of not more than $10,000 in lieu of the commissioner's action, and payment of the fine within ten days shall reinstate, restore or extend, the license if:

(1) The court finds that the licensee is guilty of violation of the law; and

(2) The court deems the suspension, revocation, or refusal too severe a penalty under the facts as found.

(b) If it appears that a license of the licensee has previously been suspended, revoked, or refused for a similar offense, the court shall not have jurisdiction to impose a fine in lieu of the commissioner's action. [L 1987, c 347, pt of §2]

**§431:9-241 REPEALED.** L 2006, c 154, §48.

**[§431:9-242] Compensation by contingency fee prohibited.** An independent bill reviewer shall not be compensated on a contingency fee basis. [L 2000, c 288, pt of §1]

**§431:9-243 Qualification for independent bill reviewer's license.** To qualify for an independent bill reviewer's license, an applicant shall comply with this article and shall:

(1) Be domiciled in this State, or in a state that will permit residents of this State to act as independent bill reviewers in the other state;

(2) Have experience, special education, or training with reference to the review or audit of billings for medical services under insurance contracts, of sufficient duration and extent to reasonably make the individual competent to fulfill the responsibilities of an independent bill reviewer;

(3) Have successfully passed any examination required under section 431:9-206; and

(4) Pay the license fees required by section 431:7-101;

provided that any applicant who holds the credential of certified professional coder granted by the American Academy of Professional Coders or the credential of registered health information administrator, registered health information technician, certified coding specialist, or certified coding associate granted by the American Health Information Management Association shall be exempt from the requirements in paragraphs (1) to (3). [L 2000, c 288, pt of §1; am L 2002, c 126, §1; am L 2006, c 154, §21]

## PART III. CONTINUING EDUCATION--REPEALED

**§§431:9-301 to 305 REPEALED.** L 2002, c 155, §108.

# ARTICLE 9A
# PRODUCER LICENSING

**Cross References**

Bail agents; sureties, see article 9N.

**[PART I. GENERAL PROVISIONS]**

**Revision Note**

Part I designation added by revisor pursuant to L 2002, c 235, §4.

**§431:9A-101 Scope.** This article governs qualifications and procedures for the licensing of insurance producers. It simplifies and organizes statutory language to improve efficiency, to permit the use of new technology, and to reduce costs associated with issuing and renewing insurance licenses. [L 2001, c 216, pt of §2; am L 2003, c 212, §55; am L 2006, c 154, §22]

**ARTICLE 9A [OLD]**
**MANAGING GENERAL AGENTS--REPEALED**

**§§431:9A-101 to 108 REPEALED.** L 2001, c 216, §47.

**Cross References**

For present provisions, see Article 9C.

**§431:9A-102 Definitions.** As used in this article, the following definitions apply:

"Approved continuing education course" means a course approved by the commissioner following receipt of recommendations from insurance professionals.

"Approved course provider" means an organization or person that has been approved by the commissioner.

"Business entity" means an association, corporation, individual, limited liability company, limited liability partnership, partnership, person, or other legal entity.

"Class" means the general categories of insurance, as set forth in sections 431:1-204 to 431:1-210, in which insurers may be authorized to transact the business of insurance.

"Commissioner" means the insurance commissioner.

"Credit hour" means the value assigned to an approved continuing education course that is equivalent to at least fifty minutes of classroom instruction.

"Home state" means the District of Columbia or any state or territory of the United States in which an insurance producer maintains the producer's principal place of residence or principal place of business and is licensed to act as an insurance producer.

"Inactive" means that the authority of a license issued by the commissioner is not in effect.

"Individual" means a natural person or a business entity.

"Insurance" is defined in section 431:1-201.

"Insurance producer" or "producer" means a person required to be licensed under the laws of this State to sell, solicit, or negotiate insurance.

"Insurer" is defined in section 431:1-202.

"License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier.

"Licensee" means any type of insurance producer or producer.

"Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection ("gap") insurance, and any other form of insurance offered in connection with an extension of credit, that is limited to partially or wholly extinguishing that credit obligation that the commissioner determines should be designated a form of limited line of credit insurance.

"Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

"Limited lines insurance" means those lines of insurance a producer may be licensed to sell pursuant to section 431:9A-107.5 or any other line of insurance sold to individuals under state law or rule for which an insurance producer license in one or more of the lines of authority set forth in section 431:9A-107(a)(1) to (4) is not required.

"Limited lines producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines insurance.

"Line of authority" means a category of insurance products, as set forth in section 431:9A-107(a), which an insurance producer may be licensed to sell pursuant to this article.

"Line of insurance" means an insurance product, contract, or policy designed to cover specified risks that fall within one or more of the classes or types of insurance as defined in sections 431:1-204 to 431:1-211, the lines of authority defined in section 431:9A-107(a), or any other section of this code.

"NAIC" means the National Association of Insurance Commissioners.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract; provided that the person engaged in the act either sells insurance or obtains insurance from insurers for producers.

"Person" is defined in section 431:1-212.

"Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

"Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

"Terminate" means:

(1) To cancel the relationship between an insurance producer and an insurer;

(2) To cancel the relationship between an appointing producer and another producer; or

(3) To terminate a producer's authority to transact insurance.

"Uniform application" means the current version of National Association of Insurance Commissioners' uniform application for resident and nonresident producer licensing.

"Uniform business entity application" means the current version of

National Association of Insurance Commissioners' uniform business entity application for resident and nonresident business entities. [L 2001, c 216, pt of §2; am L 2002, c 155, §§25, 26; am L 2003, c 55, §2; am L 2006, c 154, §23; am L 2012, c 66, §6]

**Note**

Definition of "credit hour" is retroactive to January 1, 2012. L 2012, c 66, §17.

**§431:9A-103 License required.** (a) A person shall not sell, solicit, or negotiate insurance in this State for any line, class, or classes of insurance unless the person is licensed for the proper line of authority or class in accordance with this article.

(b) The proper line of authority for which a producer is required to be licensed relative to sale, solicitation, or negotiation of any class or type of insurance set forth in sections 431:1-204 to 431:1-211 is set forth in the following table:

| **Class** | **Required Line of Authority** |
|---|---|
| Life | Life |
| Accident and Health or Sickness | Accident and Health or Sickness |
| Property | Property |
| Marine and Transportation | Casualty and Property |
| Vehicle | Casualty and Property |
| General Casualty | Casualty |
| Surety | Surety |
| Title | Title |

(c) Sale, solicitation, or negotiation of variable life and variable annuity products requires licensing in the variable life and variable annuity products line of authority.

(d) Sale, solicitation, or negotiation of personal lines insurance requires licensing in the personal lines line of authority or the property and casualty lines of authority.

(e) Sale, solicitation, or negotiation of limited lines insurance, including limited line credit and limited line travel insurance, is permitted pursuant to section 431:9A-107.5. [L 2001, c 216, pt of §2; am L 2002, c 155, §27; am L 2003, c 212, §56]

**§431:9A-104 Exceptions to licensing.** (a) Nothing in this article shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(b) A license as an insurance producer shall not be required of the following:

(1) An officer, director, or employee of an insurer or of an insurance producer; provided that the officer, director, or employee does not receive any commission or remuneration on policies written or sold to insure risks residing, located, or to be performed in this State and:

(A) The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these and are only indirectly related to

the sale, solicitation, or negotiation of insurance;

(B) The officer, director, or employee's functions relate to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(C) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor, assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(2) A person who secures and furnishes information regarding group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health or sickness insurance, for the purpose of enrolling individuals or issuing certificates under such plans, or otherwise assisting in administering the plans, or who performs administrative services related to mass marketed property and casualty insurance, where no commission is paid to the person for the service;

(3) An employer or association or its officers, directors, employees, or the trustee of any employee trust plan, to the extent that the employer, association, officers, employees, directors, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, so long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(4) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks, or in the supervision or the training of insurance producers, and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

(5) A person whose activities in this State are limited to advertising without the intent to solicit insurance in this State through communications in printed publications or other forms of electronic mass media, whose distribution is not limited to residents of this State; provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this State;

(6) A person who is not a resident of this State who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; provided that the person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(7) A salaried, full-time employee who counsels or advises the person's employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer; provided that the employee does not sell or solicit insurance or receive commissions. [L 2001, c 216, pt of §2; am L 2002, c 155, §28; am L 2003, c 212, §57]

**§431:9A-105 Insurance producer license examination.** (a) An applicant for an insurance producer license shall pass a written examination unless exempt pursuant to section 431:9A-109. The examination shall test the knowledge of the applicant concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this State.

(b) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting fees pursuant to section 431:7-101. The fees collected shall

be nonrefundable.

(c) An applicant, who fails to appear for the examination as scheduled or fails to pass the examination, shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

(d) An applicant's examination scores shall be valid for two years from the date of the examination. [L 2001, c 216, pt of §2; am L 2002, c 155, §29; am L 2003, c 212, §58; am L 2006, c 154, §24; am L 2012, c 66, §7]

**§431:9A-106 Application for license.** (a) A person applying for an insurance producer license shall make application to the commissioner on the uniform application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, accurate, and complete to the best of the applicant's knowledge and belief. Before approving the application, the commissioner shall find that the applicant:

(1) Is at least eighteen years of age;

(2) Has not committed any act that is a ground for a licensure sanction set forth in section 431:9A-112;

(3) Has paid the applicable fees set forth in section 431:7-101;

(4) Has passed, within the two years immediately preceding the date of the examination or issuance of the license, whichever is later, the applicable examination for each line of authority for which the applicant has applied; and

(5) Has submitted a full set of fingerprints, including a scanned file from a hard copy fingerprint, for the commissioner to obtain and receive national and state criminal history [record] checks from the Federal Bureau of Investigation and the Hawaii criminal justice data center, pursuant to section 846-2.7.

(b) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the commissioner shall find that:

(1) The business entity has paid all applicable fees;

(2) The business entity has designated a licensed producer who is a natural person responsible for the business entity's compliance with the insurance laws and rules of this State; and

(3) Any licensed producer so designated or empowered by a corporation or partnership may not be so designated or empowered by more than one corporation or partnership, except when the corporations or partnerships are affiliates of each other.

As used herein:

"Control" has the same meaning as in section 431:11-102.

"Corporation or partnership" includes an affiliate of another corporation or partnership, if the same person, directly or indirectly through one or more intermediaries, controls both corporations or partnerships.

(c) The commissioner may require any documents reasonably necessary to verify the information contained in an application. [L 2001, c 216, pt of §2; am L 2002, c 155, §30; am L 2003, c 212, §59; am L 2006, c 154, §25; am L 2009, c 77, §17]

**§431:9A-107 License.** (a) Except as provided in section 431:9A-112, a person who has met the requirements of sections 431:9A-105 and 431:9A-106 shall be issued an insurance producer license. An insurance producer may receive a license in one or more of the following lines of authority:

(1) Life: insurance coverage on human lives, including benefits of endowment and annuities, benefits in the event of death or dismemberment by accident, and benefits for disability income;

(2) Accident and health or sickness: insurance coverage for sickness, bodily injury, or accidental death and benefits for disability income;

(3) Property: insurance coverage for the direct or consequential loss or damage to property of every kind;

(4) Casualty: insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property;

(5) Variable life and variable annuity products: insurance coverage provided under variable life insurance contracts and variable annuities;

(6) Personal: property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(7) Credit: limited line credit insurance; or

(8) Any other line of insurance permitted under state law or rule.

(b) Except as provided in section 431:9A-112, an insurance producer license shall remain in effect so long as the fee set forth in section 431:7-101 is paid and the educational requirements for resident individual producers are timely met.

(c) An insurance producer who allows the producer's license to become inactive for nonpayment of the renewal fee may reinstate that license without the necessity of passing a written examination, if the fee payable and a penalty in the amount of fifty per cent of then unpaid fees are paid within twenty-four months from the inactivation date and the producer is in compliance with all requirements of chapter 431. If the license is not reinstated within the twenty-four-month period, the license shall automatically expire.

(d) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or an extenuating circumstance as determined by the commissioner may request a waiver of those procedures. The producer also may request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(e) The license shall contain the licensee's name, address, personal identification number, and the date of issuance, the lines of authority, the expiration date, and any other information the commissioner deems necessary.

(f) A licensee shall:

(1) Inform the commissioner by any means acceptable to the commissioner of any change of status within thirty days of the change; and

(2) Report any change of status to the business registration division if the licensee is a business entity registered with the department of commerce and consumer affairs pursuant to title 23 or title 23A, or if the

licensee has registered a trade name pursuant to part II of chapter 482.

Failure to timely inform the commissioner or the business registration division of a change of status may result in a penalty pursuant to section 431:2-203.

As used in this subsection, "change of status" includes but shall not be limited to change of legal name, assumed name, trade name, business address, home address, mailing address, business phone number, business fax number, business electronic mail address, or business website address.

(g) In order to assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that the National Association of Insurance Commissioners oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing as agreed upon by the commissioner and the nongovernmental entity. [L 2001, c 216, pt of §2; am L 2002, c 155, §31; am L 2003, c 212, §60; am L 2004, c 122, §28; am L 2006, c 154, §26; am L 2010, c 4, §8 and c 116, §1(7)]

**§431:9A-107.5 Limited license.** (a) Notwithstanding any other provision of this article, the commissioner may issue:

(1) A limited license to persons selling travel tickets of a common carrier of persons or property who shall act only as to travel ticket policies of accident and health or sickness insurance or baggage insurance on personal effects;

(2) A limited license to each individual who has charge of vending machines used in this State for the effectuation of travel insurance;

(3) A limited license to any individual who sells policies of accident and health or sickness insurance as a promotional device to improve the circulation of a newspaper in this State; or

(4) A limited line credit insurance producer license to any individual who sells, solicits, or negotiates limited line credit insurance.

(b) The commissioner may prescribe and furnish forms calling for any information that the commissioner deems proper in connection with the application for or extension of these limited licenses.

(c) The limited license shall not be issued until the license fee has been paid. [L 2002, c 155, pt of §3; am L 2003, c 212, §61; am L 2006, c 154, §27]

**§431:9A-108 Nonresident licensing.** (a) Except as provided in section 431:9A-112, a nonresident applicant shall receive a nonresident producer license if:

(1) The applicant is currently licensed and is in good standing as a resident producer in the applicant's home state;

(2) The applicant has submitted the proper request for licensure and has paid the fees required by section 431:7-101;

(3) The applicant has submitted or transmitted to the commissioner the application for licensure that the applicant submitted to the applicant's home state, or in lieu of the same, a completed uniform application; and

(4) The applicant's home state awards nonresident producer licenses to residents of this State on the same basis.

(b) The commissioner may verify the producer's licensing status through the producer database maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

(c) A nonresident producer who moves from one state to another state or a resident producer who moves from this State to another state shall file a change of address with the commissioner and shall provide certification from the new resident state within thirty days of the change of legal residence. No fee or license application shall be required. Failure to timely inform the commissioner of a change in address shall result in a penalty pursuant to section 431:2-203.

(d) Notwithstanding any other provision of this article, an applicant licensed as a limited line credit insurance producer or other type of limited lines producer in the person's home state shall receive a nonresident limited lines producer license, pursuant to subsection (a), granting the same scope of authority as granted under the license issued by the producer's home state. Limited lines insurance authority is any authority granted by the home state, that restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 431:9A-107(a)(1) through (5). [L 2001, c 216, pt of §2; am L 2003, c 212, §62; am L 2006, c 154, §28; am L 2012, c 66, §8]

**[§431:9A-108.5] Process against nonresident licensees.** (a) Each licensed nonresident producer shall appoint the commissioner as the producer's agent to receive service of legal process issued against the producer in this State upon causes of action arising within this State. Service upon the commissioner as agent shall constitute effective legal service upon the producer.

(b) The appointment shall be irrevocable for as long as there could be any cause of action against the producer arising out of the producer's insurance transactions in this State.

(c) Service of process on the commissioner shall be made in accordance with section 431:2-206. [L 2002, c 155, pt of §3]

**§431:9A-109 Exemption from examination.** (a) Subject to section 431:9A-116, an individual who applies for an insurance producer license in this State who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was licensed in good standing in that state, or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(b) A person licensed as an insurance producer in another state who moves to this State shall make application within ninety days of establishing legal residence to become a resident licensee pursuant to section 431:9A-106. No prelicensing educational component or examination shall be required of that person to obtain any line of authority

previously held in the prior state except where the commissioner determines otherwise by rule. [L 2001, c 216, pt of §2; am L 2003, c 212, §63]

**§431:9A-110 Legal, trade, and assumed names.** (a) Every insurance producer doing business in this State shall notify the commissioner in writing of the insurance producer's legal name and trade name, if applicable.

(b) An insurance producer doing business under any name other than the producer's legal name shall notify the commissioner in writing prior to using the assumed name. [L 2001, c 216, pt of §2; am L 2006, c 154, §29]

**[§431:9A-111] Temporary licensing.** (a) The commissioner may issue a temporary insurance producer license for a period not to exceed one hundred eighty days without requiring an examination if the commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(1) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned or controlled by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(3) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America; or

(4) In any other circumstance where the commissioner deems that the public interest will best be served by the issuance of this temporary license.

(b) The commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee. The commissioner may impose other similar requirements designed to protect insureds and the public. The commissioner may by order suspend or revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner, the personal representative, or the person controlling the business disposes of the business. [L 2001, c 216, pt of §2]

**§431:9A-112 License denial, nonrenewal, suspension, or revocation.** (a) The commissioner may deny, place on probation, suspend, revoke, or refuse to issue or renew an insurance producer's license and may levy a civil penalty in accordance with articles 2 and 3, or any combination of these actions, for any of the following causes:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

(2) Violating any law, or violating any rule, subpoena, or order of the commissioner or of another state's

commissioner;

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing business;

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(6) Having been convicted of a felony;

(7) Having admitted to or been found to have committed any insurance unfair trade practice or fraud;

(8) Using fraudulent, coercive, or dishonest practice or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere;

(9) Having an insurance producer license or its equivalent denied, placed on probation, suspended, or revoked in any other state, province, district, or territory;

(10) Forging another's name on an application or on any document related to a transaction;

(11) Improperly using notes or any other reference material while taking an examination for an insurance license;

(12) Accepting insurance business from a person who is not licensed;

(13) Failing to comply with an administrative or court order imposing a child support obligation;

(14) Failing to pay federal or state income taxes or failing to comply with any administrative or court order directing payment of federal or state income taxes; or

(15) Receiving certification from an administering entity pursuant to chapter 436C that the licensee or applicant is in default or breach of any obligation under any student loan, student loan repayment contract, or scholarship contract that financed the licensee's or applicant's education, or has failed to comply with a repayment plan.

(b) If the commissioner takes action pursuant to subsection (a), the commissioner shall notify the applicant or licensee in writing of the reason for that action. The applicant or licensee may make written demand upon the commissioner within ten days of the date of receipt of the notice for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within thirty days of receipt of the written demand and shall be held pursuant to chapter 91; provided that this subsection shall not apply to an action taken pursuant to subsection (a)(15), and following that action, unless otherwise provided by law, the commissioner shall without further review or hearing renew, reinstate, or grant the license only upon receipt of an authorization from the administering entity.

(c) The commissioner shall not renew or reinstate any license and shall deny, suspend, or revoke any license or application if the commissioner has received certification from an administering entity pursuant to chapter 436C that the licensee or applicant is in default or is in breach of any obligation under any student loan, student loan repayment contract, or scholarship contract, or has failed to comply with a repayment plan. Unless otherwise provided by law, if the commissioner has received such certification, the commissioner shall renew, reinstate, or grant a license only upon receipt of authorization from the administering entity.

(d) The license of a business entity may be sanctioned pursuant to subsection (a) if the commissioner finds, after hearing, that any other licensee of the business entity has engaged in misconduct under subsection (a) that was known or should have been known by one or more of the entity's partners, officers, or managers acting on behalf of the entity and the violation was neither reported to the commissioner by the entity nor corrective action taken by the entity.

(e) In addition to or in lieu of any applicable sanction under subsection (a), a licensee may, after hearing, be subject to a civil fine according to article 2.

(f) The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this article, chapter 431, 432, or 432D, against any person who is under investigation for or charged with a violation of this article, chapter 431, 432, or 432D, even if that person's license or registration has been surrendered or has lapsed by operation of law. [L 2001, c 216, pt of §2; am L 2003, c 133, §8 and c 212, §64; am L 2006, c 154, §30]

**[§431:9A-112.3] Suspension or denial of license for noncompliance with support order.** In addition to any other acts or conditions provided by law, the commissioner shall refuse to renew, reinstate, or restore, or shall deny or suspend any license if the commissioner has received certification from the child support enforcement agency pursuant to the terms of section 576D-13 that the licensee or applicant is not in compliance with an order of support or has failed to comply with a subpoena or warrant relating to a paternity or child support proceeding. Unless otherwise provided by law, following receipt of certification pursuant to this section, the commissioner shall renew, reinstate, restore, or grant the license only upon receipt of an authorization from the child support enforcement agency, office of child support hearings, or the family court. Sections 92-17, 431:9A-112, and 431:9A-126 shall not apply to a refusal to renew, reinstate, or restore a license or to a license suspension or denial pursuant to this section. [L 2003, c 212, §1]

**[§431:9A-112.5] Controlled business.** (a) The commissioner shall neither grant nor extend a producer's license to any person if the commissioner has reasonable cause to believe that:

(1) In the case of an application for license extension, during either of the two calendar years immediately preceding the extension date of the license, the aggregate amount of premiums on insurance represented by controlled business exceeded the aggregate amount of premiums on all other insurance business of the licensee; or

(2) The circumstances of the applicant for license issuance or extension are such as to cause the commissioner reasonably to believe that during the twelve-month period that would immediately follow the issuance or extension of the license, if granted, the aggregate amount of premiums on controlled business would exceed the aggregate amount of premiums on all other insurance business of the applicant.

(b) "Controlled business" means insurance procured or to be procured by or through a licensee upon:

(1) The licensee's own life, person, property, or risks, or those of the licensee's immediate family; or

(2) The life, person, property, or risks of the licensee's employer or partnership, of which the licensee or a member of the licensee's immediate family is an officer, director, substantial stockholder, partner, associate,

or employee. [L 2002, c 155, pt of §3]

**[§431:9A-113] Commissions.** (a) An insurance company or insurance producer shall not pay a commission, service fee, brokerage fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this article and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage fee, or other valuable consideration for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this article and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this State if that person was required to be licensed under this article at the time of the sale, solicitation, or negotiation and was so licensed.

(d) An insurer or insurance producer may pay or assign commissions, service fees, brokerage fees, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this State, unless the payment would violate section 431:13-103. [L 2001, c 216, pt of §2]

**§431:9A-114 Appointments.** (a) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer or is contracted with and appointed by an insurance producer so appointed.

(b) To appoint a producer as its agent, the appointing insurer or producer shall file, in a format approved by the commissioner, a notice of appointment within fifteen days from the date the agency or business entity contract is executed or the first insurance application is submitted to the insurer or producer. If the appointment form is not received by the commissioner within the fifteen-day period, the appointment shall become effective on the date on which the commissioner receives the appointment form. A producer shall disclose to a client if the conditions of subsection (a) have not been met. An insurer or producer may also elect to appoint a producer to all or some insurers within the insurer's or producer's holding company system or group by filing with the commissioner a single appointment notice.

(c) Upon receipt of the notice of appointment and within a reasonable time not to exceed thirty days, the commissioner shall verify that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the commissioner shall notify the appointing insurer or producer within five days of its determination.

(d) An appointing insurer or producer shall pay an appointment fee, in the amount and method of payment set forth in article 7, for each insurance producer appointed by the appointing insurer or producer.

(e) An appointing insurer or producer shall remit, in a manner prescribed by the commissioner, a renewal appointment fee in the amount set forth in article 7. [L 2001, c 216, pt of §2; am L 2002, c 155, §32]

**§431:9A-115 Notification to commissioner of termination.** (a) An insurer, authorized representative of the insurer, or a producer that terminates the appointment, employment, contract, or other insurance business relationship with a producer shall notify the commissioner

within thirty days following the effective date of the termination, using the applicable format prescribed by the commissioner. An insurer, an authorized representative of the insurer, or a producer who terminates a producer for one of the reasons set forth in section 431:9A-112 or who has knowledge the producer was found by a court, governmental body, or self-regulatory organization to have engaged in any of the activities in section 431:9A-112, shall use the particular format for that situation as prescribed by the commissioner. Upon the written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(b) The insurer, an authorized representative of the insurer, or a producer shall promptly notify the commissioner in a format acceptable to the commissioner if, upon further review or investigation, the insurer, an authorized representative of the insurer, or a producer discovers additional information that would have been reportable to the commissioner in accordance with subsection (a) had the insurer, authorized representative of the insurer, or producer then known of its existence.

(c) The insurer, authorized representative of the insurer, and the producer are subject to the following:

(1) Within fifteen days after making the notification required by subsections (a) and (b), the insurer, authorized representative of the insurer, or the producer shall mail a copy of the notification to the producer at the producer's last known address. If the producer is terminated for any of the causes listed in section 431:9A-112, the insurer, authorized representative of the insurer, or the producer shall provide a copy of the notification to the producer at the producer's last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within thirty days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the commissioner. The producer, by the same means, shall simultaneously send a copy of the comments to the reporting insurer, authorized representative of the insurer, or the producer, and the comments shall become a part of the commissioner's file and shall accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (e).

(d) Immunity from civil liability for notification applies as follows:

(1) In the absence of actual malice, an insurer, the insurer's authorized representative, a producer, the commissioner, or an organization of which the commissioner is a member and that compiles the information and makes it available to other commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the commissioner, from an insurer or producer; or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination under subsection (a) was reported to the commissioner, provided that the propriety of any termination under subsection (a) is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(2) In any action brought against a person that may have immunity under paragraph (1) for making any statement required by this section or for providing any information relating to any statement that may be requested by the commissioner, the party bringing the action shall plead specifically in any allegation that paragraph (1) does not apply because the person making the statement or providing the information did so with actual malice.

(3) Paragraphs (1) or (2) shall not abrogate or modify any existing statutory or common law privileges or immunities.

(e) Confidentiality and privilege from disclosure is established as follows:

(1) Any documents, materials, or other information in the control or possession of the commissioner or any agent of the commissioner that is furnished by an insurer, producer, or an employee or agent thereof who is acting on behalf of the insurer or producer, or is obtained by the commissioner, any agent of the commissioner, the insurance division, or any employee of the insurance division, in an investigation pursuant to this section shall be confidential and privileged, shall not be subject to chapter 92F, shall not be subject to subpoena, shall not be subject to discovery, and shall not be admissible in evidence in any civil action; provided that the commissioner or the commissioner's designee is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

(2) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be required to testify in any civil action concerning any confidential documents, materials, or information subject to paragraph (1).

(3) Any provision to the contrary notwithstanding, the commissioner may:

(A) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to paragraph (1), with other state, federal, and international regulatory and law enforcement agencies and authorities, the National Association of Insurance Commissioners, and their affiliates or subsidiaries; provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(B) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from state, federal, and international regulatory and law enforcement agencies and authorities and shall maintain as confidential or privileged any document, material, or information received with the notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(C) Enter into agreements governing sharing and use of information consistent with this subsection.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing, receiving, or using the information as authorized in paragraph (3).

(5) Nothing in this article shall prohibit the commissioner from releasing final, adjudicated actions including terminations that are open to public inspection pursuant to section 431:2-209 to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.

(f) An insurer, the authorized representative of the insurer, or a producer who fails to report as required under the provisions of this section or who is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with article 2. [L 2001, c 216, pt of §2; am L 2002, c 155, §33]

**[§431:9A-116] Reciprocity.** (a) The commissioner shall waive any requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by section 431:9A-108, so long as the applicant's home state awards nonresident licenses to residents of this State on the same basis.

(b) A nonresident producer's satisfaction of the producer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this State's continuing education requirements so long as the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this State on the same basis. [L 2001, c 216, pt of §2]

**[§431:9A-117] Reporting of actions.** (a) A producer shall report to the commissioner any civil or administrative action taken against the producer in any jurisdiction or by a governmental agency in any state within thirty days of the final disposition of the matter.

(b) Within thirty days of arraignment, a producer shall report to the commissioner any criminal prosecution of the producer being taken in any jurisdiction.

(c) The report shall include a copy of the initial complaint or indictment filed and any and all other relevant legal documents. [L 2001, c 216, pt of §2]

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**[§431:9A-118] Rules.** The commissioner may, in accordance with chapter 91, adopt reasonable rules as are necessary or proper to carry out the purposes of this article. [L 2001, c 216, pt of §2]

**[§431:9A-119] Scope of examination.** (a) The commissioner shall prescribe each examination, and each examination shall be of reasonably sufficient scope to test the applicant's knowledge relative to the classes of insurance that may be dealt with under the license applied for, the duties and responsibilities relating thereto, and the laws of this State that are applicable to the licensee.

(b) The commissioner is required to prepare and make available to insurance producers a printed manual specifying in general terms the subjects which may be covered in any examination for a particular license. [L 2001, c 216, pt of §2]

**[§431:9A-120] Time of examinations.** (a) The commissioner shall give examinations within this State at such times and places as may reasonably serve the convenience of both the commissioner and applicants.

(b) The commissioner may require a waiting period of not more than six months before giving a new examination to an applicant who has failed to pass two previous, similar examinations. [L 2001, c 216, pt of §2]

**[§431:9A-121] Advisory board.** The commissioner may, in the commissioner's discretion, appoint a group of individuals, to be known as the advisory board, to make recommendations to the commissioner concerning any matter relating to the examinations provided for by this article. Any individual appointed to the advisory board shall not be

entitled to any compensation for the individual's services. The commissioner shall select a group that fairly represents the insurance industry in this State. The commissioner shall decide how long each individual is to serve on the advisory board. This section shall not be subject to the requirements of chapter 92. [L 2001, c 216, pt of §2]

**§431:9A-122 Place of business.** (a) Every licensed insurance producer shall have and maintain in this State, or, if a nonresident insurance producer, in the nonresident's home state, a place of business accessible to the public.

(b) The place of business shall be where the licensee principally conducts transactions under the licensee's licenses.

(c) The licensee shall notify the commissioner of any change of business address within thirty days of the change. [L 2001, c 216, pt of §2; am L 2006, c 189, §5; am L 2010, c 116, §1(8)]

**§431:9A-123 Records of insurance producer.** (a) Every insurance producer shall keep a record of all transactions consummated under the producer's license. The record required by this section shall be in a form organized according to class of insurance and shall include:

(1) A record of each insurance contract procured or issued, together with the names of the insurers and insureds, the amount of premium paid or to be paid or the basis of the premium or consideration paid or to be paid, and a statement of the subject of the insurance; and

(2) Other and additional information as shall be customary, or as may reasonably be required by the commissioner.

(b) All the records as to any particular transaction shall be kept in the licensee's office and shall be available and open to the inspection of the commissioner during business hours during the five years immediately after the date of the completion of the transaction.

(c) This section shall not apply to life or accident and health or sickness insurance if the records required of the insurance are customarily maintained in the offices of the insurer.

(d) This section shall not apply to motor vehicle or homeowners insurance if the records required of the insurance are maintained electronically, accessible by the producer, and available within one business day. [L 2001, c 216, pt of §2; am L 2002, c 155, §34; am L 2011, c 7, §1]

**[§431:9A-123.5] Reporting and accounting for premiums.** (a) Every licensed producer shall have the responsibilities of a trustee for all premium and return premium funds received or collected under this article.

(b) The licensee, upon receipt of the funds, shall either:

(1) Remit the premiums (less commissions) and return premiums received or held by the licensee to the insurers or the persons entitled to such funds; or

(2) Maintain the funds at all times in a federally insured account with a bank, savings and loan association, or financial services loan company situated in Hawaii, separate from the licensee's own funds or funds held by the licensee in any other capacity, in an amount at least equal to the premiums (net of commissions) and return premiums received by such licensee and unpaid to the insurers or persons entitled to

such funds. Return premiums shall be returned within thirty days, unless directed otherwise in writing by the person entitled to the funds. The licensee shall not be required to maintain a separate bank account or other account for the funds of each insurer or person entitled to such funds, if and so long as the funds held for the insurer or person entitled to such funds are reasonably ascertainable from the books of account and records of the licensee. Only such additional funds as may be reasonably necessary to pay bank, savings and loan association, or financial services loan company charges may be commingled with the premium funds. If the bank, savings and loan association, or financial services loan company account is an interest earning account, the licensee may not retain the interest earned on such funds for the licensee's own use or benefit without the prior written consent of the insurers or person entitled to such funds. A premium trustee account shall be designated on the records of the bank, savings and loan association, or financial services loan company as a "trustee account established pursuant to section 431:9A-123.5, Hawaii Revised Statutes", or words of similar import.

(c) Any such licensee who, not being lawfully entitled to such funds, diverts or appropriates such funds or any portion of them to the licensee's own use, shall be subject to any penalties as provided by law. [L 2002, c 155, pt of §3]

**§431:9A-124 Prerequisites for license renewal.** (a) To qualify for a license renewal, a licensee shall:

(1) During the twenty-four months preceding a license renewal, complete the required number of credit hours as set forth in subsection (b) in approved continuing education courses; and

(2) Pay the fees as required under section 431:7-101.

(b) The required number of credit hours shall be as follows:

(1) For a licensee authorized to sell lines of insurance in only one of the following groups:

(A) Life or accident and health or sickness; or
(B) Property, marine and transportation, vehicle, general casualty, or surety;

the requisite number of credit hours shall be twenty-four credit hours, consisting of twenty-one credit hours relating to the line of authority for which the license is held and three credit hours relating to ethics training or relating to the insurance laws and the insurance rules;

(2) For a licensee with a license to sell lines of insurance in both groups in paragraph (1), the total requisite number of credit hours shall be twenty-four credit hours, consisting of:

(A) Ten credit hours relating to paragraph (1)(A);
(B) Eleven credit hours relating to paragraph (1)(B); and
(C) Three credit hours relating to ethics training or to insurance laws and rules.

For purposes of this section, ethics training shall include but shall not be limited to the study of fiduciary responsibility, commingling of funds, payment and acceptance of commissions, unfair claims practices, policy replacement considerations, and conflicts of interest.

(c) Continuing education equivalents, as determined and approved by the commissioner, may include the teaching of continuing education courses and holding certain professional designations, but shall not include the use of carryover credit hours earned in excess of the required hours in any two-year renewal cycle.

(d) Unless an extension of time has been granted in advance by the commissioner, a licensee's failure to satisfy all of the continuing education requirements by the renewal date shall result in that

licensee's license being automatically placed on an inactive status. To reactivate a license, the licensee shall submit proof to the insurance division that the requisite number of credit hours has been completed and the licensee shall pay any required fees and penalties.

(e) After a licensee completes an approved continuing education course, the approved course provider shall issue to the licensee a certificate of completion in a form approved by the commissioner that certifies that the licensee has successfully completed the course. Both the licensee and a person authorized to sign on behalf of the approved course provider shall sign the certificate of completion. The approved course provider shall electronically submit the certificate of completion to the insurance division within fifteen days of course completion.

(f) This section shall not apply to a licensee granted an exemption by the commissioner from this section pursuant to section 431:9A-116.

(g) The commissioner may grant an extension of time to meet the requirements of this section to a licensee on extended active military duty for a period of time equal to the number of days the licensee was on active military duty.

(h) A licensee need not retake the producer license examination provided that renewal requirements in this section are met or reactivation occurs within two years of the date of inactivation. [L 2001, c 216, pt of §2; am L 2002, c 155, §35; am L 2003, c 212, §§65, 66; am L 2006, c 154, §31; am L 2009, c 77, §9; am L 2012, c 66, §9]

**[§431:9A-125] Continuing education recordkeeping.** (a) Licensees shall maintain their own continuing education records and shall keep these records for four years after completion of an approved continuing education course.

(b) Approved course providers shall maintain attendance records for five years to permit the commissioner to verify the attendance and course completion of all licensees enrolled in an approved course. These course providers shall make the records available at all times to the commissioner. [L 2001, c 216, pt of §2]

**§431:9A-126 Power to fine.** (a) The order levying the fine through section 431:9A-112 shall specify the period within which the fine shall be fully paid, and that period shall be not less than thirty nor more than forty-five days from the date of the order.

(b) Upon the licensee's failure to pay any fine when due, the commissioner shall revoke the license of the licensee if not already revoked, and the fine may be recovered in a civil action brought on behalf of the commissioner by the attorney general.

(c) Any fine collected shall be paid by the commissioner to the director of finance for the account of the compliance resolution fund. [L 2001, c 216, pt of §2; am L 2003, c 212, §67]

**[§431:9A-127] Fine in lieu.** (a) Upon the hearing of an appeal from an order imposing any sanction upon a licensee in accordance with section 431:9A-112, the court may impose a fine of not more than $10,000 in lieu of the commissioner's action, and payment of that fine within ten days of the court's order shall result in the acceptance of the licensee's application or the reinstatement, restoration, or extension of that license if:

(1) The court finds that the licensee violated the law; and

(2) The court deems the sanction imposed too severe a penalty under the facts as found.

(b) If the licensee has previously been sanctioned for a similar offense, the court shall not have jurisdiction to impose a fine in lieu of the commissioner's action. [L 2001, c 216, pt of §2]

**[§431:9A-128] Nondiscrimination.** Continuing education courses provided by insurers to insurance producers shall be subject to the same standards, reviews, and credits as other continuing education courses. Nothing in this article is intended to preclude the provision of continuing education courses by insurers to insurance producers; provided that no credit shall be given for any course unless it is a continuing education course approved by the commissioner. [L 2001, c 216, pt of §2]

**§431:9A-129 Penalty.** (a) The commissioner may revoke or suspend the certificate of an approved course provider for any violation of the insurance code, subject to the right of the provider to a hearing as provided in section 431:2-308.

(b) The commissioner shall sanction the license of any licensee who has submitted an invalid, false, or fraudulent certificate of completion, subject to the right of a licensee to have a hearing as provided in chapter 91.

(c) The commissioner shall revoke the approval of an approved course provider who has issued a certificate of completion to a licensee who has not attended the continuing education course or to a licensee who has not met the course requirements, subject to the right of an approved course provider to have a hearing as provided in section 431:2-308. [L 2001, c 216, pt of §2; am L 2002, c 155, §36; am L 2003, c 212, §68]

**[§431:9A-130] Commissioner's authority to grant waiver.** Upon the receiving of a written request and a showing of good cause, the commissioner shall have the authority to grant a waiver of any requirement of an insurance law or insurance rule as applied to an applicant or a producer. [L 2001, c 216, pt of §2]

## [PART II.] LIMITED LINES MOTOR VEHICLE RENTAL COMPANY PRODUCER

**[§431:9A-141] Definitions.** Unless specified otherwise, the following definitions shall be used in this part in addition to other definitions in chapter 431:

"Limited lines motor vehicle rental company producer" or "rental company producer" means a motor vehicle rental company that is licensed by the commissioner to solicit and sell insurance coverages only in connection with and which are incidental to the rental company's business of renting motor vehicles.

"Motor vehicle rental agreement" or "rental agreement" means any written agreement setting forth the terms and conditions governing the use of a motor vehicle that is rented or leased from a rental company.

"Motor vehicle rental company" or "rental company" means any person that is primarily in the business of providing motor vehicles to the public under a motor vehicle rental agreement for a rental period not to

exceed ninety days.

"Motor vehicle renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a rental period not to exceed ninety days.

"Rental vehicle" or "vehicle" means a motor vehicle:

(1) Of the private passenger type including passenger vans, minivans, and sport utility vehicles; or

(2) Of the cargo type, including cargo vans or pickup trucks with a gross vehicle weight of less than twenty-six thousand pounds,

that do not require a commercial driver's license for the operation of the vehicle. [L 2002, c 235, pt of §1]

**§431:9A-142 Requirements for license and renewal.** (a) Applicants seeking licensure under this part shall comply with applicable licensing requirements under chapter 431.

(b) The commissioner may issue a limited lines motor vehicle rental company producer license to a motor vehicle rental company; provided that:

(1) A motor vehicle rental company having a limited lines motor vehicle rental company producer's license shall also authorize employees of the motor vehicle rental company to act individually on behalf of, and under the supervision of, the motor vehicle rental company in solicitation and sale of insurance coverages;

(2) Except as set forth in this section, a limited lines motor vehicle rental company producer and its employees shall not advertise or otherwise represent themselves as licensed insurers, insurance agents, insurance producers, or insurance brokers;

(3) A limited lines motor vehicle rental company producer may solicit or sell insurance at the rental office or by preselecting coverages in master, corporate, group rental, or individual agreements in any of the following general categories:

(A) Personal accident insurance covering the risks of travel to the motor vehicle renter and other occupants of the rental vehicle for accident and health or sickness insurance covering accidental death or dismemberment and reimbursement for medical expenses resulting from an occurrence during the rental period;

(B) Liability insurance, uninsured motorist insurance, or underinsured motorist insurance covering the motor vehicle renter and other authorized drivers of the rental vehicle for liability and damage arising from the operation of the rental vehicle;

(C) Personal effects insurance covering the motor vehicle renter and other vehicle occupants for the loss of or damage to personal effects that occur during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Incidental travel or vehicle related coverages, which the motor vehicle rental company solicits or sells in connection with the rental of its vehicles;

(4) The limited lines motor vehicle rental company producer shall have brochures or other written

materials readily available for review and dissemination to prospective motor vehicle renters that:

(A) Summarize clearly and correctly the material terms of coverages solicited or sold by the motor vehicle rental company producer, including the identity of the insurer;
(B) Disclose that the coverages solicited by the motor vehicle rental company producer may provide a duplication of coverages already provided by a renter's personal motor vehicle insurance policy or other sources of coverage;
(C) State that purchases by the motor vehicle renter of the kinds of coverages offered by the motor vehicle rental company producer is not required to rent a vehicle; and
(D) Describe the process for filing a claim if the renter elects to purchase coverages;

(5) The motor vehicle rental company producer shall disclose in the motor vehicle rental agreement evidence of insurance coverages elected or declined by the motor vehicle renter;

(6) The motor vehicle rental company producer shall conduct training programs for its employees who solicit and sell the rental company producer's insurance coverages;

(7) The motor vehicle rental company producer shall not be required to hold funds collected as payments for insurance in a separate trust account; and

(8) The motor vehicle rental company producer shall comply with all provisions of chapter 437D.

(c) The commissioner may prescribe, approve, or furnish forms calling for any information that the commissioner deems proper in connection with the application for or extension of these limited licenses.

(d) The limited license shall not be issued until all applicable licensing fees required by article 7 have been paid. [L 2002, c 235, pt of §1; am L 2003, c 212, §69; am L 2006, c 154, §32]

## [PART III.] CONTINUING EDUCATION COURSE PROVIDERS

**§431:9A-151 Continuing education course provider certificate.** (a) An approved continuing education course shall be offered only by a person who has a valid continuing education course provider certificate. Any person seeking a continuing education course provider certificate shall submit to the commissioner at least sixty days prior to the date the course will be offered:

(1) An application in duplicate on a form prescribed by the commissioner; and

(2) The appropriate application fee.

(b) A continuing education [course] provider, who is seeking renewal of the certificate, shall submit to the commissioner at least sixty days prior to the expiration of the certificate:

(1) A renewal application in duplicate in a form prescribed by the commissioner; and

(2) The appropriate renewal application fee.

(c) The continuing education course provider certificate:

(1) Shall expire:

(A) On July 1 of the calendar year immediately following the calendar year the application for the initial certificate was received, if the application was received in the months of January through June; or

(B) On July 1 of the second calendar year following the calendar year the application for the initial certificate was received, if the application was received in the months of July through December; and

(2) May thereafter be renewed by application for a period of one year beginning on July 1 and ending on July 1 of the following calendar year,

unless the certificate is earlier suspended or revoked by the commissioner.

(d) An application may be denied, or the continuing education course provider certificate may be suspended or revoked, if the commissioner determines that the applicant or an officer, director, partner, or owner of an applicant entity:

(1) Is not qualified to perform the duties and responsibilities listed in this chapter;

(2) Engaged in false, fraudulent, or deceptive advertising or in making false or untruthful statements to the public or the commissioner;

(3) Procured any past license or regulatory approval through fraud, misrepresentation, or deceit;

(4) Aided and abetted an unlicensed person in performing, directly or indirectly, any activities requiring a license;

(5) Failed to maintain a record or history of competency, trustworthiness, fair dealing, or financial integrity;

(6) Engaged in business under a past or present license issued pursuant to licensing laws, in a matter causing injury to one or more members of the public;

(7) Failed to comply, observe, or adhere to any law in a manner such that the commissioner deems the applicant to be unfit for approval;

(8) Has been refused a professional, occupational, or vocational license, has had such a license suspended, revoked, or restricted, or has been fined or placed on probation by any licensing authority; or

(9) Has been convicted of a felony or a misdemeanor involving a fraudulent act or an act of dishonesty in the acceptance, custody, or payment of money or property. [L 2003, c 55, pt of §1; am L 2006, c 154, §33]

**§431:9A-152 Continuing education course provider additional duties.** In addition to other duties and obligations imposed by law, a continuing education course provider shall be responsible for:

(1) Ensuring that each course is taught by a qualified instructor;

(2) Providing course schedules at least thirty days prior to the start date of each class;

(3) Monitoring attendance by having licensees who are taking the continuing education course, sign-in at the time of entrance to the course, and sign-out upon completion of the course, for courses other than self-study courses;

(4) Supervising and evaluating courses and instructors;

(5) Administering examinations when applicable;

(6) Verifying and submitting in the appropriate format, on a timely basis, course attendance and completion rosters and other information required by law;

(7) Signing and issuing to a licensee, in a form approved by the commissioner, a certificate of completion within fifteen days of completion of a continuing education course;

(8) Providing continuing education course application materials, including a detailed course content outline and a copy of the provider's tuition and fee refund policy, upon a licensee's request; and

(9) Publishing and abiding by a refund policy that complies with rules adopted by the commissioner. [L 2003, c 55, pt of §1; am L 2006, c 154, §34]

**§431:9A-153 Courses.** (a) No continuing education course hours shall be credited for a course unless the provider conducting the course has a valid continuing education course provider certificate at the time the course is conducted.

(b) In determining whether to approve a course, the commissioner may consider whether the course:

(1) Is a formal program of learning that contributes directly to the professional competence of licensees;

(2) Will enhance and improve the knowledge of licensees with regard to the conduct of the business of insurance in the State;

(3) Includes methods to evaluate and assess the effectiveness of the course;

(4) Is appropriately classified as "basic", "intermediate", or "advanced"; and

(5) Includes a bibliography of reference materials and supplemental teaching aids.

(c) The commissioner shall not grant continuing education credit for any course work that focuses on:

(1) Personal development;

(2) Motivational or public speaking;

(3) Salesmanship;

(4) Product presentation;

(5) Mechanical office skills, including but not limited to typing, speed reading, use of calculators, computers, or other office machinery; or

(6) Other subject matter not related to the business of insurance as determined by the commissioner.

(d) A continuing education course provider shall submit for approval to the commissioner a course application at least sixty days prior to the date the course will be offered. Course applications shall be submitted to the commissioner for approval for new courses, renewals of course certificates, or whenever changes are proposed in the course material, course hours, method of presentation, or method of examination. A continuing education course provider shall obtain the commissioner's prior approval for the course before advertising or soliciting for the course.

(e) Continuing education credit hours shall be approved in increments of not less than one credit hour.

(f) No course shall be approved for more than twenty-four credit hours.

(g) The continuing education course certificate shall expire:

(1) On July 1 of the calendar year immediately following the calendar year the application for the initial certificate was received, if the application was received in the months of January through June; or

(2) On July 1 of the second calendar year following the calendar year the application for the initial certificate was received, if the application was received in the months of July through December.

The certificate may be renewed once for a two-year period by application beginning on July 1 and ending on July 1 of the second calendar year; provided that the certificate is not suspended, expired, or revoked by the commissioner. [L 2003, c 55, pt of §1; am L 2006, c 154, §35; am L 2013, c 190, §2]

**§431:9A-154 Self-study courses.** (a) In addition to the requirements of courses generally, an approved continuing education course provider shall also require for self-study courses, including computer-based courses, a written or computer-based examination at the conclusion of the self-study course. The examination shall:

(1) Be composed of multiple choice questions, essay questions, or both;

(2) Have at least three different versions of itself, used on a random or rotating basis;

(3) If composed of multiple choice questions for a course approved for up to four credit hours, include at least twenty-five multiple choice questions;

(4) If composed of multiple choice questions for a course approved for more than four credit hours, include at least fifty multiple choice questions;

(5) Be graded by the continuing education course provider or the continuing education course provider's agent;

(6) If the examination is computer-based, not include prompts designed to aid the person taking the examination; and

(7) If the course is a computer-based course with a computer-based examination, be designed to prevent the licensee from taking the examination without reviewing the course materials.

(b) To pass a multiple-choice self-study course, the licensee shall answer at least seventy per cent of the examination questions correctly.

(c) A self-study course examination shall not be administered by a person who:

(1) Is related to, or is a business associate of, the licensee taking the examination; or

(2) Has a financial interest in the success or failure of a licensee taking the examination.

(d) The effective date of a completed examination pursuant to this section shall be the date the continuing education course provider receives the completed examination. Upon receipt of the completed examination, the continuing education course provider or the continuing education course provider's agent shall grade the examination and mail

the results to the licensee within fifteen days. [L 2003, c 55, pt of §1; am L 2006, c 154, §36]

**[§431:9A-155] Carryover credits.** No credit hours earned during a single renewal cycle may be carried over and counted towards satisfaction of the credit hour requirements for a following renewal cycle for the same license. [L 2003, c 55, pt of §1]

**[§431:9A-156] Course instructors.** (a) The commissioner may deem a continuing education course instructor unqualified if the instructor has been subject to suspension, revocation, or other disciplinary proceeding in relation to an insurance license or other financial services license by the State or other jurisdiction.

(b) A continuing education course provider shall give the commissioner access to the employment records of any instructor employed by the provider.

(c) A provider shall require the instructor to display a photo identification to any insurance division representative who conducts an official audit during an instruction period. [L 2003, c 55, pt of §1]

**[§431:9A-157] Tuition.** (a) The following are requirements that providers shall follow:

(1) Tuition fees for courses shall be reasonable and clearly identified;

(2) If the course is canceled for any reason, all fees shall be refunded in full unless the enrollment application contains a refund policy clause that expressly states otherwise. If the fees are refundable, the continuing education course provider shall refund the fees within forty-five days after the cancellation;

(3) In the event a course is postponed for any reason, a licensee shall be given the choice of attending the course at a later date or having the fee refunded in full. If a licensee chooses not to attend a postponed course, the continuing education course provider shall refund the fees within forty-five days after the postponement; and

(4) A provider may have a refund policy that addresses a licensee's cancellation or failure to complete a course, so long as that policy is clear to the licensee and in compliance with this section.

(b) A continuing education course provider may offer a continuing education course free of tuition. [L 2003, c 55, pt of §1]

**§431:9A-158 Reporting credit hours and recordkeeping.** Continuing education course providers shall:

(1) Submit course completion information as prescribed by the commissioner to the insurance division within fifteen days after the course is completed or the competency examination is scored. The information shall be transmitted in an electronic form in the format prescribed by the commissioner; and

(2) Maintain adequate records to verify the attendance and successful course completion pursuant to section 431:9A-125(b). [L 2003, c 55, pt of §1; am L 2006, c 154, §37]

**[§431:9A-159] Advertising.** (a) A course shall not be advertised as an approved course for continuing education credit unless the commissioner has approved the course in writing.

(b) Advertisements for an approved course shall include:

(1) The provider's name, course title, and course number;

(2) The statement "Approved by the Hawaii State Insurance Commissioner for continuing education credit";

(3) The number of approved credit hours; and

(4) The amount of tuition, fees, and all other associated expenses. [L 2003, c 55, pt of §1]

**[§431:9A-160] Advisory committee.** (a) The commissioner may establish an advisory committee, which shall be composed of nine members appointed by the commissioner of which:

(1) Eight members shall be practicing licensees with active licenses; and

(2) One member shall be from the insurance division.

Members shall serve staggered terms of two years each so that the terms of no more than five members expire each year.

(b) The advisory committee shall assist the commissioner by:

(1) Recommending to the commissioner policies, procedures, and administrative rules to implement this part, including:

(A) Additional criteria to be used in the consideration and review of course providers, courses, and course materials;

(B) Additional criteria to be considered in the approval or rejection of continuing education courses; and

(C) Courses, credit hours, and fees for applications of renewals for each approved course;

(2) Reviewing the continuing education course requirements for this State and other states to determine whether the courses are substantially equivalent and recommending to the commissioner whether to enter into or maintain reciprocal agreements with other states;

(3) Reviewing and critiquing proposed continuing education course materials to determine whether the course materials are appropriate for the purposes of continuing education and whether courses using these materials would comply with this part; and

(4) Providing such other and further assistance to the commissioner as the commissioner deems appropriate.

(c) The committee members shall receive no monetary compensation for services.

(d) The commissioner may grant continuing education equivalent credit to members of the advisory committee for work completed pursuant to this section. [L 2003, c 55, pt of §1]

## [ARTICLE 9B]
## REINSURANCE INTERMEDIARY

### Cross References

Credit for reinsurance, see article 4A.

Reinsurance Intermediaries: Law and Litigation. 29 UH L. Rev. 59 (2006).

**§431:9B-101 Definitions.** For purposes of this article:

"Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

"Controlling person" means any individual, firm, association, or corporation that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of the reinsurance intermediary.

"Insurer" means any individual, firm, association, or corporation duly licensed in this State pursuant to this chapter as an insurer.

"Qualified United States financial institution" means an institution that:

(1) Is organized or (in the case of a United States office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

(2) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the commissioner, or the securities valuation office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

"Reinsurance intermediary" or "producer" means a reinsurance intermediary-broker or a reinsurance intermediary-manager licensed pursuant to this article and article 9A.

"Reinsurance intermediary-broker" or "RB" means any person, other than an officer or employee of the ceding insurer, firm, association, or corporation that solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

"Reinsurance intermediary-manager" or "RM" means any individual, firm, association, or corporation that has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer (including the management of a separate division, department, or underwriting office) and acts as an agent for the reinsurer whether known as a reinsurance intermediary-manager, manager, or other similar term. Notwithstanding the above, the following persons shall not be considered a reinsurance intermediary-manager, with respect to the reinsurer, for the purposes of this article:

(1) An employee of the reinsurer;

(2) A United States manager of the United States branch of an alien reinsurer;

(3) An underwriting manager who, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to article 11, and whose compensation is not based on the volume of premiums written; and

(4) The manager of a group, association, pool, or organization of insurers that engages in joint underwriting or joint reinsurance and who is subject to examination by the commissioner of the state in which the manager's principal business office is located.

"Reinsurer" means any person, firm, association, or corporation duly licensed in this State pursuant to the applicable provisions of the insurance law as an insurer with the authority to assume reinsurance.

"To be in violation" means that the reinsurance intermediary, or insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with this article. [L 1992, c 176, pt of §6; am L 2002, c 155, §37; am L 2012, c 66, §10]

**§431:9B-102 Licensure.** (a) Persons, firms, associations, and corporations acting as a reinsurance intermediary-broker in this State shall maintain a license as a reinsurance intermediary-broker in this State. The reinsurance intermediary-broker shall maintain a license in every state where it maintains an office, either directly, as a member or employee of a firm or association, or as an officer, director, or employee of a corporation.

(b) Persons, firms, associations, and corporations acting as a reinsurance intermediary-manager for a reinsurer domiciled in this State shall maintain a license as a reinsurance intermediary-manager in this State. A reinsurance intermediary-manager license shall be required to act as a reinsurance intermediary-manager in this State for a nondomestic reinsurer.

(c) The commissioner may require a reinsurance intermediary-manager subject to subsection (b) to:

(1) File a bond from an insurance company licensed to do business within the State or with an insurance company approved by the commissioner in an amount equal to $500,000 or ten per cent of the annual reinsurance premiums managed by the reinsurance intermediary-manager, whichever is greater, except that the bond amount under this paragraph shall not exceed $10,000,000, for the protection of the reinsurer;

(2) Maintain an errors and omissions policy, with an insurance company licensed to do business within the State or with an insurance company approved by the commissioner, in an amount equal to $250,000 or twenty-five per cent of the annual reinsurance premiums managed by the reinsurance intermediary-manager, whichever is greater, except that the policy limits under this paragraph shall not exceed $10,000,000; and

(3) Provide any other report required by the commissioner.

At the commissioner's request, the reinsurance intermediary-manager shall provide the commissioner with proof of the bond and the policy, and appropriate documentation to show that the bond and the policy continue to be in effect or that a new bond and a new policy have been secured.

(d)(1) The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation that has complied with the requirements of this article. Any such license issued to a firm or association shall authorize all the members of that firm or association and any designated employees to act as reinsurance intermediaries under the license, and all those persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of the corporation, and all those persons shall be named in the application and any supplements thereto.

(2) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this article for service of process upon unauthorized insurers; and also shall furnish the commissioner with the name and address of a resident of this State upon whom notices or orders of the commissioner or process affecting the nonresident reinsurance intermediary may be served. The licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged

by the commissioner.

(3) The commissioner shall issue a nonresident reinsurance intermediary license if:

(A) The applicant is currently licensed as a resident reinsurance intermediary or insurance producer pursuant to article 9A and in good standing in the applicant's home state;

(B) The applicant has submitted the proper request for licensure and paid the fees required by section 431:7-101;

(C) The applicant has submitted or transmitted to the commissioner the application for licensure that the applicant submitted to the applicant's home state, or in lieu of the same, a completed uniform application; and

(D) The person's home state awards nonresident licenses to residents of this State on the same basis.

(e) The commissioner may refuse to issue a reinsurance intermediary license if, in the commissioner's judgment, the applicant, anyone named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy, or that any controlling person of the applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of the license. Upon written request therefor, the commissioner shall furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to disclosure pursuant to chapter 92F.

(f) Licensed attorneys at law of this State when acting in their professional capacity as such shall be exempt from this section.

(g) Licensing procedure, duration, and related matters affecting reinsurance intermediaries shall be governed by articles 7 and 9A. [L 1992, c 176, pt of §6; am L 2001, c 136, §2; am L 2004, c 122, §29; am L 2006, c 189, §6; am L 2012, c 66, §11]

**§431:9B-103 Required contract provisions; reinsurance intermediary-brokers.** Transactions between a reinsurance intermediary-broker and the insurer it represents in that capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization, at a minimum, shall provide that:

(1) The insurer may terminate the reinsurance intermediary-broker's authority at any time;

(2) The reinsurance intermediary-broker shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the reinsurance intermediary-broker, and remit all funds due to the insurer within thirty days of receipt;

(3) All funds collected for the insurer's account shall be held by the reinsurance intermediary-broker in a fiduciary capacity and deposited in a bank that is a qualified United States financial institution;

(4) The reinsurance intermediary-broker shall comply with section 431:9B-104;

(5) The reinsurance intermediary-broker shall comply with the written standards established by the insurer for the cession or retrocession of all risks; and

(6) The reinsurance intermediary-broker shall disclose to the insurer any relationship with any reinsurer to

which business will be ceded or retroceded. [L 1992, c 176, pt of §6; am L 1993, c 321, §12]

**§431:9B-104 Books and records; reinsurance intermediary-brokers.** (a) For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, the reinsurance intermediary-broker shall keep a complete record for each transaction showing:

(1) The type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) Period of coverage, including effective and expiration dates, cancellation provisions, and notice required for cancellation;

(3) Reporting and settlement requirements of balances;

(4) Rate used to compute the reinsurance premium;

(5) Names and addresses of assuming reinsurers;

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker;

(7) Related correspondence and memoranda;

(8) Proof of placement;

(9) Details regarding retrocessions handled by the reinsurance intermediary-broker including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) Financial records, including but not limited to, premium and loss accounts; and

(11) When the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(A) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(b) The insurer will have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer. [L 1992, c 176, pt of §6; am L 1993, c 6, §18]

**[§431:9B-105] Duties of insurers utilizing the services of a reinsurance intermediary-broker.** (a) An insurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-broker on its behalf unless the person, firm, association, or corporation is licensed as required by section 431:9B-102.

(b) An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business, unless the reinsurance intermediary-broker is under common control with the insurer and subject to article 11.

(c) The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business. [L 1992, c 176, pt of §6]

**§431:9B-106 Required contract provisions; reinsurance intermediary-managers.** Transactions between a reinsurance intermediary-manager and the reinsurer it represents in that capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party that shall be approved by the reinsurer's board of directors. The contract, at a minimum, shall provide that:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination;

(2) The reinsurance intermediary-manager shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the reinsurance intermediary-manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis;

(3) All funds collected for the reinsurer's account shall be held by the reinsurance intermediary-manager in a fiduciary capacity and deposited in a bank that is a qualified United States financial institution. The reinsurance intermediary-manager may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents;

(4) For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager shall keep a complete record for each transaction showing:

(A) The type of contract, limits, underwriting restrictions, classes or risks, and territory;
(B) Period of coverage, including effective and expiration dates, cancellation provisions and notice required for cancellation, and disposition of outstanding reserves on covered risks;
(C) Reporting and settlement requirements of balances;
(D) Rate used to compute the reinsurance premium;
(E) Names and addresses of reinsurers;
(F) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;
(G) Related correspondence and memoranda;
(H) Proof of placement;
(I) Details regarding retrocessions handled by the reinsurance intermediary-manager, as permitted by section 431:9B-108(d), including the identity of retrocessionaires and percentage of each contract assumed or ceded;
(J) Financial records, including but not limited to, premium and loss accounts; and
(K) When the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:
(i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or
(ii) If placed through a representative of the assuming

reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative;

(5) The reinsurer shall have access and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer;

(6) The contract shall not be assigned in whole or in part by the reinsurance intermediary-manager;

(7) The reinsurance intermediary-manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks;

(8) The contract sets forth the rates, terms, and purposes of commissions, charges, and other fees that the reinsurance intermediary-manager may levy against the reinsurer;

(9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

(A) All claims shall be reported to the reinsurer in a timely manner;

(B) A copy of the claim file shall be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(ii) Involves a coverage dispute;

(iii) May exceed the reinsurance intermediary- manager's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer;

(C) All claim files shall be the joint property of the reinsurer and reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer, the files shall become the sole property of the reinsurer or its estate; the reinsurance intermediary-manager shall have reasonable access to and the right to copy the files on a timely basis; and

(D) Any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination;

(10) If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, interim profits shall not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business (or a later period set by the commissioner for specified lines of insurance) and not until the adequacy of reserves on remaining claims has been verified pursuant to section 431:9B-108(c);

(11) The reinsurance intermediary-manager shall annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant;

(12) The reinsurer shall, at a minimum, semiannually conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager;

(13) The reinsurance intermediary-manager shall disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to the contract; and

(14) Within the scope of its actual or apparent authority the acts of the reinsurance intermediary-manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting. [L 1992, c 176, pt of §6; am L 1993, c 6, §19 and c 321, §13; am L 2012, c 66, §12]

**[§431:9B-107] Prohibited acts.** The reinsurance intermediary-manager shall not:

(1) Cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. The guidelines shall include a list of reinsurers with which those automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(2) Commit the reinsurer to participate in reinsurance syndicates;

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which the producer is appointed;

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay, a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one per cent of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer;

(6) Jointly employ an individual who is employed by the reinsurer unless the reinsurance intermediary-manager is under common control with the reinsurer subject to article 11; or

(7) Appoint a sub-reinsurance intermediary-manager. [L 1992, c 176, pt of §6]

**[§431:9B-108] Duties of reinsurers utilizing the services of a reinsurance intermediary-manager.** (a) A reinsurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-manager on its behalf unless the person, firm, association, or corporation is licensed as required by section 431:9B-102(b).

(b) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager which the reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the commissioner.

(c) If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. This opinion shall be in addition to any other required loss reserve certification.

(d) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance intermediary-manager.

(e) Within thirty days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of the termination to the commissioner.

(f) A reinsurer shall not appoint to its board of directors any officer, director, employee, controlling shareholder, or subagent of its reinsurance intermediary-manager; provided that this subsection shall not apply to relationships governed by article 11. [L 1992, c 176, pt of §6]

**[§431:9B-109] Examination authority.** (a) A reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable by the commissioner.

(b) A reinsurance intermediary-manager may be examined as if it were the reinsurer. [L 1992, c 176, pt of §6]

**[§431:9B-110] Penalties and liabilities.** (a) After a hearing conducted in accordance with section 431:2-308, a reinsurance intermediary, insurer, or reinsurer found by the commissioner to be in violation of any provisions of this article shall:

(1) For each separate violation, pay a penalty in an amount not exceeding $5,000;

(2) Be subject to revocation or suspension of its license; and

(3) If a violation was committed by a reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

(b) The decision, determination, or order of the commissioner pursuant to subsection (a) shall be subject to judicial review pursuant to chapter 91 and section 431:2-308.

(c) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided in the insurance law.

(d) Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights on those persons. [L 1992, c 176, pt of §6]

**[§431:9B-111] Rules.** The commissioner may adopt reasonable rules under chapter 91 for the implementation and administration of this article. [L 1992, c 176, pt of §6]

## [ARTICLE 9C]
## MANAGING GENERAL AGENTS

**§431:9C-101 Definitions.** For purposes of this article:

"Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

"Insurer" means any person, firm, association, or corporation duly licensed in this State as an insurance company pursuant to section 431:3-201.

"Managing general agent" means any person, firm, association, or corporation that manages all or part of the insurance business of an insurer including the management of a separate division, department, or

underwriting office and acts as an agent for the insurer regardless of whether the person, firm, association, or corporation is known as a managing general agent, manager, or similar term and who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five per cent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year and adjusts or pays claims in excess of $10,000 or negotiates reinsurance on behalf of the insurer. Notwithstanding the specified requirements, the following persons shall not be considered managing general agents for purposes of this article:

(1) An employee of the insurer;

(2) A United States manager of the United States branch of an alien insurer;

(3) An underwriting manager who, pursuant to contract, manages all the insurance operations of the insurer, is under common control with the insurer subject to article 11, and whose compensation is not based on the volume of premiums written;

(4) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under a power of attorney; and

(5) Any person, firm, association, or corporation domiciled in the State, authorized to do business only in the State, and acting as a managing general agent for an insurer licensed and conducting business only in the State.

"Producer" has the same meaning as in section 431:9A-102. "Underwrite" means the authority to accept or reject risk on behalf of the insurer. [L 2002, c 155, pt of §2; am L 2010, c 116, §1(9); am L 2011, c 81, §6]

**§431:9C-102 Licensure.** (a) No person, firm, association, or corporation shall act as a managing general agent, with respect to risks located in this State for an insurer licensed in this State, unless licensed as a producer in this State.

(b) No person, firm, association, or corporation shall act as a managing general agent representing an insurer domiciled in this State with respect to risks located outside this State unless licensed as a producer in this State. [L 2002, c 155, pt of §2; am L 2003, c 212, §70; am L 2006, c 189, §7; am L 2010, c 116, §1(10)]

**§431:9C-103 Required contract provisions.** No person, firm, association, or corporation acting as a managing general agent shall place business with an insurer unless there is in force a written contract between the managing general agent and the insurer which sets forth the responsibilities of each party; where both the managing general agent and the insurer share responsibility for a particular function, specifies the division of those responsibilities and which contains at least the following additional provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent and may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

(2) The managing general agent shall render accounts to the insurer detailing all transactions and shall remit all funds due under the contract to the insurer on not less than a monthly basis;

(3) All funds collected for the account of an insurer shall be held by the managing general agent in a fiduciary capacity and shall be deposited in an account in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer by the managing general agent. The managing general agent may retain no more than three months estimated claims payments and allocated loss adjustment expenses;

(4) Separate records of business written by the managing general agent shall be maintained in the managing general agent's office. The insurer shall have the right to access and to copy all accounts and records of the managing general agent related to the insurer's business in a form usable by the insurer; the commissioner shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the commissioner. Records shall be in an organized form according to each class of insurance and shall include the following information to the extent it is applicable:

(A) A record of each insurance contract procured or issued, together with the names of the insurers and insureds, the amount of premium paid or to be paid, or the basis of the premium or consideration paid or to be paid, and a statement of the subject of the insurance;
(B) The names of any other licensees from whom business is accepted and the names of persons to whom commissions or allowances of any kind are promised or paid;
(C) A record of each investigation or adjustment undertaken or consummated and a statement of any fee, commission, or other compensation received or to be received by an adjuster on account of each investigation or adjustment;
(D) A record of each bill reviewed and a statement of any fee, commission, or other compensation received or to be received by the independent bill reviewer on account of the bill reviewed; and
(E) Any additional information as shall be customary or as may reasonably be required by the commissioner.

This paragraph shall not apply to life or accident and health or sickness insurance if the records required of that insurance are customarily maintained in the offices of the insurer;

(5) The contract may not be assigned in whole or in part by the managing general agent;

(6) Appropriate underwriting guidelines including:

(A) The maximum annual premium volume;
(B) The basis of the rates to be charged;
(C) The types of risks which may be written;
(D) Maximum limits of liability;
(E) Applicable exclusions;
(F) Territorial limitations;
(G) Policy cancellation provisions; and
(H) The maximum policy period.

The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and rules concerning the cancellation and nonrenewal of insurance policies;

(7) The insurer shall require the managing general agent to obtain and maintain a surety bond for the protection of the insurer. The bond amount shall be $100,000 or ten per cent of the managing general agent's total nationwide annual written premium for the insurer in the prior calendar year, whichever is greater; provided that the amount of the surety bond shall not exceed $500,000;

(8) The insurer shall require the managing general agent to obtain and maintain an errors and omissions policy in the minimum amount of $1,000,000;

(9) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(A) All claims shall be reported to the insurer in a timely manner;
(B) A copy of the claim file shall be sent to the insurer upon request or as soon as it becomes known that the claim:
(i) Has the potential to exceed a threshold amount determined by the commissioner or a limit set by the insurer, whichever is less;
(ii) Involves a coverage dispute;
(iii) May exceed the managing general agent's claims settlement authority;
(iv) Is open for more than six months; or
(v) Is closed by payment of a threshold amount set by the commissioner or an amount set by the insurer, whichever is less;
(C) All claim files shall be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, the files shall become the sole property of the insurer or its estate; provided that the managing general agent shall have reasonable access to and the right to copy the files on a timely basis;
(D) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract; provided that the insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination; and
(E) Where electronic claims files are in existence, the contract shall address the timely transmission of the data;

(10) If the contract provides for a sharing of interim profits by the managing general agent and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves, controlling claim payments, or in any other manner, interim profits shall not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and, in any event, not until the profits have been verified through examination pursuant to section 431:9C-105; and

(11) The managing general agent shall not:

(A) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with whom those automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;
(B) Commit the insurer to participate in insurance or reinsurance syndicates;
(C) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which the producer is appointed;

(D) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one per cent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(E) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer;

(F) Permit its subagent to serve on the board of directors of the insurer;

(G) Employ an individual who is also employed by the insurer; or

(H) Appoint a sub-managing general agent. [L 2002, c 155, pt of §2; am L 2003, c 212, §71; am L 2010, c 116, §1(11)]

**§431:9C-104 Duties of insurers.** (a) An insurer shall have on file an independent financial examination in a form acceptable to the commissioner of each managing general agent with whom it has done business.

(b) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an independent actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. The opinion required by this subsection shall be in addition to any other required loss reserve certification required by this chapter.

(c) The insurer shall conduct at least semiannually an on-site review of the underwriting and claims processing operations of the managing general agent.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

(e) The insurer shall notify the commissioner in writing within thirty days of entering into or terminating a contract with a managing general agent. Notice of the appointment of a managing general agent shall include a statement of the duties that the managing general agent is expected to perform on behalf of the insurer, the lines of insurance for which the managing general agent shall be authorized to act, and any other information the commissioner may require.

(f) An insurer shall review its books and records each quarter to determine if any producer has become a managing general agent of the insurer. If the insurer determines that a producer has become a managing general agent of the insurer, the insurer shall promptly notify the producer and the commissioner and the insurer and producer shall both fully comply with this article within thirty days.

(g) An insurer shall not appoint to its board of directors an officer, director, employee, subagent, or controlling shareholder of any of its managing general agents; provided that this subsection shall not apply to relationships governed by article 11.

(h) The insurer shall keep the bond and the errors and omissions policy required by section 431:9C-103 on file for review by the commissioner or other applicable regulatory agency. [L 2002, c 155, pt of §2; am L 2010, c 116, §1(12)]

**[§431:9C-105] Examination authority.** The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined pursuant to article 2 as if the managing general agent was the insurer. [L 2002, c 155, pt of §2]

**[§431:9C-106] Penalties and liabilities.** (a) If after a hearing conducted in accordance with section 431:2-308 and chapter 91, the commissioner finds that any person has violated any provision of this article, the commissioner may order any or all of the following:

(1) For each separate violation, a fine in an amount not less than $500 and not more than $50,000, pursuant to section 431:3-221;

(2) Revocation or suspension of the managing general agent's license; and

(3) The managing general agent to reimburse the insurer or the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this chapter by the managing general agent.

(b) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties as provided by law.

(c) Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors. [L 2002, c 155, pt of §2]

**[§431:9C-107] Rules.** The commissioner may adopt rules in accordance with chapter 91 to effectuate the purposes of this article. [L 2002, c 155, pt of §2]

## [ARTICLE 9N]
## BAIL AGENTS; SURETIES

**[§431:9N-101] Definitions.** As used in this article:

"Bail agent" means a licensed insurance producer under article 9A who is appointed by an authorized surety insurer, furnishes bail for compensation in any court in this State, and has the power of attorney to execute or countersign bail bonds in connection with judicial proceedings. "Bail agent" shall not include a person who is a full-time salaried officer or employee of an insurer or a person who pledges United States currency, a United States postal money order, a cashier's check, or other property as security for a bail bond in connection with a judicial proceeding, whether for compensation or otherwise.

"On the board" means that the name of a bail agent has been publicly posted or disseminated by a court as being ineligible to write bail bonds. [L 2008, c 134, pt of §1]

**[§431:9N-103] Fiduciary responsibilities.** (a) In addition to the requirements of section 431:9A-123.5, bail agents shall have the responsibilities of a trustee for all premium, return premium funds, and collateral or security received or collected under this article.

(b) All premiums received, less commissions if authorized, shall be remitted to the insurer on or before the contractual due date or, if

there is no contractual due date, within forty-five days after receipt.

(c) All returned premiums received from or credited by insurers to the account of the bail agent shall be remitted to or credited to the account of the person entitled thereto within thirty days after the receipt or credit.

(d) An insurer having knowledge that a bail agent has failed to account for any collected premium to the insurer more than forty-five days after the contractual due date or, if there is no contractual due date, more than ninety days after receipt, shall promptly report the failure to the commissioner in writing.

(e) Every insurer shall remit unearned premium funds to the person entitled thereto or shall otherwise credit the account of the bail agent as soon as is practicable after entitlement to the premium funds has been established, but in no event more than forty-five days after the effective date of any cancellation or termination effected by the insurer or after the date of entitlement thereto, as established by notification of cancellation or of termination or as otherwise established. A bail agent having knowledge of a failure on the part of any insurer to comply with this subsection shall promptly report the failure to the commissioner in writing.

(f) No bail agent shall commingle premiums belonging to insurers and return premiums received or held by the bail agent or persons entitled to such funds with the bail agent's personal funds or with any other funds except those directly connected with the bail agent's bail business. [L 2008, c 134, pt of §1]

**[§431:9N-104] Bail agent not to act as attorney.** A bail agent who is also an attorney shall not represent a person to whom the attorney has furnished bail for compensation in any proceeding for which the attorney has furnished bail. The commissioner may place on probation, suspend, revoke, or refuse to renew a bail agent's license and may levy a civil fine or penalty in accordance with articles 2 and 9A, or any combination of these actions, for violation of this section. [L 2008, c 134, pt of §1]

## ARTICLE 10
## INSURANCE CONTRACTS GENERALLY

### PART I. READABILITY OF INSURANCE CONTRACTS

**§431:10-101 Scope; effective dates.** This part shall apply to all contracts filed after June 30, 1983. No contract shall be delivered or issued for delivery in this State after June 30, 1984, unless the contract meets the requirements of this part or has been approved by the commissioner. Any contract approved or permitted to be issued prior to July 1, 1984, is exempt from refiling for approval and may continue to be lawfully delivered or issued for delivery in this State provided a list of such contracts identified by contract number and accompanied by a signed certificate in the manner prescribed by section 431:10-107 is filed with the commissioner. [L 1987, c 347, pt of §2]

**§431:10-102 Definitions.** As used in this part:

"Contract" means any policy of life, accident and health or sickness, credit life, credit disability, homeowners, and motor vehicle insurance covering personally owned or personally leased private

passenger motor vehicles prepared for delivery by an insurer.

"Flesch reading ease test" means the test set forth in section 431:10-106.

"Insurer" means any company, corporation, exchange, society, or association organized on the stock, mutual, assessment, or fraternal plan of insurance and authorized under the insurance laws of this State to issue life, disability, credit life, credit disability, homeowners, and motor vehicle insurance, including but not limited to fraternal benefit societies, nonprofit health service corporations, nonprofit hospital service corporations, health maintenance organizations, and mutual benefit societies.

"Text" includes all printed material in the contract except:

(1) The insurer's name and address;

(2) The name, number, or title of the contract;

(3) The table of contents or index;

(4) Any captions or subcaptions;

(5) Any specification pages, schedules, or tables;

(6) Any language required by federal law, regulation, or agency interpretation or any written certification to exclude such language;

(7) Any language required by any collective bargaining agreement;

(8) Any medical terminology; and

(9) Any definitions. [L 1987, c 347, pt of §2; am L 1997, c 251, §11; am L 2015, c 63, §7]

**§431:10-103 Exemptions of certain contracts.** The provisions of this part shall not apply to:

(1) Any contract which is a security subject to federal jurisdiction;

(2) Any group contract covering a group of one thousand or more lives at date of issue, other than a group credit life or credit disability contract, except that any individual certificate issued under a group contract delivered or issued for delivery in this State shall not be exempt;

(3) Any group annuity contract which funds a pension, profit sharing, or deferred compensation plan;

(4) Any form used in connection with, as a conversion from, as an addition to, or in exchange under a contractual provision for a contract delivered or issued for delivery on a form approved or permitted to be issued prior to July 1, 1984; or

(5) The renewal of a contract delivered or issued for delivery prior to July 1, 1984. [L 1987, c 347, pt of §2]

**§431:10-104 General readability requirements.** In addition to any other requirements of law, no contract shall be delivered or issued for delivery in this State unless:

(1) The text is in plain language, achieving a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test prescribed by the commissioner under section 431:10-105(a);

(2) The contract is printed, except for specification pages, schedules, and tables, in not less than ten point type, one point leaded;

(3) The style, arrangement, and general appearance of the contract give no undue prominence to any endorsements, riders, or other portions of the text;

(4) A table of contents or index of principal sections is provided with the contract when the text consists of more than three thousand words printed on three or less pages or when the text has more than three pages regardless of the total number of printed words; and

(5) For any short-term health insurance policies that impose preexisting conditions provisions, any policy, application, or sales brochure shall disclose in a conspicuous manner in not less than fourteen point bold face type the following statement:

"THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE [insert exclusion period] IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE."

[L 1987, c 347, pt of §2; am L 2016, c 141, §5]

**§431:10-105 Required reading test; authorization and availability.** (a) Every insurer shall use the Flesch reading ease test to determine the readability of any contract. Whenever the commissioner determines that the Flesch reading ease test is inappropriate for the purposes of determining readability, the commissioner shall prescribe an alternative test comparable in result to the Flesch reading ease test to be used by the insurer.

(b) The commissioner shall provide each insurer with a copy of the Flesch reading ease test. Whenever an alternative test is prescribed, the commissioner shall provide a copy of the test to each insurer, accompanied by a set of instructions explaining the manner in which such test shall be conducted. [L 1987, c 347, pt of §2]

**§431:10-106 Flesch reading ease test; procedures.** (a) Whenever the Flesch reading ease test is used, its reading score shall be computed as follows:

(1) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences; and

(2) The resulting figure shall be multiplied by a factor of 1.015; then

(3) The total number of syllables shall be counted and then divided by the total number of words; and

(4) The resulting figure shall be multiplied by a factor of 84.6; then

(5) The figures computed in items (2) and (4) shall be added together and the resulting sum subtracted from 206.835 to yield the Flesch reading ease score.

(b) For the purposes of subsection (a), the following procedures shall be used:

(1) Each contract consisting of ten thousand words or less shall be analyzed in its entirety by the method prescribed in subsection (a);

(2) Each contract consisting of more than ten thousand words may be analyzed by applying the method prescribed in subsection (a) to two, two hundred word samples separated by a minimum of ten printed lines on each page of the contract;

(3) All riders, endorsements, applications, and other forms may be scored with the contract or scored as separate forms;

(4) Numbers and letters, when separated by spaces, a contraction, or a hyphenated word shall be counted as one word;

(5) A unit of words ending with a period, semicolon, or colon, excluding headings and captions, shall be counted as one sentence; and

(6) Whenever an accepted dictionary indicates that a word has two or more acceptable pronunciations, the pronunciation having the fewer number of syllables may be used. Syllable, as used in this paragraph, means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. [L 1987, c 347, pt of §2]

**§431:10-107 Filing of certificate.** (a) Every insurer shall file with the commissioner a certificate signed by an officer of the insurer stating that the contract meets the minimum Flesch reading ease score required in section 431:10-104(1).

(b) Whenever the score is lower than the minimum allowed under section 431:10-104(1), the insurer shall file the certificate indicating the lower score and requesting the contract be approved under section 431:10-108. The insurer shall file with the certificate a copy of the contract and additional information necessary to support its request. Each filing requesting an approval pursuant to section 431:10-108 shall be accompanied by a $20 fee payable to the commissioner, which fee shall be deposited in the commissioner's education and training fund.

(c) In determining the accuracy of any certificate, the commissioner may require the insurer to submit a copy of the contract and any additional information. [L 1987, c 347, pt of §2; am L 1989, c 207, §10]

**Cross References**

Commissioner's education and training fund, see §431:2-214.

**§431:10-108 Flesch reading ease score; lower score authorized; when.** The commissioner may authorize a score lower than the minimum Flesch reading ease score required in section 431:10-104(1) when the commissioner determines that the lower score:

(1) Will provide a more accurate indication of the readability of the contract;

(2) Is warranted by the nature of a particular contract form, type or class of contract forms; or

(3) Is the result of any language required by state law, regulation or agency interpretation. [L 1987, c 347, pt of §2]

**[§431:10-109] Disclosure of health care coverage and benefits.** In order to ensure that all individuals understand their health care options and are able to make informed decisions, all insurers shall provide current and prospective insureds with written disclosure of coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage.

The information provided shall be current, understandable, and available prior to the issuance of a policy, and upon request after the policy has been issued. [L 1996, c 274, §1]

## PART II. GENERAL RULES

**§431:10-201 Scope.** The provisions of this part shall apply to all classes or lines of insurance except:

(1) Ocean marine insurance as defined in section 431:1-211,

(2) Surplus line insurance, as defined in section [431:8-102], and

(3) Life insurance, or accident and health or sickness insurance; provided the contracts are neither issued for delivery in this State nor delivered in this State. [L 1987, c 347, pt of §2; am L 2002, c 155, §38]

**§431:10-202 Definitions.** For purposes of this part:

"Insurable interest" includes only interests as follows:

(1) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection.

(2) In the case of other persons, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement, or injury of the individual insured.

(3) An individual party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a close corporation or of an interest in such shares, has an insurable interest in the life of each individual party to the contract and for the purposes of the contract only, in addition to any insurable interest which may otherwise exist as to the life of the individual.

(4) A charitable organization as defined in section 467B-1 has an insurable interest in the life of each proposed insured who joins with said organization in applying for a life insurance policy naming said organization as owner and irrevocable beneficiary.

"Policy" means the written instrument in which a contract of insurance and any endorsement or addendum thereto is set forth. [L 1987, c 347, pt of §2; am L 1988, c 49, §1; am L 2005, c 22, §25]

**§431:10-203 Power to contract.** (a) Any person of competent legal capacity may contract for insurance.

(b) A minor of the age of fifteen years or more, as determined by the nearest birthday, shall be deemed to be competent to:

(1) Contract for any form of life insurance or accident and health or sickness insurance on the minor's own life or body, for the minor's own benefit or for the benefit of the minor's father, mother, spouse, child, brother, sister, or grandparent;

(2) Surrender, make loans upon, or assign any insurance issued at any time upon the minor's life or body,

subject to the provisions of the policy;

(3) Give a valid discharge for any benefit accruing or for any money payable under the contract; and

(4) Exercise any of the rights or privileges reserved to the insured in and by any such policy of insurance;

except that such minor, not otherwise emancipated, shall not be bound by any unperformed agreement to pay, by a promissory note or otherwise, any premium on any such insurance contract.

(c) Where any form of life insurance or accident and health or sickness insurance is issued at any time upon the life or body of a minor, unless the policy shall otherwise provide, or unless all of the premiums on the policy are paid by the minor, then until the minor has reached the age of eighteen years, either or both parents of the minor, or in the event of the death of one parent or the divorce of the parents and the custody of the minor being awarded to one parent, then the surviving parent or the custodial parent of the minor shall be authorized to:

(1) Surrender, make loans upon, or assign such insurance;

(2) Give a valid discharge for any benefit accruing or for money payable under the contract; and

(3) Exercise any of the rights or privileges reserved to the insured in and by any such policy of insurance without the order or intervention of any court, or the appointment of a legal guardian.

No insurer shall have any responsibility for or be required to see to the application of the proceeds paid in accordance with this section.

(d) The ownership of or property interest of the insured in any policy of life insurance issued on the life of any minor shall be deemed to be in the minor and shall continue in the minor except if:

(1) The policy shall have lapsed or shall have been surrendered, assigned, or otherwise acted upon in accordance with the provisions of this section while the minor is under the age of eighteen years;

(2) After the insured shall have reached the age of eighteen years, the policy shall have lapsed or shall have been surrendered, assigned, or otherwise acted upon by the insured; or

(3) At the time of issuance, the policy of insurance shall provide otherwise. [L 1987, c 347, pt of §2; am L 2002, c 155, §39]

**§431:10-204 Insurable interest required; personal insurances.** (a) Any individual of competent legal capacity may procure or effect an insurance contract upon the individual's own life or body for the benefit of any person.

(b) No person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under the contract are payable to the individual insured or the insured's personal representatives, or to a person having, at the time the contract was made, an insurable interest in the individual insured.

(c) If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits under the contract accruing upon the death, disablement or injury of the individual insured, the individual insured or the insured's personal representative may maintain an action to recover the benefits from the person so receiving them. [L 1987, c 347, pt of §2]

**§431:10-205 Interest of the insured.** When the name of a person intended to be insured is specified in the policy, the insurance can be applied only to the person's own proper interest. This section shall not apply to life insurance or accident and health or sickness insurance. [L 1987, c 347, pt of §2; am L 2002, c 155, §40]

**§431:10-206 Application for insurance: consent of insured required.** No life insurance or accident and health or sickness insurance contract upon an individual shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies for or consents to the insurance in writing, except in the following cases:

(1) A spouse may effectuate such insurance upon the other spouse.

(2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of or pertaining to the minor.

This section shall not apply to contracts of group life insurance or of group or blanket disability insurance as defined in this code. [L 1987, c 347, pt of §2; am L 2002, c 155, §41]

**§431:10-207 Alteration of application.** (a) Any written application for insurance which is attached to and made a part of the insurance contract shall be altered solely by the applicant or with the applicant's written consent, except that insertions may be made by the insurer for administrative purposes in such manner as to indicate clearly that the insertions are not to be ascribed to the applicant.

(b) No person shall falsify or cause to be falsified any answer to a question set forth in an insurance application. Except as provided in subsection (a), no person shall insert or cause to be inserted in the application any statement other than the statement made by the applicant.

(c) Any insurer issuing an insurance contract upon an application which has been unlawfully altered by its officer, employee, producer, or agent shall not have available, in any action arising out of the contract, any defense which is based upon the fact of such alteration, or as to any item in the application which was so altered. [L 1987, c 347, pt of §2; am L 2002, c 155, §42]

**§431:10-208 Limitations on use of application as evidence.** (a) No application for the issuance of any life insurance contract shall be admissible in evidence in any action relative to such contract, unless a true copy of the application was attached to or made a part of the policy when issued and delivered. A copy or reproduction of the application or medical examination, if any, may be used if clearly legible. This subsection shall not apply to contracts of industrial life insurance.

(b) If any policy of life insurance or accident and health or sickness insurance delivered in this State is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application for reinstatement or renewal, within thirty days of receipt of such request at any of its offices, the insurer shall deliver or mail a copy of the application to the person making the request. If the copy is not so delivered or mailed, the insurer shall be precluded from introducing the application

as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

(c) No application for insurance signed by the insurer shall be admissible in evidence in any action between the insured and the insurer arising out of the policy applied for, if the insurer fails to furnish the insured a copy of the application, reproduced by any legible means, within thirty days after receipt by the insurer of insured's written demand for a copy. This subsection also applies in instances when the application is signed on behalf of the insured and the reproduction request is made on behalf of the insured. This subsection shall not apply to life insurance contracts. [L 1987, c 347, pt of §2; am L 2002, c 155, §43]

**§431:10-209 Warranties, misrepresentations in applications.** All statements or descriptions in any application for an insurance policy or in negotiations therefor, by or on behalf of the insured, shall be deemed to be representations and not warranties. A misrepresentation shall not prevent a recovery on the policy unless made with actual intent to deceive or unless it materially affects either the acceptance of the risk or the hazard assumed by the insurer. [L 1987, c 347, pt of §2]

**Case Notes**

A misrepresentation need only relate to the insurer's decision to insure the risk. 26 F.3d 957.

Insured's failure to disclose prior prescription drug abuse, prior psychiatric treatments and previous claim for disability benefits were material for purposes of insurer's policy rescission action. 26 F.3d 957.

Where plaintiffs contended that their breach of marine insurance policy's captain warranty qualified as a "misrepresentation" within the meaning of this section, this provision applied only to statements or descriptions in an application for an insurance policy or in negotiations therefor. 281 F.3d 803.

Insured's misrepresentation of smoking history on life insurance policy application was material within meaning of this section such that recovery on policy was barred. 795 F. Supp. 1036.

Insurer entitled to rescind disability policy under this section where insured's application contained misrepresentations material to risk assumed by insurer in its decision to issue the policy. 820 F. Supp. 1241.

No summary judgment where insurer failed to show there was no genuine issue of material fact as to whether insured would have been denied insurance if insured's application made insurer aware of insured's previous losses. 80 H. 491 (App.), 911 P.2d 126.

**§431:10-210 Standard form fire insurance policy.** (a) The standard form fire insurance policy as authorized and in effect in the State of New York on December 31, 1943, or its approved equivalent, is established as the standard form fire insurance policy for this State, and no fire insurance policy shall be delivered or issued for delivery in this State in any other than the standard form or its approved equivalent with such additions or modifications as are allowed or required by this code. This section is not applicable to inland marine policies or policies written upon motor vehicles or aircraft. For the purpose of this section,

"approved equivalent" means any form of policy which does not correspond to the standard fire insurance policy, provided that the coverage with respect to the peril of fire, when viewed in its entirety, is substantially equivalent to, or more favorable to the insured than that contained in the standard fire insurance policy and approved for use by the commissioner.

(b) The commissioner shall at all times keep on file in the commissioner's office a copy of the standard form fire insurance policy certified by the superintendent of insurance of the State of New York, and copies of all forms deemed to be equivalent.

(c) Nothing in this section shall affect the validity of any policy otherwise valid or of any claim under the policy against an insurer.

(d) No part of the standard form fire insurance policy or its approved equivalent shall be omitted from the policy.

(e) Any policy which, in addition to coverage against perils of fire and lightning, includes coverage against other perils need not comply with all of the provisions of the standard form fire insurance policy or its approved equivalent if the policy provisions with respect to the perils of fire and lightning are the exact provisions of the standard form fire insurance policy or its approved equivalent.

(f) The following additions to or modifications of the standard form fire insurance policy or its approved equivalent are permitted:

(1) An insurer may use in its policies its name, location of its principal office and date of incorporation, the amount of its paid-in capital stock, the amount of subscribed capital if separately stated, the names of its officers and agents, and the number and date of the policy.

(2) The pages of the standard policy or its approved equivalent may be renumbered and rearranged for convenience in the preparation of individual contracts and to provide space for the description of the property insured, the listing of rates and premiums for coverages insured under the policy or under endorsements attached or printed thereon, and such other date as may be conveniently included for duplication on daily reports or office records, and there may be substituted for the word company a more accurate descriptive term for the type of insurer.

(3) An insurer organized under special charter provisions may so indicate upon its policy and may add a statement of the plan under which it operates in this State.

(4) An insurer may use in its policies written, typewritten or printed forms of description and specifications of the property insured.

(5) An insurer may use in its policies with the approval of the commissioner, if the same are not already included in the standard policy or its approved equivalent, any provisions which any insurer is required by law to insert in its policies not in conflict with the standard policy. The provisions shall be printed apart from the other conditions, agreements or provisions of the policy under separate title as follows: "Provisions required by law to be inserted in this policy."

(6) An insurer may affix to or include in the policy a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under the policy; provided that nothing herein shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage of loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.

(7) An insurer may affix to or include in the policy a written statement that the policy does not cover loss or damage by fire to sugarcane caused by volcanic activity; provided that nothing herein shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage by fire to sugarcane caused by volcanic activity.

(8) An insurer may use appropriate forms of additional contracts, riders or endorsements adding to or

modifying the provisions in the standard policy or its approved equivalent, or insuring against any additional perils which may by law be the subject of insurance, or insuring against indirect or consequential loss or damage. Such other perils may be perils excluded from coverage in the standard policy or its approved equivalent. Such form of contracts, riders, and endorsements may contain provisions or stipulations inconsistent with the standard policy or its approved equivalent if such provisions and stipulations are applicable only to such additional coverage or other additional peril or perils insured against.

(g) A policy issued by a mutual insurer shall contain in the body of the policy the total amount for which the insured may be liable under the charter or articles of the insurer.

(h) In the event of any conflict between this section and other provisions of this code, this section shall govern. [L 1987, c 347, pt of §2]

**§431:10-211 Content of policies in general.** (a) A policy shall specify:

(1) The names of the parties to the contract. The insurer's name shall be clearly shown in the policy;

(2) The subject of the insurance;

(3) The risks insured against and the amount of insurance;

(4) The time at which the insurance under the policy takes effect, and the period during which the insurance is to continue or the method of determining the period;

(5) A statement of the premium or premium rate; and

(6) The conditions pertaining to the insurance.

(b) If under the contract the exact amount of premiums is determinable only at termination of the contract or at periodic intervals of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished any policy examining bureau having jurisdiction or to the insured upon request.

(c) This section shall not apply to surety insurance or to group insurance contracts. [L 1987, c 347, pt of §2]

**[§431:10-211.3] Commercial general liability extended reporting requirements.** Any policy for commercial general liability coverage wherein the insurer shall offer and the insured may elect to purchase an extended reporting period for claims arising during the expiring policy period shall provide that:

(1) In the event of a cancellation, there shall be a thirty-day period during which the insured may elect to purchase coverage for the extended reporting period;

(2) The limit of liability in the policy aggregate for the extended reporting period shall be one hundred per cent of the expiring policy aggregate; and

(3) The insurer shall provide the following loss information to the first named insured within thirty days of the insured's request or upon any notice of cancellation or nonrenewal:

(A) All information on closed claims including the date and description of occurrence and amount of payments, if any;
(B) All information on open claims including the date and description of occurrence, amount of payment, if any, and

amount of reserves, if any; and

(C) All information on notices of occurrence including the date and description of occurrence and amount of resources, if any. [L 2006, c 189, §1]

**Revision Note**

Subsection designation deleted pursuant to §23G-15.

**[§431:10-211.5] Premium waiver provisions; restrictions.** (a) Whenever an insurance policy contains a provision or a rider for the waiver of premiums in the event of the total disability of the named insured, the waiver of premiums shall be applicable throughout the period of total disability or for the balance of the waiver period specified in the policy or the rider, whichever is shorter. To qualify for the premium waiver, the insured shall submit a certificate from a physician who is selected by the insured which attests to the insured's medical condition and states the period that the condition will last. If the period that the condition will last cannot be established with reasonable medical certainty, the physician shall state an opinion of the period during which the condition is likely to persist. If the insurer does not accept the insured's physician's diagnosis or estimate of the period that the condition will last, the insured will be examined by a second physician selected by the insurer at the insurer's expense. The insurer will accept the second physician's diagnosis and estimate of the period that the condition will last in order to determine total disability and waiver of premium benefits to be provided. The insured will be furnished with copies of all physicians' reports.

The insurer will also furnish the insured with an explanation of the insurer's decision regarding the total disability under the terms of the contract and the expected period it will last.

If the insured does not agree with the insurer's decision, the insured may appeal to the insurance commissioner within thirty days following receipt of the written notice of insurer's decision.

(b) When the insurer has determined there is total disability and the probable period that it will last, the insurer shall require further certification during the stated period of disability or probable disability only at its expense and not more often than once in any three calendar years, unless there is evidence of a change of circumstances that indicate a change in the medical condition of the insured.

(c) If a claim for premium waiver has been filed after expiration of the grace period specified in the insurance policy, and the qualifying disability has been proved, and the policy owner has demonstrated good faith and honest error justifying the late filing for premium waiver, the insurer shall refund premiums paid after the date the premium waiver would have been effective if the claim had been filed within the period specified in the policy for filing claims. [L 1989, c 336, §1]

**Note**

Derivation. L 1987, c 250, §1 and L 1989, c 276, §2.

**§431:10-212 Contract limitations for handicapped children and children with intellectual disabilities.** Every individual life insurance

policy, every group life insurance policy, and every hospital or medical expense insurance policy, delivered or issued for delivery in this State after May 8, 1968, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy, shall also provide in substance that attainment of such limiting age shall not operate to terminate coverage of such child while the child is and continues to be:

(1) Incapable of self-sustaining employment by reason of intellectual disability or physical handicap, and

(2) Chiefly dependent upon the policyholder for support and maintenance,

provided proof of such incapacity and dependency is furnished to the insurer by the policyholder within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two-year period following child's attainment of the limiting age. [L 1987, c 347, pt of §2; am L 2011, c 220, §§6, 12]

**§431:10-213 REPEALED.** L 1989, c 195, §43.

**§431:10-214 Right to return policy.** (a) There shall be printed on or attached to every individual life insurance policy and every individual accident and health or sickness insurance policy issued for delivery in this State a notice in ten-point bold type stating in substance that the person to whom the policy is issued is entitled to return the policy or contract within ten days of its receipt by the purchaser and to have the premium paid refunded if the purchaser is not satisfied with it for any reason. If, pursuant to such notice, a purchaser mails or delivers the policy to the company or association at its home or branch office or to the producer through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. When an individual life insurance policy is mailed or delivered by the purchaser within the ten-day period, the insurer may be reimbursed for the actual medical examination expenses incurred in processing the policy or contract, provided the foregoing notice includes a statement to this effect.

(b) This section shall not apply to single premium nonrenewable policies or travel accident policies. [L 1987, c 347, pt of §2; am L 2002, c 155, §44]

**§431:10-215 Readjustment of premiums; dividends.** (a) Any contract of group disability insurance or group life insurance may provide for the readjustment of the rate of premium based on experience at the end of the first year or of any subsequent year of insurance, and such readjustment may be made retroactive only for the policy year.

(b) If a policy dividend is declared or a reduction in rate is made or continued under any group insurance policy, the excess of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over aggregate expenditure for insurance under such policies made from funds contributed by the policyholder, or by an employer of insured persons, or by a union or association to which insured persons belong, including expenditures made in connection with administration of such policies, shall be applied by

the policyholder for the sole benefit of insured employees. [L 1987, c 347, pt of §2]

**§431:10-216 Additional contents.** A policy may contain additional provisions, which are not inconsistent with this part, and which are:

(1) Required to be inserted by the laws of the insurer's state of domicile; or

(2) Appropriate or necessary to state the rights and obligations of the parties to the contract. [L 1987, c 347, pt of §2]

**§431:10-217 Charter, bylaw provisions.** No policy shall contain any provision purporting to make any portion of the charter, bylaws or other constituent document of the insurer a part of the contract unless that portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid. [L 1987, c 347, pt of §2]

**[§431:10-217.5] Policies relating to domestic abuse cases.** (a) No insurer shall deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, on the basis that the applicant or insured person is, has been, or may be a victim of domestic abuse.

(b) Nothing in this section shall prevent an insurer from taking any of the actions set forth in subsection (a) on the basis of loss history or medical condition or for any other reason not otherwise prohibited by this section, any law, regulation, or rule.

(c) Any form filed or filed after July 15, 1998 or subject to a rule adopted under chapter 91 may exclude coverage for losses caused by intentional or fraudulent acts of any insured. Such an exclusion, however, shall not apply to deny an insured's otherwise-covered property loss if:

(1) The property loss is caused by an act of domestic abuse by another insured under the policy;

(2) The insured claiming property loss files a police report and cooperates with any law enforcement investigation relating to the act of domestic abuse; and

(3) The insured claiming property loss did not cooperate in or contribute to the creation of the property loss.

Payment by the insurer to an insured may be limited to the person's insurable interest in the property less payments made to a mortgagee or other party with a legal secured interest in the property. An insurer making payment to an insured under this section has all rights of subrogation to recover against the perpetrator of the act that caused the loss.

(d) Nothing in this section prohibits an insurer from investigating a claim and complying with chapter 431.

(e) As used in this section, "domestic abuse" means:

(1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;

(2) Sexual assault of one family or household member by another;

(3) Stalking of one family or household member by another family or household member; or

(4) Intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another household member. [L 1998, c 171, §2]

**Revision Note**

"July 15, 1998" substituted for "the effective date of this section".

**§431:10-218 Stated premium must include all charges.** (a) The premium stated in the policy shall be inclusive of all fees, charges, premiums, or other consideration charged for the insurance or for its procurement. This subsection shall not apply to surety or group insurance contracts.

(b) No insurer or its officer, employee, producer, or other representative shall charge or receive any fee, compensation, or consideration for insurance which is not included in the premium specified in the policy. [L 1987, c 347, pt of §2; am L 2002, c 155, §45]

**§431:10-219 Multi-peril policies, premiums stated separately.** Each insurer issuing a multi-peril policy shall provide the policyholder with a written statement separately stating the premiums and the amounts of insurance or limits of liability for fire and allied lines, inland marine, general liability, crime and each optional coverage, and shall state all pertinent rating factors including classifications, premium basis and rates used in the computation of the final premium. This section shall not apply to homeowners policies. [L 1987, c 347, pt of §2; am L 1989, c 228, §1]

**§431:10-220 Policy must contain entire contract.** (a) No agreement in conflict with, modifying, or extending any contract of insurance shall be valid unless in writing and made a part of the policy.

(b) No insurer or its representatives shall make any insurance contract or agreement relative thereto that is not plainly expressed in the policy.

(c) The requirements of this section shall not apply to the granting of additional benefits to all policyholders of the insurer, or a class or classes of them, which do not require increases in premium rates or reduction or restrictions of coverage. [L 1987, c 347, pt of §2]

**§431:10-221 Prohibited policy provisions: limiting actions and jurisdictions.** (a) No insurance contract delivered or issued for delivery in this State and covering subjects located, resident or to be performed in this State, shall contain any condition, stipulation or agreement:

(1) Requiring it to be construed according to the laws of any state or country except as necessary to meet the requirements of the motor vehicle financial responsibility laws or compulsory disability benefit laws of such other state or country; or

(2) Depriving the courts of this State of the jurisdiction of action against the insurer; or

(3) Limiting right of action against the insurer to a period of less than one year from the time when the

cause of action accrues in connection with all insurances other than property and marine and transportation insurances. In contracts of property insurance, or of marine and transportation insurance, the limitation shall not be to a period of less than one year from the date of the loss.

(b) Any such condition, stipulation or agreement in violation of this section shall be void, but such voiding shall not affect the validity of the other provisions of the contract. [L 1987, c 347, pt of §2]

**§431:10-222 Construction industry; indemnity agreements invalid.** Any covenant, promise, agreement or understanding in, or in connection with or collateral to, a contract or agreement relative to the construction, alteration, repair or maintenance of a building, structure, appurtenance or appliance, including moving, demolition or excavation connected therewith, purporting to indemnify the promisee against liability for bodily injury to persons or damage to property caused by or resulting from the sole negligence or wilful misconduct of the promisee, the promisee's agents or employees, or indemnitee, is invalid as against public policy, and is void and unenforceable; provided that this section shall not affect any valid workers' compensation claim under chapter 386 or any other insurance contract or agreement issued by an admitted insurer upon any insurable interest under this code. [L 1987, c 347, pt of §2]

**Cross References**

Insurance policies issued to construction professionals, see §431:1-217.

**§431:10-222.5 Pooled insurance.** (a) Insurers may offer pooled insurance which allows liability insurance and all other types of insurance required by law, not including prepaid health insurance, to be obtained for a construction project. Pooled insurance may be purchased by:

(1) The State and its public instrumentalities for specific public works construction projects, or any other construction project in the public interest which is publicly financed in whole or in part; or

(2) A private person or legal entity subject to the State's tax laws for a specific construction project.

Pooled insurance shall be limited to those construction projects that are estimated to cost $50,000,000 or more for the total construction project.

(b) For purposes of this section, "pooled insurance" means an insurance policy or policies from licensed private insurers which cover the liability of all developers, contractors, and subcontractors, for their performance directly related to the project. The insurance policy or policies shall cover only a specific public works or private construction project and shall be in effect for the limited period of time required to complete construction of that project; provided that the policy or policies shall cover claims in accordance with the terms of the policy or policies and within the applicable statute of limitations for those claims.

(c) The State, its public instrumentalities, or a private person or entity may obtain a pooled insurance policy or policies and seek contributions or reimbursements of premiums from any contractor or

subcontractor who is included as a named insured. In the alternative to the preceding, the State, its instrumentalities, or a private person or entity may arrange a premium payment guarantee from any contractor or subcontractor included as a named insured.

(d) As used in this section, "contractors" and "subcontractors" do not include architects and engineers.

(e) Nothing in this section shall be construed to alter or nullify the liability of any party to the State for claims arising from a public works construction project.

(f) In cases of conflict with section 386-124, this section shall control.

(g) For purposes of this section, the phrases "specific construction project", "specific public works construction projects, or any other construction project in the public interest", and "total construction project" shall include those projects that may have multiple sites, and projects that involve ongoing construction in phases. [L 1996, c 224, §1; am L 1998, c 268, §2]

**§431:10-223 Underwriters and combination policies.** Two or more authorized insurers may together issue:

(1) An underwriters policy bearing their names upon which their liability shall be joint and several. Any one insurer may issue policies in the name of an underwriter's department provided the policies shall plainly show the true name of the insurer.

(2) With the commissioner's approval, a combination policy which shall contain provisions substantially as follows:

(A) That the insurers shall be severally liable according to the terms of the policy for the full or specified amount of, or percentage of, any loss or damage aggregating the full amount of insurance under the policy.

(B) That service of process, or of any notice or proof of loss required by the policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers.

This section shall not apply to co-surety obligations. [L 1987, c 347, pt of §2]

**§431:10-224 Execution of policies.** (a) Every insurance contract shall be executed in the name of and on behalf of the insurer by its officer, employee or authorized representative.

(b) A facsimile signature of any executing officer, employee or representative may be used in lieu of an original signature.

(c) The facsimile signature of any person not authorized to execute contracts as of the date of the policy will not invalidate an otherwise valid insurance contract. [L 1987, c 347, pt of §2]

**§431:10-225 Delivery of policy.** (a) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled thereto within a reasonable period of time after its issuance.

(b) In the event the original policy is delivered or is so required to be delivered to or for deposit with any seller, mortgagee or pledgee of any motor vehicle or aircraft, and in which policy any interest of the

purchaser, mortgagor or pledgor in or with reference to such vehicle or aircraft is insured, a duplicate of the policy or memorandum setting forth the type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, shall be delivered by the seller, mortgagee or pledgee to each such purchaser, mortgagor or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a conspicuous statement of such fact shall be printed, written or stamped on the face of the duplicate policy or memorandum. [L 1987, c 347, pt of §2]

**§431:10-226 Renewal of policy; new policy not required.** At the option of the insurer, any insurance policy terminating at a specified expiration date and not otherwise renewable, may be renewed or extended, upon a currently authorized policy form and at the premium rate then required for a specific additional period or periods by a certificate or by endorsement of the policy. The issuance of a new policy is not required. [L 1987, c 347, pt of §2]

**[§431:10-226.5] Notice of cancellation or nonrenewal.** In the case of cancellation of a policy, the insurer shall give written notice to the insured not fewer than ten days prior to the effective date of cancellation. For nonrenewal of a policy, the insurer shall give written notice to the insured not fewer than thirty days prior to the effective date of nonrenewal. If under title 24 or a policy, a longer time period is required for a notice of cancellation or nonrenewal for the policy, the longer period shall be applicable. Cancellation or nonrenewal shall not be deemed valid unless evidence of mailing is provided. [L 2000, c 182, §3]

**§431:10-227 Retroactive annulment of liability policies prohibited.** No contract insuring against loss through liability for the bodily injury or death by accident of any individual shall be retroactively annulled by any agreement between the insurer and the insured after the occurrence of such injury or death for which the insured may be liable. The prohibition on retroactive annulment of liability shall also apply to contracts insuring against damage to the property of any person. Any such annulment or attempted annulment shall be void. [L 1987, c 347, pt of §2]

**§431:10-228 Assignment of policies.** (a) A policy may be assignable or not assignable, as provided by its terms.

(b) Subject to the terms of the policy, any policy providing the beneficiary may be changed upon the sole request of the insured, may be assigned by either pledge or transfer of title, executed by the insured alone, and delivered to the insurer, regardless of whether the insurer is the pledgee or assignee. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment. [L 1987, c 347, pt of §2]

## Case Notes

Because Hawaii law requires every insurance policy to be subject to the general rules of contract construction, and an assignment by operation of law is merely an extension of the common law tort rule of successor liability, trial court erred in concluding that an assignment by operation of law was consistent with Hawaii's rules governing construction of insurance policies. 117 H. 357, 183 P.3d 734 (2007).

Where insurance policies contained a no assignment clause that required the consent of the insurer to bind it to any assignment made by the named insured, and named insured assignor did not obtain any of the insurers' consent prior to the assignment, assignee was not an insured under any of the insurers' policies and was therefore not owed duties to defend or indemnify by insurers. 117 H. 357, 183 P.3d 734 (2007).

**§431:10-229 Dividends payable to the real party.** (a) Every insurer issuing participating policies, shall pay dividends, unused premium refunds, or savings distributed on account of any such policy, only to:

(1) The real party in interest entitled thereto as shown by the insurer's records, or

(2) Any person to whom the right thereto has been assigned in writing of record with the insurer, or

(3) Any person to whom the right thereto has been given in the policy by the real party in interest.

(b) Any person who is shown by the insurer's records to have paid for the person's own account, or to have been ultimately charged for, the premium for insurance provided by a policy in which another person is the nominal insured, shall be deemed the real party in interest proportionate to premium so paid or so charged. This subsection shall not apply as to any such dividend, refund or distribution which would amount to less than $1.

(c) This section shall not apply to contracts of group life insurance, group annuities, or group disability insurance, nor to any policy which contains a provision specifying to whom the dividend shall be paid, nor to policies issued prior to January 1, 1956. [L 1987, c 347, pt of §2]

**§431:10-230 Payment discharges insurer.** Whenever the proceeds of, or payments under, a policy or contract for life insurance, or accident and health or sickness insurance become payable in accordance with the terms of the policy or the exercise of any right or privilege under the policy, and the insurer makes payments in accordance with the terms of the policy or with a written assignment pursuant to section 431:10-229, the person designated in the policy or by the assignment as being entitled to the proceeds or payments, shall be entitled to receive them and to give full acquittance for such payment. Such payment by the insurer shall fully discharge the insurer from all claims under the policy unless before the payment is made, the insurer has received at its home office written notice, by or on behalf of some other person, that such other person claims to be entitled to such payment or some interest in the policy. [L 1987, c 347, pt of §2; am L 2002, c 155, §46]

**§431:10-231 Exemption of proceeds; accident and health or sickness.** The proceeds of all contracts of accident and health or sickness insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts shall be exempt from all liability for any debt of the insured, and from any debt of the beneficiary existing at the time the proceeds are made available for the beneficiary's use. [L 1987, c 347, pt of §2; am L 2002, c 155, §47]

**§431:10-232 Exemption of proceeds; life, endowment and annuity.** (a) All proceeds payable because of the death of the insured and the aggregate net cash value of any or all life and endowment policies and annuity contracts payable to a spouse of the insured, or to a child, parent or other person dependent upon the insured, whether the power to change the beneficiary is reserved to the insured or not, and whether the insured or the insured's estate is a contingent beneficiary or not, shall be exempt from execution, attachment, garnishment, or other process, for the debts or liabilities of the insured incurred subsequent to May 19, 1939, except as to premiums paid in fraud of creditors within the period limited by law for the recovery of such payments.

(b) When the terms of any life or endowment policy or annuity contract require that the proceeds thereof be retained by the insurer upon the death of the insured, or other maturity of the policy or contract, for payment to any beneficiary other than the insured in accordance with a settlement plan selected by the insured, the beneficiary shall have no right or power, nor shall the beneficiary be permitted by any insurer, to commute, encumber, assign, or otherwise anticipate the beneficiary's interests under the plan if the right or power is expressly denied the beneficiary by the terms of the contract or policy. If the beneficiary under the settlement plan is or was the spouse of the insured, or a child, parent or other person dependent upon the insured, the beneficiary's interests thereunder, in any case, shall be exempt from execution, attachment, garnishment, or other process for the beneficiary's debts or liabilities incurred after December 31, 1955.

(c) This section does not apply to group life insurance. [L 1987, c 347, pt of §2]

**§431:10-233 Exemption of proceeds; group life.** (a) A policy of group life insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder, shall not be liable, either before or after payment, to be applied to any legal or equitable process to pay any liability of any person having a right under the policy. The proceeds of the policy, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of the insured's debts.

(b) This section shall not apply to group life insurance policies issued under section 431:10D-203 to the extent that the proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued. [L 1987, c 347, pt of §2]

**§431:10-234 Spouses' and reciprocal beneficiaries' right in life insurance policy.** (a) Every life insurance policy made payable to or for the benefit of the spouse or the reciprocal beneficiary of the insured, and every life insurance policy assigned, transferred, or in any

way made payable to a spouse or reciprocal beneficiary, or to a trustee for the benefit of a spouse or a reciprocal beneficiary, regardless of how the assignment or transfer is procured, shall, unless contrary to the terms of the policy, inure to the separate use and benefit of such spouse or reciprocal beneficiary.

(b) Without the consent of one's spouse or reciprocal beneficiary, a married person or an individual who is registered as a reciprocal beneficiary, may contract, pay for, take out, and hold a policy on the life or health of one's spouse, reciprocal beneficiary, or children, or against loss by such spouse, or reciprocal beneficiary, or children due to disablement by accident. Premiums paid on the policy by a married person or reciprocal beneficiary shall be held to have been that person's separate estate, and the policy shall inure to the use and benefit of that person and that person's children, free from any claim by the spouse, or reciprocal beneficiary, or others. [L 1987, c 347, pt of §2; am L 1997, c 383, §58]

**§431:10-235 Forms for proof of loss furnished.** Upon written request of any person claiming to have a loss under any insurance contract, an insurer shall furnish forms of proof of loss for completion by the person. The insurer shall not, by reason of the requirement to furnish forms, have any responsibility for or with reference to the completion of the proof of loss form or the manner of completion or attempted completion. [L 1987, c 347, pt of §2]

**§431:10-236 Claim administration not waiver.** None of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer under the policy:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy.

(2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, for making proof of loss, or receiving or acknowledging receipt of such forms or proof completed or uncompleted.

(3) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim. [L 1987, c 347, pt of §2]

**§431:10-237 Construction of policies.** Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy, and as amplified, extended, restricted, or modified by any rider, endorsement or application attached to and made a part of the policy. [L 1987, c 347, pt of §2]

## Cross References

Insurance policies issued to construction professionals, see §431:1-217.

## Case Notes

Waiting period exclusion in insurance policy requiring completion of three months of continuous active service for employee to be eligible for benefits was clear and unambiguous since term "employee" must be read and

construed according to its meaning as defined in the policy as one employed on a regular full-time permanent basis. 72 H. 531, 827 P.2d 635.

Because Hawaii law requires every insurance policy to be subject to the general rules of contract construction, and an assignment by operation of law is merely an extension of the common law tort rule of successor liability, trial court erred in concluding that an assignment by operation of law was consistent with Hawaii's rules governing construction of insurance policies. 117 H. 357, 183 P.3d 734 (2007).

Cited: 451 F. Supp. 2d 1147 (2006); 725 F. Supp. 2d 1219 (2010); 877 F. Supp. 2d 993 (2012).

**§431:10-238 Validity of noncomplying forms.** Any insurance policy, rider or endorsement hereafter issued and otherwise valid, is not rendered invalid by the inclusion of any condition or provision not in compliance with the requirements of this part, but shall be construed and applied in accordance with such conditions and provisions as would have applied had the policy, rider or endorsement been in full compliance with this code. [L 1987, c 347, pt of §2]

**§431:10-239 Intervening breach.** If any breach of warranty or condition in any insurance contract occurs prior to a loss under the contract, the breach shall not avoid the contract nor avail the insurer to avoid liability, unless the breach exists at the time of loss. [L 1987, c 347, pt of §2]

**§431:10-240 Insurance contracts; punitive damages.** Coverage under any policy of insurance issued in this State shall not be construed to provide coverage for punitive or exemplary damages unless specifically included. [L 1987, c 347, pt of §2]

**Law Journals and Reviews**

Punitive Damages in Hawaii: Curbing Unwarranted Expansion. 13 UH L. Rev. 659.

**Case Notes**

Cited: 243 F. Supp. 2d 1100; 877 F. Supp. 2d 993 (2012); 882 F. Supp. 2d 1180 (2012); 955 F. Supp. 2d 1121 (2013).

**§431:10-241 Venue in certain actions.** An insured may bring a civil action against the insured's insurer in the state judicial circuit in which the insured resides or where the insured has its principal place of business provided the insured purchased the policy within the State. [L 1987, c 347, pt of §2]

**§431:10-242 Policyholder and other suits against insurer.** Where an insurer has contested its liability under a policy and is ordered by the courts to pay benefits under the policy, the policyholder, the beneficiary under a policy, or the person who has acquired the rights of

the policyholder or beneficiary under the policy shall be awarded reasonable attorney's fees and the costs of suit, in addition to the benefits under the policy. [L 1987, c 347, pt of §2]

**Case Notes**

Request by intervenor-defendant for attorneys' fees and costs denied; even assuming intervenor-defendant, as a tort victim of an insured, may under some circumstances have a "legally protectable interest" in insured's policy, intervenor-defendant was neither "the policyholder, the beneficiary under a policy, [n]or the person who has acquired the rights of the policyholder or beneficiary under the policy". 939 F. Supp. 782.

Where self-insurer rent-a-car company not an "insurer" as defined in §431:10C-103, court erred in granting attorney's fees and costs under this section. 85 H. 243, 942 P.2d 507.

Section inapplicable where, although insurer contested its liability under the policy issued to insured, insurer was not ordered by the court to pay any benefits thereunder. 103 H. 26, 79 P.3d 119.

An arbitration proceeding is not a "suit" within the meaning of this section. 103 H. 206, 81 P.3d 386.

A trial court is mandated to award attorneys' fees and costs only when such fees and costs arise in a judicial proceeding in which an insurer has contested its liability; where trial court proceeding was for confirmation of the underlying arbitration award, this section did not apply to the case. 103 H. 206, 81 P.3d 386.

Where insurer was not ordered to pay benefits under the insurance policy within the meaning of this section, insured was not entitled to attorneys' fees. 108 H. 358, 120 P.3d 257 (2005).

Trial court abused its discretion when it awarded costs and attorney's fees to claimants pursuant to this section where the trial court did not order insurers to "pay benefits" as mandated by the plain language of this section. 118 H. 174, 186 P.3d 609 (2008).

As the plain language of this section mandates an award of attorney's fees to "the policyholder, the beneficiary under a policy, or the person who has acquired the rights of the policyholder or beneficiary under the policy" whenever an insurer unsuccessfully contests its liability under a policy, insured was properly awarded attorney's fees where insurer was not successful in contesting its liability to insured for underinsured motorist benefits. 120 H. 329 (App.), 205 P.3d 594 (2009).

Circuit court did not abuse its discretion in awarding insured attorneys' fees and costs under this section where insurer disputed its liability under its auto policy and the circuit court declared that insurer had an obligation to pay insured's wage loss benefits; in light of the amount in controversy or the benefits of the services provided, the circuit court did not abuse its discretion in awarding attorneys' fees of $10,450 that incorporate a rate of $250 per hour to insured's attorneys. 124 H. 426 (App.), 246 P.3d 358 (2010).

Cited: 73 H. 322, 832 P.2d 733.

Discussed: 621 F. Supp. 2d 1025 (2008).

**§431:10-243 Interest upon proceeds of life insurance policies.** (a) Except as provided in subsection (d), in the event an action to recover the proceeds due under a life insurance policy or annuity contract is commenced and results in a judgment against the insurer, interest shall be computed under subsection (c) and paid from the date of

death of an insured or annuitant in connection with a death claim on a life insurance policy or annuity contract and from the date of maturity of an endowment or annuity contract to the date the verdict is rendered or the report or decision is made.

(b) Except as provided in subsection (d), in the event an action to recover is commenced and a settlement is reached before the verdict is rendered or the report or decision is made, interest on the settlement shall be computed under subsection (c) and paid from the date of death of an insured or annuitant in connection with a death claim on a life insurance policy or annuity contract to the date of payment and from the date of maturity of an endowment or annuity contract to the date of payment.

(c) In the event no action has been commenced, interest upon the principal sum paid to the beneficiary or policyholder shall be computed daily at the rate of interest currently paid by the insurer on proceeds left under the interest settlement option, but the rate of interest shall not be less than six per cent a year computed from the date of death of an insured or annuitant in connection with a death claim on a life insurance policy or annuity contract to the date of payment and from the date of maturity of an endowment or annuity contract to the date of payment, and shall be added to and be a part of the total sum paid.

(d) This section shall not require the payment of interest if, in connection with a death claim on a life insurance policy or annuity contract, the proceeds of the policy or contract is paid within thirty days from the date of death.

(e) This section shall not require the payment of interest for any period during which an insurer is required to pay interest under any state or federal law pertaining to interpleader.

(f) This section shall not apply to policies or contracts issued prior to June 2, 1977, which contain specific provisions to the contrary. [L 1987, c 347, pt of §2]

**§431:10-244 Filing procedure for contracts approved by commissioner.** Each insurance contract requiring approval by the commissioner pursuant to this code, section 392-48, or section 386-124 and each contract certified by the insurer to be in conformity with this code shall be accompanied by a $20 fee payable to the commissioner, which shall be deposited into the commissioner's education and training fund. [L 1988, c 363, §1; am L 2010, c 116, §1(14)]

**Cross References**

Commissioner's education and training fund, see §431:2-214.

## ARTICLE 10A
## ACCIDENT AND HEALTH OR SICKNESS INSURANCE CONTRACTS

**Note**

Article heading amended by L 2002, c 155, §48.

State innovation waiver task force; health care reform plan; reports to 2015-2017 legislature (dissolved June 30, 2017). L 2014, c 158; L 2015, c 184.

**Cross References**

Conformance to federal law, see §431:2-201.5.

Federally qualified health centers; rural health clinics; reimbursement, see §346-53.6.

Health and dental insurance data; mandatory reporting for certain insurers, see §323D-18.5.

Health maintenance organization act, see chapter 432D.

Medicaid-related mandates, see chapter 431L.

Mental health and alcohol and drug abuse treatment insurance benefits, see chapter 431M.

Patients' bill of rights and responsibilities act, see chapter 432E.

Prescription drug benefits, see chapter 431R.

Prescription drugs; mail order opt out option, see §87A-16.3.

Proposed mandatory health insurance coverage and assessment report, see §§23-51, 52.

State health insurance program, see chapter 431N.

## Attorney General Opinions

Section 431:10A-601 applied to all parts of article 10A if the category of policy under consideration included family coverage, as defined in §431:10A-103. Att. Gen. Op. 97-10.

The placement of §431:10A-601 in this article, regulating content of insurance contracts, makes clear that the legislative intent was to mandate benefits that must be made available by insurers that write contracts of insurance providing family coverage. Att. Gen. Op. 97-10.

## Law Journals and Reviews

Tax Justice and Same-Sex Domestic Partner Health Benefits: An Analysis of the Tax Equity For Health Plan Beneficiaries Act. 32 UH L. Rev. 73 (2009).

## Case Notes

As chapter 432D does not cover the field of managed care regulation and because §§432D-2, 432E-1, and this article can be read together and there is no explicit language or policy reason not to give each statute effect, chapter 432D does not repeal chapter 432E by implication. 126 H. 326, 271 P.3d 621 (2012).

Properly licensed HMOs, like plaintiff, were authorized pursuant to §432D-1 to "provide or arrange", at their option, for the closed panel health care services required under the managed care plan program; accident and health insurers were authorized under §431:10A-205(b) to arrange for medical services for members using a defined network of providers, i.e., particular "hospitals or persons"; thus, this article and chapter 432D authorized both accident and health insurers and HMOs, as risk-bearing entities, to provide the closed panel product required by the managed care plan contracts. 126 H. 326, 271 P.3d 621 (2012).

# PART I. INDIVIDUAL ACCIDENT AND HEALTH OR SICKNESS POLICIES

## Note

Part heading amended by L 2002, c 155, §48.

## Attorney General Opinions

Section 431:10A-601 applied to all parts of article 10A if the category of policy under consideration included family coverage, as defined in §431:10A-103. Att. Gen. Op. 97-10.

## Case Notes

Under this article and §431:10A-105(2)(A)(ii), standard "incontestability clause" of contract precluded insurer from denying insured "total disability benefit" contracted for, notwithstanding that HIV infection that caused the disability arguably "manifested" itself prior to policy's effective date of coverage. 86 H. 262, 948 P.2d 1103.

**§431:10A-101 Applications and exceptions.** This part shall apply to all policies of accident and health or sickness insurance delivered or issued for delivery in this State, except that nothing in this part shall apply to or affect:

(1) Any policy of workers' compensation insurance or any policy of vehicle or liability insurance with or without supplementary coverage therein;

(2) Any policy or contract of reinsurance;

(3) Any blanket or group policy of insurance; or

(4) Life insurance, endowment, or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and health or sickness insurance as:

(A) Provide additional benefits in case of death, dismemberment, or loss of sight by accident; or

(B) Operate to safeguard such contracts against lapse, or to give a special surrender value, special benefit, or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract. [L 1987, c 347, pt of §2; am L 2002, c 155, §49]

**§431:10A-102 Accident and health or sickness insurance policy defined.** The term, policy of accident and health or sickness insurance, includes any policy or contract covering the class of insurance described in section 431:1-205. [L 1987, c 347, pt of §2; am L 2002, c 155, §50]

**§431:10A-102.5 Limited benefit health insurance.** (a) Except as provided in subsection (b) or elsewhere in this article, when used in this article, the terms "accident insurance", "health insurance", or "sickness insurance" shall not include an accident-only, specified disease, hospital indemnity, long-term care, disability, dental, vision, medicare supplement, or other limited benefit health insurance contract that pays benefits directly to the insured or the insured's assigns and in which the amount of the benefit paid is not based upon the actual costs incurred by the insured.

(b) When used in sections 431:10A-104, 431:10A-105, 431:10A-106, 431:10A-107, 431:10A-108, 431:10A-109, 431:10A-110, 431:10A-111, 431:10A-

112, 431:10A-113, 431:10A-114, 431:10A-117, 431:10A-118, 431:10A-601, 431:10A-602, 431:10A-603, and 431:10A-604, except as otherwise provided, the terms "accident insurance", "accident and health or sickness insurance", "health insurance", or "sickness insurance" shall include an accident-only, specified disease, hospital indemnity, long-term care, disability, dental, vision, medicare supplement, or other limited benefit health insurance contract regardless of the manner in which benefits are paid; provided that if any of the requirements set forth in the foregoing sections as applied to long-term care insurance conflict with the provisions of article 10H, the provisions of article 10H shall govern and control. [L 2010, c 115, §1; am L 2011, c 12, §1; am L 2014, c 186, §7]

**§431:10A-103 Family coverage defined.** As used in this part, family coverage means a policy that insures, originally or upon subsequent amendment, an adult member of a family who shall be deemed the policyholder and any two or more eligible members of that family, including spouse, dependent children or any children under a specified age which shall not exceed nineteen years, and any other person dependent upon the policyholder. [L 1987, c 347, pt of §2; am L 1993, c 205, §21]

**Attorney General Opinions**

Section 431:10A-601 applied to all parts of article 10A if the category of policy under consideration included family coverage, as defined in this section. Att. Gen. Op. 97-10.

**§431:10A-104 Form of policy.** (a) A policy of accident and health or sickness insurance shall neither be delivered nor issued for delivery to any person in this State unless:

(1) The entire monetary and other considerations are expressed in the policy;

(2) The time at which the insurance takes effect and terminates is expressed in or determinable from the policy;

(3) It purports to insure only one person, except that a policy may provide family coverage as defined in section 431:10A-103 or reciprocal beneficiary family coverage as defined in section 431:10A-601;

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten point with a lower case unspaced alphabet length not less than one hundred twenty point. The text shall include all printed matter except the name and address of the insurer, name or title of the policy, a brief description, if any, and captions and subcaptions;

(5) The exceptions and reductions of indemnity are set forth in the policy and, except for the required and optional provisions set forth in sections 431:10A-105 and 431:10A-106, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as exceptions, or exceptions and reductions; provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with the benefit provision to which it applies;

(6) Each policy form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page; and

(7) It does not contain any provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(b) If any policy is issued by an insurer domiciled in this State for delivery to a person residing in a territory, district or another state of the United States, and if the official having responsibility for the administration of the insurance laws of such state, district or territory shall have advised the commissioner that the policy is not subject to approval or disapproval by the official, the commissioner may by ruling require that the policy meet the standards set forth in subsection (a) and in section 431:10A-105 and section 431:10A-106. [L 1987, c 347, pt of §2; am L 1997, c 383, §5; am L 2002, c 155, §51; am L 2004, c 122, §30]

**§431:10A-105 Required provisions.** Except as provided in section 431:10A-107, each policy of accident and health or sickness insurance delivered or issued for delivery to any person in this State shall contain the provisions set forth below. These provisions shall be in the words in which they appear below; provided that the insurer may substitute corresponding provisions of different wording certified by an officer of the insurer to be in substantial conformance with the wording below that are in each instance not less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the specified caption or by appropriate individual or group captions or subcaptions that are substantially similar to the specified captions. The provisions required by this section are as follows:

(1) "Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless the approval is endorsed on or attached to this policy. No agent has authority to change this policy or to waive any of its provisions";

(2) (A) "Time Limit on Certain Defenses:

(i) After three years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void this policy or to deny a claim for loss incurred or disability as defined in the policy commencing after the expiration of the three-year period; and

(ii) No claim for loss incurred or disability as defined in the policy commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded on the date of loss from coverage by name or specific description had existed prior to the effective date of coverage of this policy";

(B) The policy provision set forth in subparagraph (A)(i) shall not be construed to affect any legal requirement for avoidance of a policy or denial of a claim during the initial three-year period, nor to limit the application of section 431:10A-106(1) through (4) in the event of misstatement with respect to age, occupation, or other

insurance; and

(C) A policy that the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of subparagraph (A)(i) the following provision from which the clause in parentheses may be omitted at the insurer's option: "Incontestable: After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application";

(3) (A) "Grace period: A grace period of (insert a number not less than seven for weekly premium policies, ten for monthly premium policies, and thirty-one for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force";

(B) A policy that contains a cancellation provision may add at the end of the provision required by subparagraph (A): "Subject to the right of the insurer to cancel in accordance with the cancellation provision"; and

(C) A policy in which the insurer reserves the right to refuse any renewal shall have at the beginning of the provision required by subparagraph (A): "Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted";

(4) (A) "Reinstatement: If any renewal premium is not paid within the time granted to the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided that if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of the application by the insurer or, lacking approval, upon the forty-fifth day following the date of conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than ten days after that date. In all other respects, the insured and insurer shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date

of reinstatement"; and

(B) The last sentence in subparagraph (A) may be omitted from any policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue;

(5) (A) "Notice of Claim: Written notice of claim shall be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of the office as the insurer may designate for the purpose) or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer"; and

(B) In a policy providing a loss of time benefit that may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences in subparagraph (A): "Subject to the qualification set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in giving notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which notice is actually given";

(6) "Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant any forms that are usually furnished by it for filing proofs of loss. If the forms are not furnished within fifteen days after the giving of notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made";

(7) "Proofs of Loss: In case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, written proof of loss must be furnished to the insurer at its office within ninety days after the termination of the period for which the insurer is liable, and in case of claim for any other loss within ninety days after the date of loss. Failure to furnish proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within the time required, provided proof is furnished as soon as reasonably possible and in no event, except the absence of legal capacity, later than fifteen months from the time proof is otherwise required";

(8) "Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment shall be paid immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment shall be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability shall be paid immediately upon receipt of due written proof";

(9) (A) "Payment of Claims: Indemnity for loss of life shall be payable in accordance with the beneficiary designation and

the provisions respecting payment which may be prescribed herein and effective at the time of payment. If no designation or provision is then effective, the indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the designated beneficiary or to the estate of the insured. All other indemnities shall be payable to the insured"; and

(B) Either or both of the following provisions may be included with the provision set forth in subparagraph (A) at the option of the insurer:

(i) "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount not exceeding $2,000 to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of the payment"; and

(ii) "Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of loss, be paid directly to the hospital or person rendering the services; but it is not required that the service be rendered by a particular hospital or person";

(10) "Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law";

(11) "Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No action at law or in equity shall be brought after the expiration of three years after the time written proof of loss is required to be furnished"; and

(12) (A) "Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy"; and

(B) The first clause of subparagraph (A), relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option. [L 1987, c 347, pt of §2; am L 1993, c 205, §22; am L 2002, c 155, §52; am L 2004, c 122, §31; am L 2010, c 116, §1(15); am L 2011, c 43, §15]

**Case Notes**

Paragraphs (2)(A) and (C) liberally construed to prevent disability insurer from excluding coverage of insured's total disability due to HIV infection based on contractual provisions. 86 H. 262, 948 P.2d 1103.

Under this article and paragraph (2)(A)(ii), standard "incontestability clause" of contract precluded insurer from denying insured "total disability benefit" contracted for, notwithstanding that HIV infection that caused the disability arguably "manifested" itself prior to policy's effective date of coverage. 86 H. 262, 948 P.2d 1103.

**[§431:10A-105.5] Federal law compliance.** An accident and health or sickness insurer shall comply with applicable federal law. The commissioner shall enforce the consumer protections and market reforms relating to insurance as set forth in the federal Patient Protection and Affordable Care Act, Public Law 111-148. [L 2011, c 15, §1]

**[§431:10A-105.6] Prohibition on rescissions of coverage.** (a) Notwithstanding sections 431:10-226.5 and 431:10A-106 to the contrary, a group health plan or health insurance insurer shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud;

(2) The individual makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage; or

(3) The individual fails to timely pay required premiums or contributions toward the cost of coverage; provided that the rescission is in compliance with federal regulations.

As used in this subsection, "a person seeking coverage on behalf of the individual" shall not include an insurance producer or employee or authorized representative of the health carrier.

(b) A health carrier shall provide at least thirty days advance written notice to each plan enrollee or, for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) regardless of whether, in the case of group health insurance coverage, the rescission applies to the entire group or only to an individual within the group.

(c) This section applies regardless of any applicable contestability period. [L 2014, c 186, §1]

**§431:10A-106 Optional provisions.** Except as provided in section 431:10A-107, no policy of accident and health or sickness insurance delivered or issued for delivery to any person in this State shall contain the provisions set forth below unless the provisions are in the words in which they appear below; provided that the insurer may substitute corresponding provisions of different wording certified by an

officer of the insurer to be in substantial conformance with the wording below that are in each instance not less favorable in any respect to the insured or the beneficiary. The provisions listed in this section are optional provisions. Any of the following provisions contained in the policy shall be preceded individually by the specified caption or, at the option of the insurer, by appropriate individual or group captions or subcaptions substantially similar to the specified caption. The provisions are as follows:

(1) "Change of Occupation: If the insured is injured or contracts sickness after having changed occupations to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only the portion of the indemnities provided in this policy that the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured's occupation changes to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is more recent. In applying this provision, the classification of occupational risk and the premium shall be those as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if a filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in the state where the insured resided prior to the occurrence of the loss or prior to the date of proof of change in occupation";

(2) "Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the insured's correct age";

(3) Other insurance in this insurer shall be in one of the following forms:

(A) "Other Insurance in This Insurer: If an accident and health or sickness policy or policies previously issued by the insurer to the insured concurrently in force, making the aggregate indemnity for (insert type of coverage or coverages) in excess of $ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for the excess shall be returned to the insured or to the insured's estate"; or

(B) "Other Insurance in This Insurer: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer shall return all premiums paid for all other policies";

(4) Insurance with other insurers. Either or both of the following forms shall be used:

(A) (i) "Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for the proportion of the loss that would otherwise have been payable plus the total of the like amounts under all the other valid coverages for the same loss of which this insurer had notice

bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the like amount of other coverage shall be taken as the amount which the services rendered would have cost in the absence of the other coverage"; and

(ii) "Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for benefits under this policy shall be for the proportion of the indemnities otherwise provided hereunder for a loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all the indemnities for the loss, and for the return of the portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined";

(B) If the provision set forth in subparagraph (A)(i) is included in a policy that also contains the provision set forth in subparagraph (A)(ii), there shall be added to the caption of the subparagraph (A)(i) provision the phrase, "expense incurred benefits";

(C) The insurer may, at its option, include in the provision set forth in subparagraph (A)(i) a definition of other valid coverage, approved as to form by the commissioner, which shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this State or any other state or territory of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of a definition the term shall not include group insurance, automobile medical payment insurance, or coverage provided by hospital or medical service organizations, union welfare plans, or employer or employee benefit organizations. For the purpose of applying the provision set forth in subparagraph (A)(i) with respect to any insured, any amount of benefit provided for an insured pursuant to any compulsory benefit statute (including any workers' compensation or employers' liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying the provision set forth in subparagraph (A)(i), no third party liability coverage shall be included as other valid coverage;

(D) If the provision set forth in subparagraph (A)(ii) is included in a policy that also contains the provision set forth in subparagraph (A)(i), there shall be added to the caption of the subparagraph (A)(ii) provision the phrase,

"other benefits"; and

(E) The insurer may, at its option, include in the provision set forth in subparagraph (A)(ii) a definition of other valid coverage, approved as to form by the commissioner, which shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this State or any other state or territory of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of a definition the term shall not include group insurance, or benefits provided by union welfare plans or employer or employee benefit organizations. For the purpose of applying the provision set forth in subparagraph (A)(ii) with respect to any insured, any amount of benefit provided for an insured pursuant to any compulsory benefit statute including any workers' compensation or employers' liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying the provision set forth in subparagraph (A)(ii), no third party liability coverage shall be included as other valid coverage;

(5) (A) "Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, exceeds the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is greater, the insurer shall be liable only for the proportionate amount of benefits under this policy as the amount of the monthly earnings or average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all coverage upon the insured at the time disability commences and for the return of the part of the premiums paid during the two preceding years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in the coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time";

(B) The policy provision in subparagraph (A) may be inserted only in a policy which the insured has the right to continue in force, subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue; and

(C) The insurer may, at its option, include in the provision set forth in subparagraph (A) a definition of valid loss of time coverage approved as to form by the commissioner, which shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance

authorities of this State or any state, district, or territory of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of approved coverages. In the absence of a definition the terms shall not include any coverage provided for an insured pursuant to any compulsory benefit statute including any workers' compensation or employers' liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations;

(6) "Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted from the claim";

(7) "Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer. The notice shall state when, not less than five days thereafter, the cancellation shall be effective. After the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on a later date specified in the notice. In the event of cancellation, the insurer shall return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation";

(8) "Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on the effective date is hereby amended to conform to the minimum requirements of the applicable statutes";

(9) "Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation"; and

(10) "Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." [L 1987, c 347, pt of §2; am L 2002, c 155, §53; am L 2004, c 122, §32; am L 2010, c 116, §1(16)]

**§431:10A-107 Inapplicable or inconsistent provisions.** If any provision of section 431:10A-105 to section 431:10A-111 is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer 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 make the provision contained in the policy consistent with the coverage provided by the policy. An officer of the insurer shall certify conformity with the requirements of state statutes in accordance with this section. [L 1987, c 347, pt of §2; am L 2010, c 116, §1(17)]

**§431:10A-108 Order of certain policy provisions.** The provisions which are the subject of section 431:10A-105 and section 431:10A-106, or any corresponding provisions which are used in lieu thereof, shall be printed in the consecutive order of the provisions in such sections or,

at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related; provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued. [L 1987, c 347, pt of §2]

**§431:10A-109 Third party ownership.** The word, insured, as used in this part, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured, or from being entitled under such a policy to any indemnities, benefits, and rights provided therein. [L 1987, c 347, pt of §2]

**§431:10A-110 Requirements of other jurisdictions.** (a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this part and which is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any state or country, contain any provision permitted or required by the laws of such state or country. [L 1987, c 347, pt of §2]

**§431:10A-111 Other policy provisions.** No policy provision which is not subject to section 431:10A-105 or section 431:10A-106 shall make a policy, or any portion of the policy, less favorable in any respect to the insured or the beneficiary than the provisions which are subject to this part. [L 1987, c 347, pt of §2]

**§431:10A-112 Policy conflicting with this part.** A policy delivered or issued for delivery to any person in this State in violation of this part shall be held valid, but shall be construed as provided in this part. When any provision in a policy governed by this part is in conflict with any specific provision of this part, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of this part. [L 1987, c 347, pt of §2]

**§431:10A-113 Filing procedure.** The commissioner may adopt reasonable rules concerning the procedure for the filing or submission of policies subject to this article as are necessary, proper, or advisable to the administration of this article. Each filing shall be accompanied by a $20 fee payable to the commissioner, which fee shall be deposited in the commissioner's education and training fund. This provision shall not abridge any other authority granted the commissioner by law. [L 1987, c 347, pt of §2; am L 1988, c 363, §2(3)]

**Cross References**

Commissioner's education and training fund, see §431:2-214.

**§431:10A-114 Age limit.** If any policy of accident and health or

sickness insurance contains a provision establishing as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. [L 1987, c 347, pt of §2; am L 2002, c 155, §54]

**§431:10A-115 Coverage of newborn children.** (a) All policies providing family coverage, as defined in section 431:10A-103 and reciprocal beneficiary family coverage, as defined in section 431:10A-601, on an expense incurred basis shall provide that the benefits applicable for children shall be payable for newborn infants from the moment of birth; provided that the coverage for newly born children shall be limited to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth and payment of the required premium must be furnished the insurer within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

(b) This section shall not be construed to provide or include coverages for routine well-baby services. The requirements of this section shall apply to all policies delivered or issued for delivery in this State more than one hundred twenty days after June 12, 1974. [L 1987, c 347, pt of §2; am L 1997, c 383, §6]

**§431:10A-115.5 Coverage for child health supervision services.** (a) All health insurance policies issued in this State which provide coverage for the children of the insured shall provide coverage for child health supervision services from the moment of birth through age five years. These services shall be exempt from any deductible provisions, and immunizations shall be exempt from any copayment provisions, which may be in force in these policies or contracts.

(b) Child health supervision services shall include twelve visits at approximately the following intervals: birth; two months; four months; six months; nine months; twelve months; fifteen months; eighteen months; two years; three years; four years; and five years. Services to be covered at each visit shall include a history, physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests, in keeping with prevailing medical standards. For purposes of this subsection, the term "prevailing medical standards" means the recommendations of the Immunizations Practices Advisory Committee of the United States Department of Health and Human Services and the American Academy of Pediatrics; provided that in the event that the recommendations of the committee and the academy differ, the department of health shall determine which recommendations shall apply.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this

section, except that the limitations authorized by this subsection shall not apply to immunizations recommended by the Immunizations Practices Advisory Committee of the United States Department of Health and Human Services and the American Academy of Pediatrics; provided that in the event that the recommendations of the committee and the academy differ, the department of health shall determine which recommendations shall apply.

(d) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(e) For the purposes of this section, "child health supervision services" means physician-delivered, physician-supervised, physician assistant-delivered, or nurse-delivered services as defined by section 457-2 ("registered nurse") which shall include as the minimum benefit coverage for services delivered at intervals and scope stated in this section. [L 1988, c 201, §1; am L 1993, c 83, §1 and c 362, §3; am L 2009, c 151, §18]

**§431:10A-116 Coverage for specific services.** Every person insured under a policy of accident and health or sickness insurance delivered or issued for delivery in this State shall be entitled to the reimbursements and coverages specified below:

(1) Notwithstanding any provision to the contrary, whenever a policy, contract, plan, or agreement provides for reimbursement for any visual or optometric service, which is within the lawful scope of practice of a duly licensed optometrist, the person entitled to benefits or the person performing the services shall be entitled to reimbursement whether the service is performed by a licensed physician or by a licensed optometrist. Visual or optometric services shall include eye or visual examination, or both, or a correction of any visual or muscular anomaly, and the supplying of ophthalmic materials, lenses, contact lenses, spectacles, eyeglasses, and appurtenances thereto;

(2) Notwithstanding any provision to the contrary, for all policies, contracts, plans, or agreements issued on or after May 30, 1974, whenever provision is made for reimbursement or indemnity for any service related to surgical or emergency procedures, which is within the lawful scope of practice of any practitioner licensed to practice medicine in this State, reimbursement or indemnification under the policy, contract, plan, or agreement shall not be denied when the services are performed by a dentist acting within the lawful scope of the dentist's license;

(3) Notwithstanding any provision to the contrary, whenever the policy provides reimbursement or payment for any service, which is within the lawful scope of practice of a psychologist licensed in this State, the person entitled to benefits or performing the service shall be entitled to reimbursement or payment, whether the service is performed by a licensed physician or licensed psychologist;

(4) Notwithstanding any provision to the contrary, each policy, contract, plan, or agreement issued on or after February 1, 1991, except for policies that only provide coverage for specified diseases or other limited benefit coverage, but including policies issued by companies subject to chapter 431, article 10A, part II and chapter 432, article 1 shall provide coverage for screening by low-dose mammography for occult breast cancer as follows:

(A) For women forty years of age and older, an annual mammogram; and

(B) For a woman of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer, a mammogram upon the recommendation of the woman's physician.

The services provided in this paragraph are subject to any coinsurance provisions that may be in force in these policies, contracts, plans, or agreements.

For the purpose of this paragraph, the term "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. An insurer may provide the services required by this paragraph through contracts with providers; provided that the contract is determined to be a cost-effective means of delivering the services without sacrifice of quality and meets the approval of the director of health;

(5) (A) (i) Notwithstanding any provision to the contrary, whenever a policy, contract, plan, or agreement provides coverage for the children of the insured, that coverage shall also extend to the date of birth of any newborn child to be adopted by the insured; provided that the insured gives written notice to the insurer of the insured's intent to adopt the child prior to the child's date of birth or within thirty days after the child's birth or within the time period required for enrollment of a natural born child under the policy, contract, plan, or agreement of the insured, whichever period is longer; provided further that if the adoption proceedings are not successful, the insured shall reimburse the insurer for any expenses paid for the child; and

(ii) Where notification has not been received by the insurer prior to the child's birth or within the specified period following the child's birth, insurance coverage shall be effective from the first day following the insurer's receipt of legal notification of the insured's ability to consent for treatment of the infant for whom coverage is sought; and

(B) When the insured is a member of a health maintenance organization (HMO), coverage of an adopted newborn is effective:

(i) From the date of birth of the adopted newborn when the newborn is treated from birth pursuant to a provider contract with the health maintenance organization, and written notice of enrollment in accord with the health maintenance organization's usual enrollment process is provided within thirty days of the date the insured notifies the health maintenance organization of the insured's intent to adopt the infant for whom coverage is sought; or

(ii) From the first day following receipt by the health maintenance organization of written notice of the insured's ability to consent for treatment of the infant for whom coverage is sought and enrollment of the adopted newborn in accord with the health maintenance organization's usual enrollment process if the newborn has been treated from birth by a provider not contracting or affiliated with the health maintenance organization; and

(6) Notwithstanding any provision to the contrary, any policy, contract, plan, or agreement issued or renewed in this State shall provide reimbursement for services provided by advanced practice registered nurses licensed pursuant to chapter 457. Services rendered by advanced practice registered nurses are subject to the same policy limitations generally applicable to health care providers within the policy, contract, plan,

or agreement. [L 1987, c 347, pt of §2; am L 1990, c 112, §2; am L 1991, c 268, §§1, 5; am L 1994, c 279, §3; am L 1995, c 47, §1; am L 1999, c 13, §2 and c 222, §3; am L 2002, c 155, §55; am L 2015, c 35, §45]

**Note**

Director of health to monitor mammogram screening services to assure that the demand for screening does not exceed the ability of the medical community to safely provide the services. L 1990, c 112, §5.

**Cross References**

Sunset evaluations modified, see §§26H-4, 5.
Civil relief for state military forces, see chapter 657D.
Federally funded programs, see §431:10A-602.
Newborn adopted children, see §432:1-602.6.
Risk-based capital for insurers, see §§431:3-401 to 414.

**[§431:10A-116.2] Mammograms; referral not required.** (a) For purposes of the annual screening mammogram coverage required under section 431:10A-116, no insurer shall require an insured person forty years of age and older to obtain a referral from a primary care provider or other physician for an annual screening mammogram.

(b) If the screening mammogram indicates that follow up services are advisable, a referral shall be made to the patient's primary care physician or other physician, as designated by the patient. [L 2012, c 92, §1]

**§431:10A-116.3 Coverage for telehealth.** *[Section effective until December 31, 2016. For section effective January 1, 2017, see below.]* (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.

(b) No accident and health or sickness insurance plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the insurer, and the provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. There shall be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be

required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical and other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) For the purposes of this section, "telehealth" means the use of telecommunications services, as defined in section 269-1, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter. [L 1998, c 278, §2; am L 2002, c 155, §56; am L 2006, c 219, §2; am L 2009, c 20, §3; am L 2014, c 159, §3]

**§431:10A-116.3 Coverage for telehealth.** *[Section effective January 1, 2017. For section effective until December 31, 2016, see above.]* (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No accident and health or sickness insurance plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the insurer, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care

provider-patient relationship.

(e) All insurers shall provide current and prospective insureds with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to the issuance of a policy, contract, plan, or agreement, and upon request after the policy, contract, plan, or agreement has been issued.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

(g) For the purposes of this section:

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter. [L 1998, c 278, §2; am L 2002, c 155, §56; am L 2006, c 219, §2; am L 2009, c 20, §3; am L 2014, c 159, §3; am L 2016, c 226, §6]

**Note**

Applicability of L 2016, c 226 requirement for reimbursement for telehealth services to health benefits plans under chapter 87A. L 2016, c 226, §13.

**Cross References**

Practice of telehealth, see §453-1.3.

**§431:10A-116.5 In vitro fertilization procedure coverage.** (a) All individual and group accident and health or sickness insurance policies which provide pregnancy-related benefits shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures performed on the insured or the insured's dependent spouse; provided that:

(1) Benefits under this section shall be provided to the same extent as the benefits provided for other pregnancy-related benefits;

(2) The patient is the insured or covered dependent of the insured;

(3) The patient's oocytes are fertilized with the patient's spouse's sperm;

(4) The:

(A) Patient and the patient's spouse have a history of infertility of at least five years' duration; or

(B) Infertility is associated with one or more of the following medical conditions:

(i) Endometriosis;

(ii) Exposure in utero to diethylstilbestrol, commonly known as DES;

(iii) Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

(iv) Abnormal male factors contributing to the infertility;

(5) The patient has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under the insurance contract; and

(6) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

(b) For the purposes of this section, the term "spouse" means a person who is lawfully married to the patient under the laws of the State.

(c) The requirements of this section shall apply to all new policies delivered or issued for delivery in this State after June 26, 1987. [L 1987, c 332, §1 and L 1989, c 276, §4; am L 2003, c 212, §72; am L 2013, c 47, §1]

**§431:10A-116.6 Contraceptive services.** (a) Notwithstanding any provision of law to the contrary, each employer group accident and health or sickness policy, contract, plan, or agreement issued or renewed in this State on or after January 1, 2000, shall cease to exclude contraceptive services or supplies for the subscriber or any dependent of the subscriber who is covered by the policy, subject to the exclusion under section 431:10A-116.7 and the exclusion under section 431:10A-

102.5.

(b) Except as provided in subsection (c), all policies, contracts, plans, or agreements under subsection (a), that provide contraceptive services or supplies, or prescription drug coverage, shall not exclude any prescription contraceptive supplies or impose any unusual copayment, charge, or waiting requirement for such supplies.

(c) Coverage for oral contraceptives shall include at least one brand from the monophasic, multiphasic, and the progestin-only categories. A member shall receive coverage for any other oral contraceptive only if:

(1) Use of brands covered has resulted in an adverse drug reaction; or

(2) The member has not used the brands covered and, based on the member's past medical history, the prescribing health care provider believes that use of the brands covered would result in an adverse reaction.

(d) Coverage required by this section shall include reimbursement to a prescribing health care provider or dispensing entity for prescription contraceptive supplies intended to last for up to a twelve-month period for an insured.

(e) For purposes of this section:

"Contraceptive services" means physician-delivered, physician-supervised, physician assistant-delivered, advanced practice registered nurse-delivered, nurse-delivered, or pharmacist-delivered medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.

"Contraceptive supplies" means all United States Food and Drug Administration-approved contraceptive drugs or devices used to prevent unwanted pregnancy.

(f) Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the provider's practice and privileges. [L 1993, c 365, §1; am L 1999, c 267, §2; am L 2003, c 201, §3 and c 212, §73; am L 2016, c 141, §6 and c 205, §2]

**Note**

Applicability of L 2016, c 205 amendment. L 2016, c 205, §§4, 5, and 7.

**§431:10A-116.7 Contraceptive services; religious employers exemption.** (a) A "religious employer" is an entity for which each of the following is true:

(1) The inculcation of religious values is the purpose of the entity;

(2) The entity primarily employs persons who share the religious tenets of the entity;

(3) The entity is not staffed by public employees; and

(4) The entity is a nonprofit organization as defined under section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

For the purpose of this definition, any educational, health care, or other nonprofit institution or organization owned or controlled by the religious employer is included in this exemption.

(b) Notwithstanding any other provision of this chapter, any religious employer may request an accident and health or sickness insurance plan without coverage for contraceptive services and supplies that are contrary to the religious employer's religious tenets. If so requested, the accident and health or sickness insurer, mutual benefit society, or health maintenance organization shall provide a plan without coverage for contraceptive services and supplies. This subsection shall not be construed to deny an enrollee coverage of, and timely access to, contraceptive services and supplies.

(c) Each religious employer that invokes the exemption provided under this section shall:

(1) Provide written notice to enrollees upon enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons;

(2) Provide written information describing how an enrollee may directly access contraceptive services and supplies in an expeditious manner; and

(3) Ensure that enrollees who are refused contraceptive services and supplies coverage under this section have prompt access to the information developed under paragraph (2). Such notice shall appear, in not less than twelve-point type, in the policy, application, and sales brochure for such policy.

(d) Nothing in this section shall be construed to exclude coverage for prescription contraceptive supplies ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for prescription contraception that is necessary to preserve the life or health of an enrollee.

(e) Accident and health or sickness insurers, mutual benefit societies, and health maintenance organizations shall allow enrollees in a health plan exempted under this section to directly purchase coverage of contraceptive supplies and outpatient contraceptive services. The enrollee's cost of purchasing such coverage shall not exceed the enrollee's pro rata share of the price the group purchaser would have paid for such coverage had the group plan not invoked a religious exemption.

(f) This section shall not be construed as to require an accident and health or sickness insurer, mutual benefit society, health maintenance organization, health care facility, or health care provider to provide any health care services without appropriate payment of premium or fee.

(g) For purposes of this section:

"Contraceptive services" means physician-delivered, physician-supervised, physician assistant-delivered, advanced practice registered nurse-delivered, nurse-delivered, or pharmacist-delivered medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.

"Contraceptive supplies" means all United States Food and Drug Administration-approved contraceptive drugs or devices used to prevent unwanted pregnancy. [L 1999, c 267, §1; am L 2003, c 201, §4 and c 212, §74; am L 2016, c 141, §7]

**§431:10A-117 Franchise plan.** (a) As used in this section, "employees" include:

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

(2) The individual proprietor or partners, if the employer is an individual proprietor or partnership.

(b) Insurance may be issued pursuant to this part on a franchise plan under the terms of which accident and health or sickness insurance is issued to:

(1) Five or more employees of any corporation, co-partnership, or individual employer, or any governmental corporation, agency, or department thereof; or

(2) Ten or more members, employees, or employees of members of any trade or professional association, of a labor union, or of any other association having had an active existence for at least two years; provided that:

(A) Such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance;
(B) Such persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for; and
(C) There is an arrangement whereby the premiums on the policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association for its members, or by some designated person acting on behalf of the employer or association. [L 1987, c 347, pt of §2; am L 2002, c 155, §57; am L 2004, c 122, §33]

**§431:10A-118 Genetic information nondiscrimination in accident and health or sickness insurance coverage.** (a) No insurer may:

(1) Use an individual's or a family member's genetic information, or request for genetic services, to deny or limit any coverage or establish eligibility, continuation, enrollment, or premium payments;

(2) Request or require collection or disclosure of an individual's or a family member's genetic information; or

(3) Disclose an individual's or a family member's genetic information without the written consent of the person affected, the person's legal guardian, or a person with power of attorney for health care for the person affected. This consent shall be required for each disclosure and shall include the name of each person or organization to whom the disclosure will be made.

(b) As used in this section:
"Family member" means, with respect to the individual, another individual related by blood to that individual.
"Genetic information" means information about genes, gene products, hereditary susceptibility to disease, or inherited characteristics that may derive from the individual or family member.
"Genetic services" means health services to obtain, assess, or interpret genetic information for diagnosis, therapy, or genetic counseling.
(c) This section shall not apply to any action taken in connection with policies of life insurance, disability income insurance, and long-term care insurance delivered or issued for delivery in this State. [L 1997, c 91, §1; am L 2003, c 212, §75]

**Law Journals and Reviews**

Privacy and Genetics: Protecting Genetic Test Results in Hawai'i. 25 UH L. Rev. 449.

**[§431:10A-118.3] Nondiscrimination on the basis of actual gender identity or perceived gender identity; coverage for services.** (a) No individual and group accident and health or sickness policy, contract, plan, or agreement that provides health care coverage shall discriminate with respect to participation and coverage under the policy, contract, plan, or agreement against any person on the basis of actual gender identity or perceived gender identity.

(b) Discrimination under this section includes the following:

(1) Denying, canceling, limiting, or refusing to issue or renew an insurance policy, contract, plan, or agreement on the basis of a person's or the person's family member's actual gender identity or perceived gender identity;

(2) Demanding or requiring a payment or premium that is based on a person's or the person's family member's actual gender identity or perceived gender identity;

(3) Designating a person's or the person's family member's actual gender identity or perceived gender identity as a preexisting condition to deny, cancel, or limit coverage; and

(4) Denying, canceling, or limiting coverage for services on the basis of actual gender identity or perceived gender identity including but not limited to the following:

(A) Health care services related to gender transition; provided that there is coverage under the policy, contract, plan, or agreement for the services when the services are not related to gender transition; and

(B) Health care services that are ordinarily or exclusively available to individuals of one sex.

(c) The medical necessity of any treatment shall be determined pursuant to the insurance policy, contract, plan, or agreement and shall be defined in a manner that is consistent with other covered services.

(d) Any coverage provided shall be subject to copayment, deductible, and coinsurance provisions of an individual and group accident and health or sickness policy, contract, plan, or agreement that are no less favorable than the copayment, deductible, and coinsurance provisions for substantially all other medical services covered by the policy, contract, plan, or agreement.

(e) As used in this section unless the context requires otherwise:

"Actual gender identity" means a person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.

"Gender transition" means the process of a person changing the person's outward appearance or sex characteristics to accord with the person's actual gender identity.

"Perceived gender identity" means an observer's impression of another person's actual gender identity or the observer's own impression that the person is male, female, a gender different from the gender designed at birth, a transgender person, or neither male nor female.

"Transgender person" means a person who has gender identity disorder or gender dysphoria, has received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth. [L 2016, c 135, §2]

**Note**

Applicability of section. L 2016, c 135, §§5, 7.

**§431:10A-119 Hospice care coverage.** (a) Any other law to the contrary notwithstanding, commencing on January 1, 2000, all authorized insurers that provide for payment of or reimbursement for hospice care shall reimburse hospice care services for each insured policyholder covered for hospice care according to the following:

(1) A minimum daily rate as set by the Centers for Medicare and Medicaid Services for hospice care;

(2) Reimbursement for residential hospice room and board expenses directly related to the hospice care being provided; and

(3) Reimbursement for each hospice referral visit during which a patient is advised of hospice care options, regardless of whether the referred patient is eventually admitted to hospice care.

(b) Every insurer shall provide notice to its policyholders regarding the coverage required by this section. Notice shall be in writing and in literature or correspondence sent to policyholders, beginning with calendar year 2000, along with any other mailing to policyholders, but in no case later than July 1, 2000. [L 1999, c 77, §4; am L 2011, c 43, §16]

**§431:10A-120 Medical foods and low-protein modified food products; treatment of inborn error of metabolism; notice.** (a) Each policy of accident and health or sickness insurance, other than life insurance, disability income insurance, and long-term care insurance, issued or renewed in this State, each employer group health policy, contract, plan, or agreement issued or renewed in this State, all accident and health or sickness insurance policies issued or renewed in this State, all policies providing family coverages as defined in section 431:10A-103, and all policies providing reciprocal beneficiary family coverage as defined in section 431:10A-601, shall contain a provision for coverage for medical foods and low-protein modified food products for the treatment of an inborn error of metabolism for its policyholders or dependents of the policyholder in this State; provided that the medical food or low-protein modified food product is:

(1) Prescribed as medically necessary for the therapeutic treatment of an inborn error of metabolism; and

(2) Consumed or administered enterally under the supervision of a physician or osteopathic physician licensed under chapter 453.

Coverage shall be for at least eighty per cent of the cost of the medical food or low-protein modified food product prescribed and administered pursuant to this subsection.

(b) Every insurer shall provide notice to its policyholders regarding the coverage required by this section. The notice shall be in writing and prominently placed in any literature or correspondence sent to policyholders and shall be transmitted to policyholders during calendar year 2000 when annual information is made available to policyholders, or in any other mailing to policyholders, but in no case

later than December 31, 2000.

(c) For the purposes of this section:

"Inborn error of metabolism" means a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.

"Low-protein modified food product" means a food product that:

(1) Is specially formulated to have less than one gram of protein per serving;

(2) Is prescribed or ordered by a physician or osteopathic physician as medically necessary for the dietary treatment of an inborn error of metabolism; and

(3) Does not include a food that is naturally low in protein.

"Medical food" means a food that is formulated to be consumed or administered enterally under the supervision of a physician or osteopathic physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. [L 1999, c 86, §2; am L 2002, c 155, §58; am L 2003, c 212, §76; am L 2009, c 11, §50]

**§431:10A-121 Coverage for diabetes.** Each policy of accident and health or sickness insurance providing coverage for health care, other than an accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, or other limited benefit health insurance policy, that is issued or renewed in this State, shall provide coverage for outpatient diabetes self-management training, education, equipment, and supplies, if:

(1) The equipment, supplies, training, and education are medically necessary; and

(2) The equipment, supplies, training, and education are prescribed by a health care professional authorized to prescribe. [L 2000, c 243, §2; am L 2002, c 155, §59]

**[§431:10A-122] Colon cancer screening coverage.** (a) Each policy of accident and health or sickness insurance providing coverage for health care, except for policies that only provide coverage for specified diseases or other limited benefit coverage, shall provide coverage for colorectal-cancer screening by all A and B grade screening modalities as recommended by the United States Preventive Services Task Force.

(b) Beginning March 1, 2011, all health insurance providers in Hawaii shall inform their insured about the risk associated with undiagnosed colorectal-cancer and encourage the insured to consult with the insured's physician about available screening options. [L 2010, c 157, §1]

**Note**

Section applies to policies, contracts, and plans of health insurance issued or renewed after January 1, 2011. L 2010, c 157, §5.

**[§431:10A-125] Primary care provider; advanced practice registered nurse.** (a) Each policy of accident and health or sickness insurance delivered or issued for delivery in this State shall recognize advanced practice registered nurses, as defined under section 457-8.5(a), as participating providers, and shall include coverage for care provided by participating advanced practice registered nurses practicing within the scope of their licenses for purposes of health maintenance, diagnosis, or treatment, to the extent that the policy provides benefits for identical services rendered by another health care provider.

(b) Notwithstanding any other law to the contrary, an insurer may recognize a participating advanced practice registered nurse as a primary care provider if the insured's policy requires the selection of a primary care provider. The insurer shall include participating advanced practice registered nurses who practice as primary care providers on any publicly available list of participating primary care providers; provided that the insurer retains the right to determine the contracting criteria for a participating primary care provider.

(c) For the purposes of this section, "participating advanced practice registered nurse" means an advanced practice registered nurse who has contracted with the insurer to provide health care services to its insureds. [L 2009, c 169, §2]

**§431:10A-126 Cancer treatment.** (a) Notwithstanding section 23-51, all individual and group accident and health or sickness insurance policies that include coverage or benefits for the treatment of cancer shall provide payment or reimbursement for all types of chemotherapy that are considered medically necessary as defined in section 432E-1.4.

(b) The cost-sharing for generic and non-generic oral chemotherapy shall be provided at the same or lower amount or percentage as is applied to generic and non-generic intravenously administered chemotherapy; provided that an insurer shall not increase the cost-share for intravenously administered chemotherapy in order to achieve compliance with this subsection.

(c) Individual and group accident and health or sickness insurance policies shall not increase enrollee cost-sharing for non-generic medications used for the treatment of cancer to any greater extent than such policies increase enrollee cost-sharing for other covered non-generic medication.

(d) For the purposes of this section:

"Cost-share" or "cost-sharing" means copayment, coinsurance, or deductible provisions applicable to coverage for medications or treatments.

"Intravenously administered chemotherapy" means a physician-prescribed cancer treatment that is administered through injection directly into the patient's circulatory system by a physician, physician assistant, nurse practitioner, nurse, or other medical personnel under the supervision of a physician and in a hospital, medical office, or other clinical setting.

"Oral chemotherapy" means a United States Food and Drug Administration-approved, physician-prescribed cancer treatment that is taken orally in the form of a tablet or capsule and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or

supervision of a physician outside of a hospital, medical office, or other clinical setting.

(e) This section shall not apply to an accident-only, specified disease, hospital indemnity, long-term care, or other limited-benefit health insurance policy. [L 2009, c 168, §1; am L 2012, c 30, §1]

**§431:10A-131 REPEALED.** L 2009, c 149, §9.

**Cross References**

Insurance fraud, see §§431:2-401 to 431:2-410.

**[§431:10A-132] Orthodontic services for orofacial anomalies; benefits and coverage; notice.** (a) Each individual and group accident and health or sickness insurance policy, contract, plan, or agreement issued or renewed in this State after December 31, 2015, shall provide to the policyholder and individuals under twenty-six years of age covered under the policy, contract, plan, or agreement, coverage of medically necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or birth defect syndromes. Coverage required by this section shall be paid for by medical insurance.

(b) Every insurer shall provide written notice to its policyholders regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to policyholders and shall be transmitted to policyholders within calendar year 2016 when annual information is made available to members or in any other mailing to members, but in no case later than December 31, 2016.

(c) Orthodontic services for treatment of orofacial anomalies provided under this section shall be subject to a maximum benefit of $5,500 per treatment phase, but shall not be subject to limits on the number of visits to an orthodontist. After December 31, 2016, the insurance commissioner, on an annual basis, shall adjust the maximum benefit for inflation using the medical care component of the United States Department of Labor Consumer Price Index for all urban consumers. The commissioner shall publish the adjusted maximum benefit annually no later than April 1 of each calendar year, which shall apply during the following calendar year to accident and health or sickness insurance policies, contracts, plans, or agreements subject to this section. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, or service other than orthodontic services, shall not be applied toward any maximum benefit established under this subsection.

(d) Coverage under this section may be subject to copayment, deductible, and coinsurance provisions of an accident and health or sickness insurance policy, contract, plan, or agreement that are no less favorable than the copayment, deductible, and coinsurance provisions for other medical services covered by the policy, contract, plan, or agreement.

(e) This section shall not be construed as limiting benefits that are otherwise available to an individual under an accident and health or sickness insurance policy, contract, plan, or agreement.

(f) Coverage for treatment under this section shall not be denied

on the basis that the treatment is habilitative or non-restorative in nature.

(g) This section shall not apply to limited benefit health insurance as provided pursuant to section 431:10A-102.5.

(h) As used in this section, unless the context clearly requires otherwise:

"Orofacial anomalies" means cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.

"Orthodontic services" mean direct or consultative services provided by a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.

"Treatment of orofacial anomalies" includes the care prescribed, provided, or ordered for an individual diagnosed with an orofacial anomaly by a craniofacial team that includes a licensed dentist, orthodontist, oral surgeon, and physician, and is coordinated between specialists and providers. [L 2015, c 213, §3]

**[§431:10A-133] Autism benefits and coverage; notice; definitions.** (a) Each individual or group accident and health or sickness insurance policy issued or renewed in this State after January 1, 2016, shall provide to the policyholder and individuals under fourteen years of age covered under the policy coverage for the diagnosis and treatment of autism.

(b) This section shall not apply to disability, accident-only, medicare, medicare supplement, student accident and health or sickness insurance, dental-only, and vision-only policies or policies or renewals of six months or less.

(c) Every insurer shall provide written notice to its policyholders regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to policyholders and shall be transmitted to policyholders within calendar year 2016 when annual information is made available to policyholders or in any other mailing to policyholders, but in no case later than December 31, 2016.

(d) Coverage for applied behavioral analysis provided under this section shall be subject to a maximum benefit of $25,000 per year for services for children ages thirteen and under. This section shall not be construed as limiting benefits that are otherwise available to an individual under an accident and health or sickness insurance policy. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, or service other than applied behavioral analysis shall not be applied toward the maximum benefit established under this subsection.

(e) Coverage under this section may be subject to copayment, deductible, and coinsurance provisions of an accident and health or sickness insurance policy that are no less favorable than the copayment, deductible, and coinsurance provisions for substantially all medical services covered by the policy.

(f) Treatment for autism requests shall include a treatment plan. Except for inpatient services, if an individual is receiving treatment for autism, an insurer may request a review of the treatment plan for continued authorization of coverage for treatment for autism at the insurer's discretion.

(g) The medical necessity of treatment covered by this section

shall be determined pursuant to the policy and shall be defined in the policy in a manner that is consistent with other services covered under the policy. Except for inpatient services, if an individual is receiving treatment for autism, an insurer may request a review of the medical necessity of that treatment at the insurer's discretion.

(h) This section shall not be construed as reducing any obligation to provide services to an individual under any publicly funded program, an individualized family service plan, an individualized education program, or an individualized service plan.

(i) Coverage under this section shall exclude coverage for:

(1) Care that is custodial in nature;

(2) Services and supplies that are not clinically appropriate;

(3) Services provided by family or household members;

(4) Treatments considered experimental; and

(5) Services provided outside of the State.

(j) Insurers shall include in their network of approved autism service providers only those providers who have cleared state and federal criminal background checks as determined by the insurer.

(k) If an individual has been diagnosed as having autism meeting the diagnostic criteria described in the Diagnostic and Statistical Manual of Mental Disorders available at the time of diagnosis, upon publication of a more recent edition of the Diagnostic and Statistical Manual of Mental Disorders, that individual may be required to undergo repeat evaluation to remain eligible for coverage under this section.

(l) Treatment for autism shall not be covered pursuant to this section unless provided by an autism service provider that is licensed by a state licensure board. If a state licensure board that licenses providers to provide autism services is unavailable, the autism service provider shall:

(1) Be certified by the Behavior Analyst Certification Board, Inc.; provided that certification by the Behavior Analyst Certification Board, Inc., shall be valid for purposes of this subsection for no more than one year; or

(2) Meet any existing credentialing requirements determined by the insurer.

(m) As used in this section, unless the context clearly requires otherwise:

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

"Autism" means autism spectrum disorder as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

"Autism service provider" means any person, entity, or group that provides treatment for autism and meets the minimum requirements pursuant to subsection (l).

"Behavioral health treatment" means evidence based counseling and treatment programs, including applied behavior analysis, that are:

(1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and

(2) Provided or supervised by an autism service provider.

"Diagnosis of autism" means medically necessary assessments, evaluations, or tests conducted to diagnose whether an individual has autism.

"Pharmacy care" means medications prescribed by a licensed physician or registered nurse practitioner and any health-related services that are deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a licensed psychiatrist.

"Psychological care" means direct or consultative services provided by a licensed psychologist.

"Therapeutic care" means services provided by licensed speech pathologists, registered occupational therapists, licensed social workers, licensed clinical social workers, or licensed physical therapists.

"Treatment for autism" includes the following care prescribed or ordered for an individual diagnosed with autism by a licensed physician, psychiatrist, psychologist, licensed clinical social worker, or registered nurse practitioner if the care is determined to be medically necessary:

(1) Behavioral health treatment;

(2) Pharmacy care;

(3) Psychiatric care;

(4) Psychological care; and

(5) Therapeutic care. [L 2015, c 235, §3]

**[§431:10A-134] Human immunodeficiency virus and acquired immunodeficiency syndrome screening coverage.** (a) Each policy of accident and health or sickness insurance issued or renewed in this State, except for policies that only provide coverage for specified diseases or other limited benefit coverage as described in section 431:10A-102.5, shall provide coverage for annual screenings for sexually transmitted diseases, including screenings for human immunodeficiency virus and acquired immunodeficiency syndrome.

(b) Each accident and health or sickness insurer shall reimburse all costs associated with the coverage under subsection (a) to any physician or health care provider complying with this section. [L 2016, c 204, §2]

**Note**

Applicability of section. L 2016, c 204, §§6, 8.

**[§431:10A-140] Formulary; accessibility requirements.** (a) Each insurer offering or renewing an individual or group accident and health or sickness insurance policy on or after January 1, 2017, shall provide the following information via a public website and through a toll-free number that is posted on the insurer's website:

(1) Its formulary; provided that notice of any changes due to the addition of a new drug or deletion of any existing drug shall be made available no later than seventy-two hours after the effective date of the change; provided further that notice of other changes, including drug strength or form, shall be made available within fourteen calendar days of the effective date of the change;

(2) Provide a system that allows an insured or potential insured to determine whether prescription drugs are covered under the plan's medical benefits and typically administered by a provider, along with any cost-sharing imposed on such drugs;

(3) Indicate a dollar amount range of cost-sharing typically paid by an insured of each specific drug included on the formulary based on the information the insurer has available, as follows:

(A) $100 and under: $;
(B) Over $100 to $250: $$;
(C) Over $250 to $500: $$$;
(D) Over $500 to $1,000: $$$$; and
(E) Over $1,000: $$$$$; and

(4) Display standardized content for the formulary for each product offered by the plan pursuant to recommendations made by the formulary accessibility working group established pursuant to Act 197, Session Laws of Hawaii 2015.

(b) For the purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under a policy, including drugs covered under the policy's pharmacy benefit and medical benefit as defined by the health care service plans.

(c) This section shall not apply to limited benefit health insurance as provided in section 431:10A-102.5; provided further that this section shall not apply to medicare, medicaid, or other federally financed plans. [L 2015, c 197, §1]

## PART II. GROUP AND BLANKET DISABILITY INSURANCE

### Attorney General Opinions

Section 431:10A-601 applied to all parts of article 10A if the category of policy under consideration included family coverage, as defined in §431:10A-103. Att. Gen. Op. 97-10.

**§431:10A-201 Definitions.** For the purposes of this article:

"Blanket disability insurance policy" means any policy or contract of accident and health or sickness insurance which does not require individual applications for covered persons and is:

(1) A policy issued to any common carrier of passengers, which shall be deemed the policyholder, that covers a group defined as all persons who may become passengers who shall be insured against loss or damage resulting from death or bodily injury either while or as a result of being passengers;

(2) A policy issued in the name of any volunteer fire department, first aid or ambulance squad, or volunteer police organization, which shall be deemed the policyholder, that covers all the members of the

policyholder organization against loss from accidents resulting from hazards incidental to duties in connection with such organizations;

(3) A policy issued in the name of any established organization, whether incorporated or not, that is recognized by the community as being operated for the welfare of the community and its members and not for profit, which shall be deemed the policyholder, that covers all volunteer workers who serve without pecuniary compensation and the members of the organization against loss from accidents occurring while engaged in the actual performance of duties or activities of the policyholder organization;

(4) A policy issued to an employer, who shall be deemed the policyholder, that covers any group of employees defined by reference to exceptional hazards incident to employment and that insures employees against death or bodily injury resulting from or caused by exposure to exceptional hazards;

(5) A policy issued to a college, school, institute of learning, or to the head or principal of a college, school, or institute of learning, which or who shall be deemed the policyholder, that covers students or employees; or

(6) A policy issued to a substantially similar group that, pursuant to the discretion of the commissioner, may be properly eligible for blanket disability insurance;

provided that a blanket disability insurance policy shall not affect the liability of policyholders for the death of or injury to, any such member of such group.

"Employees" means the compensated officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, the individual proprietors, partners, and employees of individuals and firms of which the business is under common control through stock ownership, contract, or otherwise, the individual proprietor or partners if the employer is an individual proprietor or a partnership and if specified by the policy, and retired employees.

"Employer" means any municipal corporation or governmental unit, agency, or department as well as private individuals, firms, corporations, and other persons.

"Group disability insurance" means that form of accident and health or sickness insurance covering groups of persons, with or without their dependents and family members, and issued under a master policy to:

(1) Groups that qualify for group life insurance under sections 431:10D-201 to 431:10D-211 and 431:10D-211.5 of this code; or

(2) An automobile club formed for purposes other than obtaining group insurance that covers the members of the club. [L 1987, c 347, pt of §2; am L 2002, c 155, §60; am L 2010, c 32, §2]

**§431:10A-202 Health care groups.** A policy of group disability insurance may be issued to a corporation, as policyholder, existing primarily for the purpose of assisting individuals who are its subscribers in securing medical, hospital, dental, and other health care services for themselves and their dependents, covering all and not less than five hundred such subscribers and dependents, with respect only to medical, hospital, dental, and other health care services. [L 1987, c 347, pt of §2]

**§431:10A-203 Standard provisions.** Every policy of group or blanket

disability insurance shall contain in substance the following provisions, or provisions which in the opinion of the commissioner are more favorable to the individuals insured, or at least as favorable to such individuals and more favorable to the policyholder. No such policy of group or blanket disability insurance shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the individuals insured than would be permitted by the standard provisions required for individual accident and health or sickness insurance policies.

(1) Representations. There shall be a provision that:

(A) All statements, made by the policyholder or by the individuals insured, shall be deemed to be representations and not warranties;
(B) No statement, made in the application by the policyholder, shall be used in any contest unless a copy of the application, if any, of the policyholder shall be attached to the policy when issued;
(C) No statement made by any individual insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such individual or to the individual's beneficiary, if any; and
(D) A misrepresentation, unless it is made with actual intent to deceive or unless it materially affects either the acceptance of the risk or the hazard assumed by the insurer, shall not prevent a recovery on the policy.

(2) Certificates. There shall be a provision that the insurer shall issue to the policyholder for delivery to each insured employee or member, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage, and to whom the benefits are payable. If family members are insured, only one certificate need be issued for each family. This paragraph shall not apply to blanket disability insurance policies.

(3) Additional insureds. There shall be a provision that to the group originally insured may be added, from time to time, eligible new employees, members, or dependents, as the case may be, in accordance with the terms of the policy.

(4) Age limitations. There shall be a provision specifying:

(A) The ages, if any, to which the insurance provided shall be limited;
(B) The ages, if any, for which additional restrictions are placed on benefits; and
(C) The additional restrictions placed on the benefits at such ages.

(5) Payment of premiums. There shall be a provision that all premiums due under the policy shall be remitted by the employer or employers of the persons insured, by the policyholder or by some other designated person acting on behalf of the association or group insured, to the insurer on or before the due date thereof within such grace period as may be specified therein. [L 1987, c 347, pt of §2; am L 1989, c 195, §24; am L 2002, c 155, §61]

**§431:10A-204 Optional provision, examination and autopsy.** There may be a provision that the insurer shall have the right and opportunity

to examine the person of any individual covered under the policy when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law. [L 1987, c 347, pt of §2]

**§431:10A-205 Payment of benefits.** (a) The benefits payable under any policy or contract of group or blanket disability insurance shall be payable to the insured member of the group or to the beneficiary designated by the insured member, other than the policyholder, subject to provisions of the policy in the event the claimant is insane or otherwise incompetent, or in the event there is no designated beneficiary as to all or any part of any sum payable at the death of the individual insured; provided, that if the entire cost of the insurance has been borne by the employer such benefits may be made payable to the employer.

(b) Any group or blanket disability policy may provide that all or any portion of any indemnities provided by the policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount so paid.

(c) No group disability income policy shall contain any provision integrating the benefits of the policy with social security benefits whereby the amount of the disability benefit actually being paid to the disabled person under the terms and conditions of the policy will be diminished when there occurs an increase in social security benefits either by operation of amendments to the Social Security Act or by cost of living adjustments which become effective after the first day the disabled person becomes entitled to benefits. [L 1987, c 347, pt of §2]

**Case Notes**

Properly licensed HMOs, like plaintiff, were authorized pursuant to §432D-1 to "provide or arrange", at their option, for the closed panel health care services required under the managed care plan program; accident and health insurers were authorized under subsection (b) to arrange for medical services for members using a defined network of providers, i.e., particular "hospitals or persons"; thus, article 431:10A and chapter 432D authorized both accident and health insurers and HMOs, as risk-bearing entities, to provide the closed panel product required by the managed care plan contracts. 126 H. 326, 271 P.3d 621 (2012).

**§431:10A-206 Coverage of newborn children.** All group or blanket disability policies providing family coverage, as defined in section 431:10A-103 and reciprocal beneficiary family coverage, as defined in section 431:10A-601, on an expense incurred basis shall provide coverage for newborn children in compliance with section 431:10A-115. [L 1987, c 347, pt of §2; am L 1997, c 383, §7; am L 2002, c 155, §62]

**§431:10A-206.5 Coverage for child health supervision services.** (a) All accident and health or sickness insurance policies issued in this State that provide coverage for the children of the insured shall provide coverage for child health supervision services from the moment of birth through age five years. These services shall be exempt from any

deductible provisions, and immunizations shall be exempt from any copayment provisions, which may be in force in these policies or contracts.

(b) Child health supervision services shall include twelve visits at approximately the following intervals: birth; two months; four months; six months; nine months; twelve months; fifteen months; eighteen months; two years; three years; four years; and five years. Services to be covered at each visit shall include a history, physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests, in keeping with prevailing medical standards. For purposes of this subsection, the term "prevailing medical standards" means the recommendations of the Immunizations Practices Advisory Committee of the United States Department of Health and Human Services and the American Academy of Pediatrics; provided that in the event that the recommendations of the committee and the academy differ, the department of health shall determine which recommendations shall apply.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section, except that the limitations authorized by this subsection shall not apply to immunizations recommended by the Immunizations Practices Advisory Committee of the United States Department of Health and Human Services and the American Academy of Pediatrics; provided that in the event that the recommendations of the committee and the academy differ, the department of health shall determine which recommendations shall apply.

(d) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(e) For the purposes of this section, "child health supervision services" means physician-delivered, physician-supervised, physician assistant-delivered, or nurse-delivered services as defined by section 457-2 ("registered nurse"), which shall include as the minimum benefit coverage for services delivered at intervals and scope stated in this section. [L 1988, c 201, §2; am L 1993, c 83, §2 and c 362, §4; am L 2003, c 212, §77; am L 2016, c 141, §8]

**§431:10A-207 Coverage for specific services.** Every person insured under a group or blanket disability insurance policy shall be entitled to the reimbursements and coverages specified in section 431:10A-116. [L 1987, c 347, pt of §2; am L 2002, c 155, §63]

**[§431:10A-208] Qualified medical child support order.** (a) An employer, who provides health coverage to dependent children of an employee, shall recognize a child identified in a qualified medical child support order as an eligible dependent without regard to any enrollment season restrictions.

(b) A qualified medical child support order shall:

(1) Specify the name and last known mailing address, if any, of the plan member and the name and mailing address of each recipient child covered by the order;

(2) Include a reasonable description of the type of coverage to be provided to the recipient child, or the manner in which the type of coverage is to be determined;

(3) State the period during which it applies;

(4) Specify the plan to which it applies; and

(5) Not require a plan to provide any type or form of benefit or option that the plan does not otherwise provide. [L 1994, c 145, §2]

## PART III. MEDICARE SUPPLEMENT POLICIES

### Attorney General Opinions

Section 431:10A-601 applied to all parts of article 10A if the category of policy under consideration included family coverage, as defined in §431:10A-103. Att. Gen. Op. 97-10.

**§431:10A-301 Definitions.** For the purposes of this part:
"Applicant" means:

(1) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group medicare supplement policy, the proposed certificate holder.

"Certificate" means any certificate delivered or issued for delivery in this State under a group medicare supplement policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this State medicare supplement policies or certificates.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare supplement policy" means a group or individual policy of accident and health or sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et seq.), or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

"Policy form" means the form on which the policy is delivered or issued for delivery by the issuer. [L 1987, c 347, pt of §2; am L 1989, c 195, §25; am L 1990, c 84, §1; am L 1992, c 195, §1; am L 1996, c 28, §1; am L 2003, c 212, §78]

**§431:10A-302 Applicability and scope.** (a) Notwithstanding any provision in this part to the contrary, this part shall apply to:

(1) All medicare supplement policies delivered or issued for delivery in this State; and

(2) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

(b) This part shall not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations.

(c) The commissioner shall have all rights and powers with respect to the group or master policy and certificate issued pursuant to the medicare supplement policy as if the group or master policy was issued and delivered to a person domiciled in this State.

(d) Except as otherwise specifically provided in section 431:10A-307(d), this part is not intended to prohibit or apply to insurance policies or health care benefit plans including group conversion policies, issued to medicare eligible persons that are not marketed or held to be medicare supplement policies or benefit plans. [L 1987, c 347, pt of §2; am L 1989, c 207, §11; am L 1990, c 84, §2; am L 1992, c 195, §2; am L 1996, c 28, §2; am L 2004, c 122, §34]

**§431:10A-303 REPEALED.** L 1990, c 84, §10.

**§431:10A-304 Standards for policy provisions.** (a) No medicare supplement policy or certificate in force in the State shall contain benefits that duplicate benefits provided by medicare.

(b) The commissioner shall adopt reasonable rules to establish specific standards for the provisions of medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this State, including the provisions of part I of this article. No requirement of this chapter relating to minimum required policy benefits, other than the minimum standards contained in this part, shall apply to medicare supplement policies and certificates. The standards may cover, but shall not be limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage;

(4) Probationary periods;

(5) Benefit limitations, exceptions, and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definition of terms.

(c) The commissioner may adopt reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by law, which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under any medicare supplement policy or certificate.

(d) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months after the effective date of coverage because it involved a preexisting condition.

The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. [L 1987, c 347, pt of §2; am L 1989, c 195, §26; am L 1990, c 84, §3; am L 1992, c 195, §3]

**§431:10A-305 Rules.** (a) The commissioner shall adopt reasonable rules to establish minimum standards for benefits and claims payment, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates.

(b) The commissioner may adopt from time to time, reasonable rules as are necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations adopted thereunder, including but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for medicare select policies and certificates. [L 1987, c 347, pt of §2; am L 1989, c 195, §27; am L 1990, c 84, §4; am L 1992, c 195, §4; am L 1993, c 205, §23; am L 1996, c 28, §3]

**§431:10A-306 Loss ratio standards.** Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices. For the purposes of rules adopted under this section, group medicare supplement policies and certificates issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be regarded as group policies. [L 1987, c 347, pt of §2; am L 1989, c 195, §28; am L 1990, c 84, §5; am L 1992, c 195, §5; am L 1996, c 28, §4]

**§431:10A-307 Disclosure standards.** (a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered or issued for delivery in this State unless an outline of coverage is delivered to the applicant at or prior to the time application is made.

(b) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (a). For the purposes of this section, format means style, arrangement and overall appearance, including such items as the size, color, prominence of type, and the

arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the renewal provisions including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The commissioner may prescribe by rule a standard form and contents of an informational brochure for persons eligible for medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare, but in no event later than the time of policy delivery.

(d) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and health or sickness insurance policies sold to persons eligible for medicare, other than:

(1) Medicare supplement policies; or

(2) Disability income policies.

(e) The commissioner may adopt reasonable rules to govern the full and fair disclosure of information in connection with the replacement of accident and health or sickness insurance policies, subscriber contracts, or certificates by persons eligible for medicare. [L 1987, c 347, pt of §2; am L 1990, c 84, §6; am L 1992, c 195, §6; am L 1996, c 28, §5; am L 2002, c 155, §64]

**§431:10A-308 Notice of free examination.** Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner. [L 1987, c 347, pt of §2; am L 1989, c 195, §29; am L 1990, c 84, §7; am L 1992, c 195, §7]

**§431:10A-309 Filings; approval of forms.** (a) No medicare supplement policy or certificate shall be delivered or issued for delivery in this State after the date specified in rules adopted by the commissioner unless the form of the policy or certificate is approved in

accordance with this section.

(b) Every issuer providing medicare supplement insurance benefits to a resident of this State shall file with the commissioner a copy of the policy and any certificate used in this State, including copies of any riders or endorsements of applications which may be attached to or made a part of the policy. The commissioner may require a certification from the issuer that, to the best of the certifier's knowledge and belief, the filing complies with the minimum standards established in the rules and all applicable Hawaii laws and rules.

(c) Every issuer providing medicare supplement policies or certificates in this State shall file annually its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this State. The commissioner may require the issuer to submit a certification by a qualified actuary that the premium rates, to the best of the actuary's knowledge and belief, are in accordance with the loss ratio standards adopted by rule.

(d) The commissioner may disapprove any policy or certificate or withdraw approval of a previously approved policy or certificate if the commissioner finds that:

(1) It is not in accordance with applicable laws and rules in any respect;

(2) It is or it contains provisions which are misleading, deceptive, inconsistent, or ambiguous; or

(3) The benefits are unreasonable in relation to the premium charge.

(e) A policy or certificate shall be deemed approved if:

(1) It is in accordance with all applicable laws and rules;

(2) It has not been disapproved earlier than sixty-one days after the date of filing;

(3) It fully meets all filing requirements; and

(4) It is received by the commissioner.

(f) The commissioner shall promptly give written notice to the issuer of the commissioner's approval of a policy or certificate or, if a policy or certificate is disapproved or approval is withdrawn, of such disapproval or withdrawal together with the reasons for it and of the procedure by which the issuer may request and be granted a hearing on the merits of such action.

(g) The commissioner by rule may establish requirements and procedures for medicare supplement filings. [L 1987, c 347, pt of §2; am L 1990, c 84, §8; am L 1992, c 195, §8; am L 2004, c 122, §35]

**§431:10A-310 Filing requirements for advertising.** (a) Every issuer of medicare supplement insurance policies or certificates in this State shall file a copy of any medicare supplement advertisement intended for use in this State whether through written, radio, or television medium to the commissioner for review. The commissioner may require a certification from the entity that to the best of the certifier's knowledge and belief the advertisement complies with the provisions of this chapter and all applicable rules.

(b) If the commissioner finds the advertisement to be in violation of any provision of this chapter or any rule, the commissioner shall

order the issuer to cease and desist use of the advertisement pursuant to section 431:2-203.

(c) In conjunction with a cease and desist order issued pursuant to subsection (b), the commissioner may order the issuer to refund to the insured the premium paid for the medicare supplement policy. Any refund of an amount paid by the insured for the medicare supplement insurance shall be paid within fifteen days to the person entitled thereto; provided that by rule the commissioner may prescribe an amount below which no refund need be made. [L 1989, c 195, §3; am L 1990, c 84, §9; am L 1992, c 195, §9; am L 2004, c 122, §36]

**§431:10A-311 Penalties.** In addition to any other applicable penalties for violations of this chapter, pursuant to section 431:2-203, the commissioner may require issuers violating any provision of this part or rules adopted pursuant to this part to cease marketing or selling any medicare supplement policy in this State which is related directly or indirectly to a violation or may require the issuer to take actions necessary to comply with the provisions of this part, or both. [L 1989, c 195, §4; am L 1992, c 195, §10]

**§431:10A-312 Severability.** If any provision of this part or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the part and the application of such provision to other persons or circumstances shall not be affected thereby. [L 1989, c 195, §5]

## PART IV. EXTENDED HEALTH INSURANCE

### Attorney General Opinions

Section 431:10A-601 applied to all parts of article 10A if the category of policy under consideration included family coverage, as defined in §431:10A-103. Att. Gen. Op. 97-10.

**§431:10A-401 Purpose.** It is the purpose of this part to provide a means of more adequately meeting the needs of persons who are sixty-five years of age or older and their spouses for insurance coverage against financial loss from accident or disease through the combined resources and experience of a number of insurers; to make possible the fullest extension of such coverage by encouraging insurers to combine their resources and experience and to exercise their collective efforts in the development and offering of policies of such insurance to all such applicants at costs lower than those generally available through individual insurers; and to regulate the joint activities herein authorized in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), as amended. [L 1987, c 347, pt of §2]

**§431:10A-402 Definitions.** Unless the context otherwise requires, for the purposes of this part:

(1) Association means a voluntary unincorporated association formed for the purpose of enabling cooperative action to provide accident and health or sickness insurance as defined in section 431:1-205, in accordance with this part in this or any other state having legislation enabling the issuance of insurance of the

type provided in this part.

(2) Insurer means any insurance company authorized to transact accident and health or sickness insurance in this State.

(3) Extended health insurance means hospital, surgical, and medical expense insurance provided by a policy issued as provided by this part. [L 1987, c 347, pt of §2; am L 2002, c 155, §65]

**§431:10A-403 Association of insurers; policyholder; policy.** (a) Any insurer may join with one or more other insurers to plan, develop, underwrite, offer and provide to any person who is sixty-five years of age or older and to the spouse of such person, extended health insurance against financial loss from accident or disease, or both. The insurance may be offered, issued and administered jointly by two or more insurers by a group policy issued to a policyholder through an association formed for the purpose of offering, selling, issuing and administering such insurance.

(b) The policyholder may be an association, a trustee, or any other person. A master group policy issued to an association or to a trustee or any person appointed by an association for the purpose of providing the insurances described in this part shall be another form of group disability insurance.

Any form of policy approved by the commissioner for an association shall be offered throughout the State to all persons sixty-five and older and their spouses, and the coverage of any person insured under such a form of policy shall not be cancellable except for nonpayment of premiums unless the coverage of all persons insured under such form of policy is also cancelled.

(c) Any such policy may provide, among other things, that the benefits payable under the policy are subject to reduction if the individual insured has any other coverage providing hospital, surgical or medical benefits whether on an indemnity basis or a provision of service basis resulting in such insured being eligible for more than one hundred per cent of covered expenses which the insured is required to pay. Any insurer issuing individual policies providing extended hospital, surgical or medical benefits to persons sixty-five years of age and older and their spouses may also use such a policy provision. [L 1987, c 347, pt of §2]

**§431:10A-404 Persons authorized to transact insurance.** Notwithstanding the provisions of article 9A, any person licensed to transact accident and health or sickness insurance as a producer may transact extended health insurance and may be paid a commission in accordance with commission schedules filed with the commissioner as required by section 431:10A-406. [L 1987, c 347, pt of §2; am L 2001, c 216, §16; am L 2002, c 155, §66; am L 2003, c 212, §79]

**[§431:10A-404.5] Genetic information nondiscrimination in extended health insurance coverage.** (a) No insurer may:

(1) Use an individual's or a family member's genetic information, or request for genetic services, to deny or limit any coverage or establish eligibility, continuation, enrollment, or premium payments;

(2) Request or require collection or disclosure of an individual's or a family member's genetic

information; or

(3) Disclose an individual's or a family member's genetic information without the written consent of the person affected, the person's legal guardian, or a person with power of attorney for health care for the person affected. This consent shall be required for each disclosure and shall include the name of each person or organization to whom the disclosure will be made.

(b) As used in this section:

"Family member" means, with respect to the individual, another individual related by blood to that individual.

"Genetic information" means information about genes, gene products, hereditary susceptibility to disease, or inherited characteristics that may derive from the individual or family member.

"Genetic services" means health services to obtain, assess, or interpret genetic information for diagnosis, therapy, or genetic counseling.

(c) This section shall not apply to any action taken in connection with policies of life insurance, disability income insurance, and long-term care insurance delivered or issued for delivery in this State. [L 2002, c 217, §2]

**Law Journals and Reviews**

Privacy and Genetics: Protecting Genetic Test Results in Hawai‘i. 25 UH L. Rev. 449.

**§431:10A-405 Association; powers, process; examination.** Any association formed for the purposes of this part may hold title to property, may enter into contracts, and may limit the liability of its members to their respective pro rata shares of the liability of such association. Any such association may sue and be sued in its associate name and for such purpose only shall be treated as a domestic corporation. Service of process against the association, made upon a managing agent, any of its members or any agent authorized by appointment to receive service of process, shall have the same force and effect as if the service had been made upon all members of the association. The association's books and records shall also be subject to examination under the provisions of article 2, either separately or concurrently with examination of any of its member insurers. [L 1987, c 347, pt of §2]

**§431:10A-406 Forms; rates; approval.** (a) The forms of the policies, applications, certificates, or other evidence of insurance coverage, commission schedules, and applicable premium rates relating thereto shall be filed with the commissioner.

(b) No policy, contract, certificate, or other evidence of insurance, application, or other form shall be sold, issued, or used and no endorsement shall be attached to or printed or stamped thereon unless its form has been approved by the commissioner or thirty days have expired after such filing without written notice from the commissioner of disapproval. The commissioner shall disapprove the forms for such insurance if the commissioner finds:

(1) That they are unjust, inequitable, misleading, or deceptive; or

(2) That the rates are by reasonable assumptions excessive in relation to the benefits provided.

In determining whether the rates by reasonable assumptions are excessive in relation to the benefits provided, the commissioner shall give due consideration to past and prospective claim experience, within and outside this State, and to fluctuations in such claim experience, to a reasonable risk charge, to contribution to surplus and contingency funds, to past and prospective expenses, both within and outside this State, and to all other relevant factors within and outside this State, including any differing operating methods of the insurers joining in the issue of the policy. In exercising the powers conferred by this part, the commissioner shall not be bound by any other requirement of this code with respect to standard provisions to be included in accident and health or sickness policies or forms.

(c) After hearing, upon written notice, the commissioner may withdraw an approval previously given if the commissioner is of the opinion that an original submission would have been disapproved. Such withdrawal of approval shall be effective not less than ninety days after the giving of notice of withdrawal. [L 1987, c 347, pt of §2; am L 2003, c 212, §80]

**§431:10A-407 Duplication of benefits; adjustment.** If and when a program of hospital, surgical, and medical benefits is enacted by the federal government or by the State, the extended health insurance benefits provided by policies issued under this section shall be adjusted to avoid any duplication of benefits offered by the federal or state programs. The premium rates applicable thereto shall be adjusted to conform with the adjusted benefits. [L 1987, c 347, pt of §2]

**§431:10A-408 Annual report filed by association.** The association shall submit an annual report to the commissioner which shall become public information and shall include the following:

(1) The number of persons insured;

(2) The names of the insurers participating in the association with respect to insurance offered under this part;

(3) The calendar year experience applicable to such insurance offered under this part. Item (3) shall include:

(A) Premiums earned,
(B) Claims paid during the calendar year,
(C) The amount of claims reserve established,
(D) Administrative expenses,
(E) Commissions,
(F) Promotional expenses,
(G) Taxes,
(H) Contingency reserve,
(I) Other expenses, and
(J) Profit and loss for the year.

The commissioner shall require the association to provide any and all information concerning the operations of the association deemed relevant by the commissioner for inclusion in the report. [L 1987, c 347, pt of §2]

**§431:10A-409 Articles of association; agent, membership list;**

**deception.** (a) Any association formed in accordance with this part shall file the following with the commissioner:

(1) The articles of association;

(2) All amendments and supplements to the articles of association;

(3) A designation in writing of a resident of this State as agent for the service of process; and

(4) A list of insurers who are members of the association and all supplements thereto.

(b) The name of any association or any advertising or promotional material used in connection with extended health insurance to be sold, offered or issued pursuant to this section shall not be such as to mislead or deceive the public. [L 1987, c 347, pt of §2]

**§431:10A-410 Violation of other laws.** No act done, action taken, or agreement made pursuant to the authority conferred by this part shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this State which does not specifically refer to insurance. [L 1987, c 347, pt of §2]

## PART V. LONG-TERM CARE INSURANCE--REPEALED

**§§431:10A-521 to 531 REPEALED.** L 1999, c 93, §8.

### Cross References

For present provisions, see article 10H, this chapter.

## [PART VI. MISCELLANEOUS PROVISIONS]

**[§431:10A-601] Reciprocal beneficiary family coverage defined; policyholder and employer responsibility for costs; availability.** (a) Any other law to the contrary notwithstanding, reciprocal beneficiary family coverage, as defined in subsection (b), shall be made available to reciprocal beneficiaries, as defined in chapter 572C, but only to the extent that family coverage, as defined in section 431:10A-103, is currently available to individuals who are not reciprocal beneficiaries.

(b) As used in this section, "reciprocal beneficiary family coverage" means a policy that insures, originally or upon subsequent amendment, a reciprocal beneficiary who shall be deemed the policyholder, the other party to the policyholder's reciprocal beneficiary relationship registered pursuant to chapter 572C, and dependent children or any child of any other person dependent upon either reciprocal beneficiary.

(c) If a reciprocal beneficiary policyholder incurs additional costs or premiums, if any, by electing reciprocal beneficiary family coverage under this section, the employer may pay additional costs or premiums. [L 1997, c 383, §4; am L 2004, c 122, §37]

### Attorney General Opinions

Section applied only to insurers, and not mutual benefit societies or health maintenance organizations. Att. Gen. Op. 97-5.

As provided by subsection (c), an employer does not violate the reciprocal beneficiaries act [L 1997, c 383] if it chooses not to pay any additional cost or premium incurred by the employee in electing reciprocal beneficiary family coverage. Att. Gen. Op. 97-10.

Section applied to all parts of article 10A if the category of policy under consideration included family coverage, as defined in §431:10A-103. Att. Gen. Op. 97-10.

The division will be responsible for enforcement of health insurance provisions of the reciprocal beneficiaries act [L 1997, c 383]; those provisions can only be enforced against insurers, not employers. Att. Gen. Op. 97-10.

The employer is not required to pay the additional costs incurred by an employee's election for reciprocal beneficiary coverage. The focus is on the insurance contract and the policyholder and recognizes that the reciprocal beneficiary, as policyholder, is the one who incurs the cost. Att. Gen. Op. 97-10.

The placement of this section in article 10A makes clear that the legislative intent was to mandate benefits that must be made available by insurers that write contracts of insurance providing family coverage; moreover, the statute specifies that the coverage be made available to reciprocal beneficiaries, not to employers. Att. Gen. Op. 97-10.

There is nothing in the reciprocal beneficiaries act [L 1997, c 383] that would prevent an insurer from making reciprocal beneficiary family coverage available in a policy separate from the policy it uses to make regular family coverage available. Att. Gen. Op. 97-10.

To the extent that the reciprocal beneficiaries act [L 1997, c 383] does impose obligations on insurers, it may provide a basis for affected persons to seek relief by, for example, seeking declaratory relief under chapter 632. Att. Gen. Op. 97-10.

**Law Journals and Reviews**

Tax Justice and Same-Sex Domestic Partner Health Benefits: An Analysis of the Tax Equity For Health Plan Beneficiaries Act. 32 UH L. Rev. 73 (2009).

**§431:10A-602 Federally funded programs; exemption.** Requirements relating to mandated coverages shall not be applicable to any insurer offering accident and health or sickness insurance under a federally funded program under the Social Security Act, as amended; provided that this exemption shall apply only to that part of the insurer's business under the federally funded program. [L 1999, c 159, §1; am L 2003, c 212, §81]

**§431:10A-603 Self-employed persons, exemption.** The requirements of this article related to mandated coverages for persons insured under accident and health or sickness policies shall not apply to accident and health or sickness policies for self-employed persons in this State; provided that this exemption shall apply only to those portions of the accident and health or sickness policies that cover self-employed persons in this State and individuals included in the self-employed person's family coverage. [L 2004, c 122, §1; am L 2006, c 154, §38]

**[§431:10A-604] Bona fide trade associations.** (a) At the option of

a bona fide trade association, or its designated agent, an insurer that sells health insurance to the bona fide trade association shall treat the bona fide trade association and its members as a group for the purpose of issuing group disability insurance; provided that:

(1) The bona fide trade association shall have been formed for purposes other than obtaining insurance;

(2) The insurer shall be prohibited from restricting, in any manner, the number or types of health plans issued by another insurance entity that the bona fide trade association may offer to its members, including but not limited to such restrictions as clauses that reduce competition between insurers or clauses that require a bona fide trade association to allow an insurer to match the price or terms offered by another insurer; and

(3) Each member of the bona fide trade association shall not be required to be insured under the group policy;

and provided further that this section shall be inapplicable if less than two persons from the bona fide trade association seek to be insured under the group policy.

(b) As used in this section:

"Bona fide trade association" means an association of persons organized to promote common interests and comprised of persons engaged in a business, trade, or profession that:

(1) Has been actively in existence for five years;

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) Does not condition membership in the association on any health status related factor pertaining to an individual (including an employee of an employer or a dependent of an employee);

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status related factor pertaining to such members (or individuals eligible for coverage through a member);

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(6) Meets such additional requirements as may be imposed under state law. [L 2004, c 118, §§1, 5; am L 2006, c 41, §2]

## ARTICLE 10B
## CREDIT LIFE INSURANCE
## AND CREDIT DISABILITY INSURANCE

**§431:10B-101 Purpose.** The purpose of this article is to promote the public welfare by regulating credit life insurance and credit disability insurance. Nothing in this article is intended to prohibit or discourage reasonable competition. The provisions of this article shall be liberally construed. [L 1987, c 347, pt of §2]

**§431:10B-102 Scope.** All life insurance and all accident and health or sickness insurance in connection with loans or other credit transactions shall be subject to this article, except such insurance in connection with a loan or other credit transaction of more than ten years' duration; nor shall insurance be subject to this article where the

issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor. Nothing in this article shall be construed to relieve any person from compliance with any other applicable law. [L 1987, c 347, pt of §2; am L 2002, c 155, §67]

**§431:10B-103 Definitions.** For the purpose of this article:

(1) Credit life insurance means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction;

(2) Credit disability insurance means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(3) Creditor means the lender of money, or seller or lessor of goods, services, or property, rights, or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any such lender, seller or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them, or any other person in any way associated with any of them;

(4) Debtor means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction;

(5) Indebtedness means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction. [L 1987, c 347, pt of §2]

**§431:10B-104 Forms of credit life insurance and credit disability insurance.** Credit life insurance and credit disability insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan;

(2) Individual policies of accident and health or sickness insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(3) Group policies of life insurance issued to creditors pursuant to section 431:10D-203 providing insurance upon the lives of debtors on the term plan; and

(4) Group policies of accident and health or sickness insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage. [L 1987, c 347, pt of §2; am L 2003, c 212, §82]

**§431:10B-105 Amount of credit life insurance and credit disability insurance.** (a) Credit life insurance.

(1) The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and, where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater; except that if the sole purpose of the loan is to provide future advances to the debtor to meet education or education related expenses of the debtor, the debtor's spouse, children or other dependents, the amount of insurance may equal, but may not exceed, the total amount of the described expenses forecast at the time of entry into the loan agreement with the creditor, less the amount of all repayments by the debtor. In the case of revolving loan or revolving charge accounts, the insurance shall at no time exceed the unpaid indebtedness.

(2) Notwithstanding the provisions of subsection (a)(1), insurance on agricultural credit transaction commitments not exceeding one year in duration may be written up to the amount of the loan commitment, on a nondecreasing or level term plan.

(b) Credit disability insurance. The total amount of periodic indemnity payable by credit disability insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness. The amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments. [L 1987, c 347, pt of §2]

**§431:10B-106 Term of credit life and credit disability insurance.** The term of any credit life insurance or credit disability insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor; except that where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to the indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and the evidence is furnished more than thirty days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event, there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 431:10B-109. [L 1987, c 347, pt of §2]

**§431:10B-107 Provisions of policies and certificates of insurance: disclosure to debtors.** (a) Credit life insurance and credit disability insurance subject to this article shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance or credit disability insurance or any combination thereof, shall, in addition to other requirements of law, set forth:

(1) The name and home office address of the insurer;

(2) The name or names of the debtor, or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor;

(3) The premium or amount of payment, if any, by the debtor, separately for credit life insurance and credit disability insurance;

(4) A description of the coverage including the amount and term thereof;

(5) Any exceptions, limitations, and restrictions; and

(6) Shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.

(c) Notwithstanding subsection (b), a certificate issued under a group policy where the debtor is obligated to pay the insurance premium or payment periodically with the debt payments on the decreasing amount of the insurance or where the indebtedness is a revolving loan or revolving charge account, the rate of insurance premium or payment per unit of coverage may be set forth instead of the premium or amount of payment, if any, by the debtor.

(d) Each such individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.

(e) If an individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit disability insurance, the amount, term, and a brief description of the coverage provided, shall be delivered to the debtor at the time the indebtedness is incurred. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this section is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in section 431:10B-106.

(f) If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made. [L 1987, c 347, pt of §2]

**§431:10B-108 Filing, approval, and withdrawal of forms and premium rates.** (a) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery in this State and the schedules of premium rates pertaining thereto shall be filed with the commissioner for approval. Each filing shall be accompanied by a $20 fee payable to the commissioner, which fee shall be deposited in the commissioner's education and training fund. Forms and rates so filed shall be approved at the expiration of forty-five days after filing, unless earlier approved or disapproved by the commissioner. The commissioner by written notice to the insurer, within the forty-five-day period, may extend the period for an additional thirty days.

(b) The commissioner, within the waiting period or any extension thereof after the filing of the policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders and premium rates, shall disapprove any form or any premium

rates if:

(1) The benefits provided are not reasonable in relation to the premium charge; or

(2) The form contains provisions that are:

(A) Unjust, unfair, inequitable, misleading, or deceptive;
(B) Encourage misrepresentation of the coverage; or
(C) Are contrary to any provision of this code or of any rule adopted thereunder.

(c) The benefits provided by the policy form shall not be deemed reasonable in relation to the premium charged or to be charged if the ratio of losses incurred to premiums earned is not at least sixty per cent. The commissioner may adopt by rules prima facie acceptable premium rates that shall reasonably be expected to produce a sixty per cent loss ratio. The prima facie rates shall be usable without actuarial or statistical justification when filed together with an otherwise acceptable policy form; provided that the ratio of losses for the most recent three years is at least sixty per cent. The rules shall specify the plans of benefits to which the premium rates shall apply.

(d) The commissioner shall approve deviations to rates higher than the prima facie acceptable rates upon filing of reasonable evidence that loss experience for a creditor or a class of creditors exceeds the average loss experience used to determine the prima facie rates if the commissioner determines the use of the higher rates will result in a ratio of claims incurred to premiums earned that is not less than sixty per cent. Except where the deviated rate exceeds the prima facie rate for reducing term credit life insurance and its actuarial equivalent for other forms of credit life insurance, a reasonable variance from the sixty per cent loss ratio standard may be required. The deviation may be limited to the debtors or creditors whose experience was the statistical basis for the filing.

(e) Whenever the commissioner determines it to be prudent, the commissioner may require insurers to file information as the commissioner deems necessary to determine whether the approved deviation from prima facie rates is still justified. If the commissioner determines the insurer's loss experience no longer justifies a deviation from the prima facie rates, then, upon giving notice as required in subsection (g), the commissioner shall disapprove the deviation and any form including the rate set forth therein.

(f) Credit life insurance policies for which premium rates vary by individual ages or by age brackets shall be filed as provided in this section. The commissioner shall approve or disapprove the filings in accordance with the sixty per cent loss ratio standard and the other applicable provisions of law.

(g) If the commissioner notifies the insurer that the form or premium rate is disapproved, it shall be unlawful thereafter for the insurer to issue or use the form or premium rate. In the notice, the commissioner shall specify the reason for the commissioner's disapproval and state that a hearing will be granted within twenty days after request in writing by the insurer. No policy, certificate of insurance, or notice of proposed insurance, nor any application, endorsement, or rider, or premium rate, shall be issued or used until the expiration of forty-five days after it has been so filed, unless the commissioner gives the commissioner's prior written approval.

(h) The commissioner at any time after hearing held not less than twenty days after written notice to the insurer, may withdraw the

commissioner's approval of a form or premium rate on any ground set forth in subsection (b). The written notice of the hearing shall state the reason for the proposed withdrawal.

(i) It shall be unlawful for the insurer to issue or use forms or premium rates after the effective date of their withdrawal.

(j) If a group policy of credit life insurance or credit disability insurance:

(1) Has been delivered in this State before July 1, 1969, or

(2) Has been or is delivered in another state before or after July 1, 1969, the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this State as specified in subsections (b) and (e) of section 431:10B-107. The forms shall be approved by the commissioner if:

(i) They conform with the requirements specified in those subsections;

(ii) They are accompanied by a certification in a form satisfactory to the commissioner that the substance of the forms are in substantial conformity with the master policy; and

(iii) The schedules of premium rates applicable to the insurance evidenced by the certificate or notice are not in excess of the insurer's schedules of premium rates filed with and approved by the commissioner;

provided the premium rate in effect on existing group policies may be continued until the first policy anniversary date following July 1, 1969.

(k) Any order or final determination of the commissioner under this section shall be subject to chapter 91. [L 1987, c 347, pt of §2 as superseded by c 348, §16; am L 1988, c 363, §3; am L 1989, c 207, §12; am L 2000, c 182, §10; am L 2004, c 122, §38]

**§431:10B-109 Premiums and refunds.** (a) Any insurer may revise its schedules of premium rates from time to time, and shall file the revised schedules for approval with the commissioner. No insurer shall issue any credit life insurance policy or credit disability insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as then on file with and approved by the commissioner.

(b) Each individual policy, group certificate, or notice of proposed insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for the insurance shall be paid or credited promptly to the person entitled thereto; provided that the commissioner, by rules and regulations, shall prescribe a minimum refund and no refund which would be less than the minimum need be made. The formula to be used in computing the refund shall be filed with and approved by the commissioner.

(c) If a creditor requires a debtor to make any payment for credit life insurance or credit disability insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the next payment due on the account.

(d) The amount charged to a debtor for any credit life or credit disability insurance shall not exceed the premium charged by the insurer, as computed at the time the charge to the debtor is determined.

(e) Nothing in this article shall be construed to authorize any payments for insurance now prohibited under any statute, or rule

thereunder, governing credit transactions. [L 1987, c 347, pt of §2]

**§431:10B-110 Issuance of policies.** (a) All policies of credit life insurance and credit disability insurance shall be delivered or issued for delivery in this State only by an insurer authorized to do an insurance business in this State, and shall be issued only through holders of certificates, licenses or authorizations issued by the commissioner.

(b) The enrolling of debtors under a group creditor policy and the issuance of certificates of insurance pursuant thereto or the issuing of individual policies by a creditor shall not be considered a sale or solicitation of insurance or the transaction of an insurance business. A limited license issued under section 431:9A-107.5 shall be required for such acts. A producer's license shall not be required.

(c) A group creditor policy issued by an admitted insurer to a creditor on which the entire premium is paid by the creditor wholly from the creditor's funds shall be considered a seller-purchaser relationship and not a principal-agent relationship. Notwithstanding subsection (a), a license shall not be required for the issuance of certificates of insurance under group creditor policy that is subject to this subsection. [L 1987, c 347, pt of §2; am L 2001, c 216, §17; am L 2002, c 155, §68]

**§431:10B-111 Claims.** (a) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of the claimant to one specified.

(c) No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claims representative for the insurer in adjusting claims; provided that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer. [L 1987, c 347, pt of §2]

**§431:10B-112 Existing insurance and choice of insurer.** When credit life insurance or credit disability insurance is required as additional security for any indebtedness, the creditor shall give the debtor written notice of the debtor's option to furnish the required insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business in this State. [L 1987, c 347, pt of §2]

**§431:10B-113 Enforcement.** (a) The commissioner may, after notice and hearing as provided in chapter 91, issue such rules and regulations as the commissioner deems appropriate for the supervision of this article.

(b) Whenever the commissioner finds that there has been a violation of this article or of any rules or regulations issued pursuant thereto,

and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the commissioner, the commissioner shall set forth the details of the commissioner's findings together with an order for compliance by a specified date. The order shall be binding on the insurer and any other person authorized or licensed by the commissioner on the date specified, unless sooner withdrawn by the commissioner or a stay of the order has been ordered by a court of competent jurisdiction.

(c) In all proceedings before the commissioner, the commissioner shall have the same powers with respect to administering oaths, compelling the attendance of witnesses and the production of documentary evidence, and examining witnesses as are granted the commissioner in section 431:2-204.

(d) In cases of disobedience by any person of any order or subpoena issued by the commissioner, or the refusal of any witness to testify to any matter regarding which the witness may be questioned lawfully, the commissioner may apply to any court for an order to compel testimony or production of documents. [L 1987, c 347, pt of §2]

**§431:10B-114 Penalties.** In addition to any other penalty provided by law, any person, firm or corporation which violates an order of the commissioner after it has become final, and while the order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to this State a sum not to exceed $250 for each violation which may be recovered in a civil action; except that if the violation is found to be wilful, the amount of the penalty shall be a sum not to exceed $1,000. The commissioner, in the commissioner's discretion, may revoke or suspend the license or certificate of authority of the person, firm or corporation guilty of the violation. An order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review. [L 1987, c 347, pt of §2]

## ARTICLE 10C
## MOTOR VEHICLE INSURANCE

### PART I. GENERAL PROVISIONS

#### Cross References

Applicability of article to captive insurers, see §431:19-115.5.

#### Law Journals and Reviews

Tort and Insurance "Reform" in a Common Law Court. 14 UH L. Rev. 55.

#### Case Notes

Rent-a-car company's rental agreement provision, which attempted to shift primary responsibility for providing minimum insurance coverage to the renter's personal insurance policy, violated the public policy enumerated in this chapter. 88 H. 274, 965 P.2d 1274.

The owner of a vehicle has the primary obligation to provide minimum coverage for the owned vehicle and this obligation may not be avoided through a unilateral contract with a permissive user of the vehicle. 88 H. 274, 965 P.2d 1274.

When a defendant is charged with a violation of this article, §805-13 is the proper procedural statute for the district court, enforcement officers, and the prosecutor's office to follow. 86 H. 331 (App.), 949 P.2d 171.

As §1-1 does not establish the supremacy of the 1840 Constitution over the current state constitution, or somehow render the documents concurrent, whether chapter 431 violated the 1840 Constitution was immaterial for purposes of defendant's conviction. 90 H. 130 (App.), 976 P.2d 444.

**§431:10C-101 Short title.** This article shall be known and may be cited as the Hawaii motor vehicle insurance law. [L 1987, c 347, pt of §2]

**§431:10C-102 Purpose.** (a) The purpose of this article is to:

(1) Create a system of reparations for accidental harm and loss arising from motor vehicle accidents;

(2) Compensate these damages without regard to fault; and

(3) Limit tort liability for these accidents.

(b) To effectuate this system of motor vehicle insurance and to encourage participation by all drivers in the motor vehicle insurance system:

(1) Those uninsured drivers who try to obtain the privilege of driving a motor vehicle without the concomitant responsibility of an ability to compensate adequately those who are injured as a result of a motor vehicle accident are to be dealt with more severely in the criminal or civil areas than those who obtain the legally required motor vehicle insurance coverage;

(2) Those persons truly economically unable to afford insurance are provided for under the public assistance provisions of this article. [L 1987, c 347, pt of §2; am L 1997, c 251, §12]

**§431:10C-103 Definitions.** As used in this article:

"Accidental harm" means bodily injury, death, sickness, or disease caused by a motor vehicle accident to a person.

"Alternative care provider" means any person providing medical or rehabilitative services in section 431:10C-302(a)(10) to a claimant covered by a motor vehicle insurance policy.

"Anesthetist" means a registered nurse-anesthetist who performs anesthesia services under the supervision of a licensed physician.

"Criminal conduct" means:

(1) The commission of an offense punishable by imprisonment for more than one year;

(2) The operation or use of a motor vehicle with the specific intent of causing injury or damage; or

(3) The operation or use of a motor vehicle as a converter without a good faith belief by the operator or user that the operator or user is legally entitled to operate or use such vehicle.

"Injury" means accidental harm not resulting in death.

"Insured" means:

(1) The person identified by name as insured in a motor vehicle insurance policy complying with section 431:10C-301; and

(2) A person residing in the same household with a named insured, specifically:

(A) A spouse or reciprocal beneficiary or other relative of a named insured; and
(B) A minor in the custody of a named insured or of a relative residing in the same household with a named insured.

A person resides in the same household if the person usually makes the person's home in the same family unit, which may include reciprocal beneficiaries, even though the person temporarily lives elsewhere.

"Insured motor vehicle" means a motor vehicle:

(1) Which is insured under a motor vehicle insurance policy; or

(2) The owner of which is a self-insurer with respect to such vehicle.

"Insurer" means every person holding a valid certificate of authority to engage in the business of making contracts of motor vehicle insurance in this State. For purposes of this article, insurer includes reciprocal or inter-insurance exchanges.

"Maximum limit" means the total personal injury protection benefits payable for coverage under section 431:10C-103.5(a), per person on account of accidental harm sustained by the person in any one motor vehicle accident shall be $10,000, regardless of the number of motor vehicles or policies involved.

"Medical fee schedule" refers to the Medicare Resource Based Relative Value Scale System applicable to Hawaii, entitled "Workers' Compensation Supplemental Medical Fee Schedule".

"Monthly earnings" means:

(1) In the case of a person regularly employed, one-twelfth of the average annual compensation before state and federal income taxes at the time of injury or death;

(2) In the case of a person regularly self-employed, one-twelfth of the average annual earnings before state and federal income taxes at the time of injury or death; or

(3) In the case of an unemployed person or a person not regularly employed or self-employed, one-twelfth of the anticipated annual compensation before state and federal income taxes that would have been paid from the time the person would reasonably have been expected to be regularly employed.

"Motor vehicle" means any vehicle of a type required to be registered under chapter 286, including a trailer attached to such a vehicle, but not including motorcycles and motor scooters.

"Motor vehicle accident" means an accident arising out of the operation, maintenance, or use of a motor vehicle, including an object drawn or propelled by a motor vehicle.

"Motor vehicle insurance policy" means an insurance policy that meets the requirements of section 431:10C-301.

"Operation, maintenance, or use with respect to a motor vehicle" includes occupying, entering into, and alighting from it, but does not include:

(1) Conduct in the course of loading or unloading the vehicle, unless the accidental harm occurs in the immediate proximity of the vehicle; and

(2) Conduct within the course of a business of repairing, servicing, or otherwise maintaining vehicles, unless the conduct occurs outside the premises of such business.

"Owner" means a person who holds the legal title to a motor vehicle;

except that in the case of a motor vehicle which is the subject of a security agreement or lease with a term of not less than one year with the debtor or lessee having the right to possession, such term means the debtor or lessee. Whenever transfer of title to a motor vehicle occurs, the seller shall be considered the owner until delivery of the executed title to the buyer, from which time the buyer holding the equitable title shall be considered the owner.

"Person" means, when appropriate to the context, not only individuals, but corporations, firms, associations, and societies.

"Person receiving public assistance benefits" means:

(1) Any person receiving benefits consisting of direct cash payments through the department of human services; or

(2) Any person receiving benefits from the Supplemental Security Income Program under the Social Security Administration.

"Regulation" means any rule and regulation promulgated by the commissioner pursuant to chapter 91.

"Replacement vehicle" means a specific, comparable, and available vehicle in as good or better overall condition than the total loss vehicle.

"Self-insurer, with respect to any motor vehicle", means a person who has satisfied the requirements of section 431:10C-105.

"U-drive motor vehicle" means a motor vehicle which is rented or leased or offered for rent or lease to a customer from an operator of a U-drive rental business.

"U-drive rental business" means the business of renting or leasing to a customer a motor vehicle for a period of six months or less notwithstanding the terms of the rental or lease if in fact the motor vehicle is rented or leased for a period of six months or less.

"Underinsured motor vehicle" means a motor vehicle with respect to the ownership, maintenance, or use for which sum of the limits of all bodily injury liability insurance coverage and self-insurance applicable at the time of loss is less than the liability for damages imposed by law.

"Uninsured motor vehicle" means any of the following:

(1) A motor vehicle for which there is no bodily injury liability insurance or self-insurance applicable at the time of the accident; or

(2) An unidentified motor vehicle that causes an accident resulting in injury; provided the accident is reported to the police or proper governmental authority within thirty days or as soon as practicable thereafter.

"Without regard to fault" means irrespective of fault as a cause of accidental harm, and without application of the principle of liability based on negligence. [L 1987, c 347, pt of §2; am L 1989, c 195, §30; am L 1992, c 123, §2 and c 124, §2; am L 1997, c 251, §13 and c 383, §59; am L 1998, c 275, §4; am L 1999, c 137, §3; am L 2000, c 24, §4 and c 66, §1; am L 2004, c 10, §§13, 14, 18(3), (4)]

## Case Notes

Provision excluding welfare recipients from receiving medical coverage under no-fault automobile insurance policies violated medicaid provision of Social Security Act. 928 F.2d 898.

Vehicle was "uninsured" where vehicle operator's liability insurance did not cover injured passenger and vehicle owner had no insurance. 807

F. Supp. 98.

Households of plaintiff and spouse were separate and not a family unit for purposes of paragraph (11). 812 F. Supp. 1083.

Where named insured is a corporation, son of officer/shareholder of corporation is not an "insured" under paragraph (11). 816 F. Supp. 633.

Insurer not obligated to defend or indemnify insured, or otherwise pay any sums to defendants; defendant's shooting was no accident from insured's viewpoint or perspective. 834 F. Supp. 329.

Where insurer contended that plaintiff lacked standing to bring bad faith claim because plaintiff, a covered person under taxicab owner's insurance contract, was not defined as an insured in no-fault insurance statute, plaintiff, a third party beneficiary of taxicab owner's policy, was essentially an insured and to treat plaintiff otherwise made no sense. 947 F. Supp. 429.

Because police officer's injuries did not arise out of the use of a vehicle, there was no uninsured motorist coverage under either of the two policies at issue. Officer had argued that officer's injuries arose out of three "uses" of automobiles, e.g., officer was "using" a vehicle by trying to "secure" it. 187 F. Supp. 2d 1231.

Trial court erred in concluding that insurance company did not owe defendant duty to defend or indemnify on basis that shooting did not arise out of a motor vehicle "accident". 74 H. 620, 851 P.2d 321.

Car rental company not an "insurer" as defined under paragraph (5). 82 H. 351, 922 P.2d 964.

Where self-insurer rent-a-car company not an "insurer" as defined in this section, court erred in granting attorney's fees and costs under §431:10-242. 85 H. 243, 942 P.2d 507.

Insofar as Hawaii administrative rule §16-23-11 conflicted with paragraph (10)(B) (1987) by limiting survivors' benefits to $15,000 despite the presence of expanded no-fault coverage, §16-23-11 was void as a matter of law. 88 H. 344, 966 P.2d 1070.

Facts and circumstances of the case demonstrated that plaintiff was temporarily absent from father's home while attending college in Hawaii at the time of the accident; thus, trial court did not err in concluding that plaintiff was a resident of plaintiff's father's, the named insured's household in California and therefore a covered person under the insurance policy for underinsured motorist benefits. 107 H. 192, 111 P.3d 601 (2005).

Plaintiff not entitled to uninsured motorist benefits under Hawaii motor vehicle insurance law where an "uninsured motor vehicle" as defined in this section was not involved in causing plaintiff's injuries. 81 H. 110 (App.), 912 P.2d 607.

Pursuant to §431:10C-304(1)(B) (1987) and paragraph (10)(B) (1987), upon the death of an insured, the insurer is obligated to provide the insured's survivor a survivor's loss benefit of up to either (1) $15,000 where the insured has purchased only the basic no-fault coverage, or (2) the expanded limits of no-fault benefits where the insured has contracted for it under an optional additional coverage. 88 H. 345 (App.), 966 P.2d 1071.

Under paragraph (10)(A) (1993), no-fault benefits are expenses which are appropriate, reasonable and necessarily incurred and are not restricted to treatment characterized as "curative" as opposed to "palliative". 90 H. 213 (App.), 978 P.2d 179.

As motorcycles are excluded from the definition of "motor vehicle" under this section, appellant's accident with a motorcycle was not a "motor vehicle accident" under the definition set forth in this section; appellant was thus not entitled to no-fault benefits under §431:10C-

303(a) (1993). 91 H. 299 (App.), 983 P.2d 200.

Other than the named insured, the only persons residing in the same household with a named insured who qualify as "insureds" under this section are "a spouse or reciprocal beneficiary or other relative of a named insured" and "a minor in the custody of a named insured or of a relative residing in the same household with a named insured"; as plaintiff was not a descendant of an ancestor common with the insureds, nor adopted by or married to a daughter or other relative of them, plaintiff was not a "relative" of and could not qualify as an "insured" on the sole basis that plaintiff resided in the same household with the insureds. 113 H. 196 (App.), 150 P.3d 845 (2007).

Construing the language of §431:10C-301 and this section governing uninsured motorist (UM) and underinsured motorist (UIM) insurance according to their plain and commonly understood meaning and in pari materia with §§663-10.9 and 663-11, UM and UIM policies must provide coverage for all damages which an insured is legally entitled to recover from the owner or operator of an uninsured or underinsured motor vehicle, which necessarily encompasses damages for which the owner or operator of an uninsured or underinsured motor vehicle is jointly and severally liable pursuant to §§663-10.9 and 663-11. 120 H. 329 (App.), 205 P.3d 594 (2009).

To obtain underinsured motorist (UIM) coverage in Hawaii, the liability for damages must exceed the total amount of bodily injury liability limits applicable at the time of the loss and the policy limits for uninsured motorist coverage and payments or settlements are not part of that analysis; thus, trial court correctly determined that the joint and several "damages imposed by law" against the driver exceeded the cumulative limits of driver's bodily injury policies, driver met the statutory definition of an UIM, and the insurer therefore was obligated to pay victim UIM benefits to compensate victim for the difference. 120 H. 329 (App.), 205 P.3d 594 (2009).

Mentioned: 732 F. Supp. 2d 1107 (2010).

**§431:10C-103.5 Personal injury protection benefits; defined; limits.** (a) Personal injury protection benefits, with respect to any accidental harm, means all appropriate and reasonable treatment and expenses necessarily incurred as a result of the accidental harm and which are substantially comparable to the requirements for prepaid health care plans, including medical, hospital, surgical, professional, nursing, advanced practice nursing licensed pursuant to chapter 457, dental, optometric, naturopathic medicine, chiropractic, ambulance, prosthetic services, medical equipment and supplies, products and accommodations furnished, x-ray, psychiatric, physical therapy pursuant to prescription by a medical doctor, occupational therapy, rehabilitation, and therapeutic massage by a licensed massage therapist when prescribed by a medical doctor.

(b) Personal injury protection benefits, when applied to a motor vehicle insurance policy issued at no cost under section 431:10C-410(3)(A), shall not include benefits under subsection (a) for any person receiving public assistance benefits.

(c) Personal injury protection benefits shall be subject to an aggregate limit of $10,000 per person for services provided under this section. An insurer may offer additional coverage in excess of the $10,000 aggregate limit for services provided under this section, or as provided by rule of the commissioner. [L 1997, c 251, pt of §2; am L

1998, c 275, §5; am L 1999, c 222, §4; am L 2000, c 65, §1; am L 2004, c 56, §1; am L Sp 2009, c 22, §11(2); am L 2015, c 35, §46]

**Case Notes**

Disputed issue of material fact existed as to whether or not the information requested by defendant insurer from plaintiff personal injury protection company was necessary and reasonable; defendant insurer was entitled to do some investigation to determine whether claimed benefits are appropriate and reasonable. 732 F. Supp. 2d 1107 (2010).

**§431:10C-103.6 Personal injury protection benefits tied to prepaid health care plan for description of coverage only.** (a) The benefits provided under section 431:10C-103.5 shall be substantially comparable to the requirements for prepaid health care plans, as provided in chapter 393 and rules of the department of labor and industrial relations, pertaining to the Prepaid Health Care Act. The reference to the Prepaid Health Care Act is only for purposes of describing the coverages and exclusions, without regard to any specific insurer or plan, and shall not be construed to transfer coverage to the prepaid health care plans. The precise charges and utilization rates shall be as contained in the workers' compensation schedules as provided under section 431:10C-308.5, unless modified by the commissioner by rule under chapter 91.

(b) Chiropractic treatments shall be allowed for not more than the lesser of the following:

(1) Thirty visits at no more than $75 a visit, plus no more than five x-rays at no more than $50 each; or

(2) Treatment as defined by the Hawaii State Chiropractic Association guidelines in effect on January 25, 1997.

(c) Acupuncture treatments shall be allowed for no more than thirty visits at no more than $75 a visit.

(d) Naturopathic treatments shall be allowed for no more than thirty visits at no more than $75 a visit.

(e) The combined total of naturopathic, chiropractic, and acupuncture treatments may not exceed thirty visits.

(f) The benefits under section 431:10C-103.5 may be with copayment, and shall be subject to and apply the utilization requirements applicable under prepaid health care plans, under chapter 393. [L 1997, c 251, pt of §2; am L 1998, c 275, §6; am L 2004, c 56, §2]

**§431:10C-104 Conditions of operation and registration of motor vehicles.** (a) Except as provided in section 431:10C-105, no person shall operate or use a motor vehicle upon any public street, road, or highway of this State at any time unless such motor vehicle is insured at all times under a motor vehicle insurance policy.

(b) Every owner of a motor vehicle used or operated at any time upon any public street, road, or highway of this State shall obtain a motor vehicle insurance policy upon such vehicle which provides the coverage required by this article and shall maintain the motor vehicle insurance policy at all times for the entire motor vehicle registration period.

(c) Any person who violates the provisions of this section shall be subject to the provisions of section 431:10C-117(a).

(d) The provisions of this article shall not apply to any vehicle owned by or registered in the name of any agency of the federal government, or to any antique motor vehicle as defined in section 249-1. [L 1987, c 347, pt of §2; am L 1989, c 195, §31; am L 1996, c 56, §2; am L 1997, c 251, §14]

**Case Notes**

Car rental company's use limitation provision not violative of compliance with minimum insurance requirements as limitation provision is proper exercise of company's authority to restrict scope of a renter's permissive use. 82 H. 351, 922 P.2d 964.

Section requires motor vehicle owner to insure vehicle for periods and amounts established; it does not mandate that insurers provide coverage for any and all accidents that occur on a public road, street, or highway. 82 H. 351, 922 P.2d 964.

Against public policy for rent-a-car company vehicle owner to acquire coverage for its vehicles as required by subsection (b) by contractually shifting primary responsibility for providing minimum insurance coverage to permissive user's policy and providing liability coverage under the unilateral contract with the permissive user only where user's personal insurance policy is insufficient to meet the minimum statutorily required amount. 88 H. 274, 965 P.2d 1274.

Obtaining insurance after trial has concluded is an insufficient basis to obtain either a new trial, an amended judgment, or relief from judgment under this section. 90 H. 441, 978 P.2d 879.

Subsection (b) applied to defendant, where defendant argued that traffic statutes involved only applied to businesses and state vehicles; subsection (b) did not violate defendant's freedom of movement. 77 H. 222 (App.), 883 P.2d 644.

Driving without no-fault insurance is a "traffic offense". 78 H. 33 (App.), 889 P.2d 1092.

Even if police had specific articulable facts to believe defendant committed offense, police were not authorized to order defendant out of defendant's car, physically arrest defendant, and search defendant incident thereto. 78 H. 98 (App.), 890 P.2d 685.

State must prove beyond reasonable doubt three elements in order to convict a driver who is not the owner of the vehicle. 86 H. 331 (App.), 949 P.2d 171.

State of mind of defendant is an element of an offense under this section; court must presume that borrower of motor vehicle reasonably believed vehicle was insured; in order to convict defendant, State must prove that state of mind of a person who borrowed an uninsured motor vehicle was "knowing" or "reckless". 86 H. 331 (App.), 949 P.2d 171.

When a defendant is charged with a violation of this section, §805-13 is the proper procedural statute for the district court, enforcement officers, and the prosecutor's office to follow. 86 H. 331 (App.), 949 P.2d 171.

Self-insurance under §431:10C-105 should be considered a defense, which the prosecution need not disprove unless some evidence to support the defense has been introduced. 90 H. 130 (App.), 976 P.2d 444.

**§431:10C-104.5 REPEALED.** L 2001, c 55, §31.

**§431:10C-105 Self-insurance.** (a) The motor vehicle insurance

required by section 431:10C-104 may be satisfied by any owner of a motor vehicle if:

(1) The owner meets the requirements of part VI of this article; and

(2) The commissioner is satisfied that in case of injury, death, or property damage, any claimant would have the same rights against the owner as the claimant would have had if a motor vehicle insurance policy had been applicable to the vehicle.

(b) A person desiring to qualify as a self-insurer shall apply to the commissioner on a form or in a format approved by the commissioner pursuant to rules. [L 1987, c 347, pt of §2; am L 1997, c 251, §16; am L 2000, c 24, §5; am L 2004, c 122, §39]

**Cross References**

Self-insurer requirements, see §§431:10C-601 to 608.

**Case Notes**

Use restriction in rental agreement purporting to limit self-insurer rent-a-car company's liability in the event of an accident in which renter was intoxicated was in violation of public policy. 85 H. 243, 942 P.2d 507.

Where there was no underlying insurance contract from which the duty of good faith settlement practices could arise, injured third-party claimant had no right to sue self-insured car rental company for bad faith. 105 H. 112, 94 P.3d 667.

For purposes of §431:10C-104(a), self-insurance under this section should be considered a defense, which the prosecution need not disprove unless some evidence to support the defense has been introduced. 90 H. 130 (App.), 976 P.2d 444.

Proof of self-insurance under this section is a "defense" within the meaning of §701-115. 90 H. 130 (App.), 976 P.2d 444.

**§431:10C-106 Specialty insurers not prohibited.** Nothing in this article shall prevent an insurer from offering motor vehicle insurance policies for only U-drive motor vehicles. [L 1987, c 347, pt of §2; am L 1989, c 208, §2; am L 1997, c 251, §17]

**§431:10C-107 Verification of insurance: motor vehicles.** (a) Every insurer shall issue to its insureds a paper or electronic motor vehicle insurance identification card for each motor vehicle for which the basic motor vehicle insurance coverage is written. The electronic motor vehicle insurance identification card may be accessed directly through the licensed insurer's website, application, or database. The identification card shall contain the following:

(1) Name of make and factory or serial number of the motor vehicle; provided that insurers of five or more motor vehicles which are under common registered ownership and used in the regular course of business shall not be required to indicate the name of make and the factory or serial number of each motor vehicle;

(2) Policy number;

(3) Names of the insured and the insurer; and

(4) Effective dates of coverage including the expiration date.

(b) The identification card shall be in the insured motor vehicle or accessible on a mobile electronic device, as defined in section 291C-137, at all times and shall be exhibited to a law enforcement officer upon demand.

(c) The identification card shall be resistant to forgery by whatever means appropriate. The commissioner shall approve the construction, form, and design of the identification card to ensure that the card is forgery resistant.

(d) The commissioner shall issue a certificate of self-insurance periodically, as necessary, for use in each motor vehicle insured under section 431:10C-105.

(e) The identification card issued by an insurer shall not be issued for a period exceeding the period for which premiums have been paid or earned; provided that this subsection shall apply only to the first application of a person for a motor vehicle insurance policy and shall not apply to applications for commercial and fleet vehicles. [L 1987, c 347, pt of §2; am L 1997, c 251, §18; am L 1998, c 207, §1; am L 2000, c 24, §6; am L 2016, c 82, §3]

**§431:10C-108 Unlawful use of motor vehicle insurance identification card.** It shall be a violation of this article:

(1) For any person to make, issue, or knowingly use any fictitious or fraudulently altered motor vehicle insurance identification card; or

(2) For any person to display or cause or permit to be displayed a motor vehicle insurance identification card knowing that the motor vehicle insurance policy was canceled as provided in section 431:10C-111 and section 431:10C-112. [L 1987, c 347, pt of §2; am L 1997, c 251, §19]

**§431:10C-109 Motor vehicle insurance identification card after cancellation of policy; return to insurer, civil sanctions.** (a) When a motor vehicle insurance policy is canceled before the end of the policy period, the insured shall within thirty days after being notified of the cancellation:

(1) Return the motor vehicle insurance identification card to the insurer for the policy; or

(2) If the card is lost or stolen, submit to the insurer an affidavit signed by the insured stating that fact to the insurer.

(b) The insurer's notice of cancellation shall include:

(1) The reason for the cancellation; and

(2) A statement of actions which may be taken under this section if the card is not returned.

(c) If the card or affidavit is not returned within the period specified, the insurer may:

(1) If the premiums for the period shown on the motor vehicle insurance identification card have been prepaid, withhold the unearned portions of the premiums until the identification card or an affidavit signed by the insured has been returned. In addition, all premiums shall be considered "earned" until the card is returned.

(2) If the premiums for the period shown on the identification card have not been paid in full, bring a civil action for three times the unpaid portion of the premiums. Notwithstanding section 607-14, the insurer shall be awarded reasonable attorney's fees and court costs. If the motor vehicle insurance identification card is returned after the civil action is filed but before the matter is taken to trial, the insurer shall be awarded damages of not less than $100, but not more than the amount of the unpaid premiums together with reasonable attorney's fees and costs as provided in this section.

(d) Notwithstanding the provisions of this section, the imposition of criminal sanctions under section 431:10C-117 shall not be precluded. [L 1987, c 347, pt of §2; am L 1989, c 195, §32; am L 1997, c 251, §20; am L 2005, c 22, §26]

**§431:10C-110 Rejection of application, joint underwriting plan placement.** A producer, including a branch office of a foreign or alien insurer, upon rejection of an application for a motor vehicle insurance policy or optional additional insurance, shall immediately offer, subject to the guidelines established by rules of the commissioner, to place the requested insurance coverages with the joint underwriting plan. [L 1987, c 347, pt of §2; am L Sp 1993, c 4, §2; am L 1997, c 251, §21; am L 2001, c 216, §18]

**Cross References**

Joint underwriting plan, see §431:10C-401, et seq.

**[§431:10C-110.5] Replacing motor vehicle insurance policy through an insurer's affiliate or subsidiary.** An insurer shall be exempt from provisions governing policy cancellations or nonrenewals in sections 431:10C-111, 431:10C-111.5, and 431:10C-112 if:

(1) The insurer offers to replace the insured's policy through the insurer's affiliate or subsidiary;

(2) The replacement policy is effective upon the expiration of the existing policy;

(3) The replacement policy provides the same or better coverage, terms, and conditions as the existing policy at a lower premium than the existing policy;

(4) The insurer provides at least thirty days written notice of the prospective replacement to the insured; provided that the insured may waive notice pursuant to this paragraph; and

(5) The insured accepts the replacement policy. [L 2011, c 11, §1]

**§431:10C-111 Cancellation and nonrenewal of policies: when prohibited, when permitted.** (a) An insurer may not cancel or refuse to renew a motor vehicle insurance policy, including optional additional insurance under the requirements of section 431:10C-302, once issued except when:

(1) The license of the principal operator to operate the type of motor vehicle is suspended or revoked;

(2) Premium payments for the policy are not made after reasonable demand therefor;

(3) The nonrenewal or conditional renewal is limited in accordance with section 431:10C-111.5; or

(4) A motor vehicle insurance policy has been in effect for sixty days or less and cancellation of the policy is not based on any of the criteria prohibited by subsection (c).

(b) An insurer may refuse to renew optional additional coverage in excess of that which the insurer is required to make available to the insured under section 431:10C-302 where the insured is a member of a class set forth in section 431:10C-407(b)(1)(A) or (B) at the time of the refusal to renew.

(c) No insurer shall refuse to continue a motor vehicle insurance policy based solely upon a person's race, creed, ethnic extraction, age, sex, length of driving experience, marital status, residence, physical handicap, or because an insured has elected to obtain any required or optional coverage or deductible required by law. If an insured alleges that the insurer's refusal to continue the motor vehicle insurance policy is based solely upon the insured's race, creed, ethnic extraction, age, sex, length of driving experience, marital status, residence, physical handicap, or because the insured has elected to obtain any required or optional coverage or deductible provided by law, the burden of proof shall rest with the insurer to prove that the refusal to continue the policy was not based on noncompliance with this subsection.

(d) An insurer may also refuse to renew motor vehicle insurance policies:

(1) If the commissioner determines that the financial soundness of the insurer would be impaired by the writing of additional policies of insurance; or

(2) The insurer ceases to write any new policies of insurance of any kind in this State.

(e) Within fifteen days of a cancellation and the return of the motor vehicle insurance identification card or a signed affidavit stating the card was lost or stolen, the insurer shall refund the pro rata unearned portion, if any, of any prepaid premiums. Premiums shall be considered "earned" as provided in section 431:10C-109. [L 1987, c 347, pt of §2; am L 1989, c 195, §33; am L Sp 1993, c 4, §3; am L 1997, c 251, §22; am L 2004, c 122, §40 and c 124, §1]

**Case Notes**

As this section applied to insured's Hawaii joint underwriting plan insurance policy such that insurer could not have canceled insured's policy unless it complied with the provisions of this section, insurer's failure to do so rendered its cancellation invalid. 105 H. 445, 99 P.3d 96.

**§431:10C-111.5 Limit on nonrenewals and conditional renewals.** (a) The total number (rounded to the nearest whole number) of notices of intention not to renew a motor vehicle insurance policy, and of notices of intention to condition renewal upon reduction of limits of any coverage, which an insurer may issue, shall be limited for each calendar year to two per cent of the total number of covered policies of the insurer in force at last year-end in each of the insurer's rating

territories in use in this State that have completed their required policy periods. However, the insurer may non-renew or conditionally renew one policy in any of the insurer's rating territories in use in this State if the applicable percentage limitation results in less than one policy. Cancellations, notices of intention not to renew, and notice of intention to conditionally renew made pursuant to section 431:10C-111(a)(1) and (a)(2), and section [431:10C-111(d)] shall be independent of and in addition to those permitted under this subsection.

(b) For every two new motor vehicle insurance policies that the insurer voluntarily writes in each rating territory, the insurer shall be permitted to non-renew or conditionally renew one additional motor vehicle insurance policy in that territory in excess of the two per cent limit established in subsection (a), subject to a fair and nondiscriminatory formula developed by the commissioner that shall consider the number of motor vehicle insurance policies written less cancellations initiated by the insurer within the first sixty days of the policy period. [L Sp 1993, c 4, §1; am L 1998, c 275, §8]

**Revision Note**

Subsection (a) reprinted to correct reference in main volume.

**§431:10C-112 Notice of cancellation or nonrenewal; effect on term of coverage.** (a) In the case of cancellation or nonrenewal of a motor vehicle insurance policy by the insurer, the insurer shall mail a written notice of prospective cancellation or nonrenewal to the insured not fewer than thirty days prior to the effective date of the cancellation or nonrenewal. The insurer shall continue all motor vehicle insurance and optional additional coverages in force for thirty days following the mailing; provided that in the case of cancellation for the nonpayment of premiums the insurer shall:

(1) Mail a written notice of prospective cancellation to the insured not fewer than twenty days prior to the effective date of the cancellation; and

(2) Continue all motor vehicle insurance and optional additional coverages in force for twenty days following the mailing.

Cancellation or nonrenewal shall not be deemed valid unless the mailing required by this section is supported by a certificate of mailing properly validated by the United States Postal Service.

(b) If the insurer has manifested in writing an offer to renew to the named insured at least thirty days prior to the end of the policy period and the offer is not accepted before the expiration of the policy term, the policy shall lapse upon that expiration date and section 431:10C-111 shall not apply. Notwithstanding other valid methods of acceptance, an offer shall be deemed accepted as of the date of mailing of the acceptance. The date of mailing may be evidenced by the postmark or a certificate of mailing properly validated by the United States Postal Service. [L 1987, c 347, pt of §2; am L 2004, c 124, §2]

**§431:10C-112.5 Notice of cancellation for insurer ceasing to issue motor vehicle insurance policies.** Any insurer authorized to issue motor vehicle insurance policies, which ceases to engage in the motor vehicle insurance business in this State, shall give written notice to each insured not less than sixty days prior to the effective date of closing

its business. [L 1992, c 123, pt of §1; am L 1997, c 251, §23]

**§431:10C-113 Violation of rejection, cancellation and nonrenewal provisions.** (a) Whoever knowingly violates, or conspires to violate, the provisions of section 431:10C-110 and section 431:10C-111 shall be assessed a civil penalty in an amount not to exceed $1,000 for each separate violation. Each violation of section 431:10C-110 with respect to a policyholder or applicant for insurance shall constitute a separate violation.

(b) The principles of law and equity regarding fraud and misrepresentation of material fact shall apply with respect to optional-additional coverages which are in excess of those which the insurer is required to make available to insureds under section 431:10C-302. [L 1987, c 347, pt of §2]

**Cross References**

Insurance fraud, see §431:10C-307.7.

**§431:10C-114 Insured's obligations upon termination of insurance.** An owner of a motor vehicle registered in this State who fails to maintain insurance as required by section 431:10C-104 shall:

(1) Immediately surrender the registration certificate and license plates for the vehicle to the county director of finance; and

(2) Not operate or permit operation of the vehicle in this State until insurance has again been obtained. [L 1987, c 347, pt of §2]

**§431:10C-115 Drivers education fund underwriters fee.** (a) The commissioner shall assess and levy upon each insurer, and self-insurer, a drivers education fund underwriters fee of $3 a year on each motor vehicle insured by each insurer or self-insurer. This fee is due and payable on an annual basis by means and at a time to be determined by the commissioner.

(b) The commissioner shall deposit the fees into a special drivers education fund account.

(c) The commissioner shall allocate the fees deposited for each fiscal year in the following manner:

(1) $1 per registration to the commissioner to be expended for the operation of the drivers education program provided in section 286-128(d); and

(2) $2 per registration to the director of commerce and consumer affairs for:

(A) The drivers education program administered by the department of education for high school students; and

(B) The traffic safety education program established and administered by the department of education pursuant to section 302A-417.

(d) Motor vehicles insured under the joint underwriting plan shall be excluded from the drivers education fund assessment.

(e) The commissioner shall adopt rules in accordance with chapter 91 for the execution of this section and the distribution of this fund.

[L 1987, c 347, pt of §2; am L 1989, c 208, §3; am L 1992, c 254, §3; am L 1993, c 280, §27; am L 1995, c 204, §2; am L 1996, c 89, §15 and c 243, §1; am L 1997, c 368, §6; am L 2000, c 24, §7; am L 2002, c 242, §1]

**§431:10C-115.5 REPEALED.** L 1999, c 163, §21.

**§431:10C-115.6 Disclosure of personal injury protection limits and payments.** Every insurer shall advise every person entitled to personal injury protection benefits, as defined in section 431:10C-103.5(a), of the maximum amount of personal injury protection benefits available under the policy within thirty days of receiving an initial notice, claim, or application for personal injury protection benefits. The disclosure of personal injury protection policy limits shall include a description of the nature of personal injury protection benefits, matters covered by personal injury protection benefits, and the procedure for submitting personal injury protection claims. [L 1992, c 123, pt of §1; am L 1997, c 251, §25]

**[§431:10C-115.7] Plain language billings.** A bill for a new and renewal policy or a notification included with the bill for the payment of premiums shall clearly identify each coverage in the policy, with the price of each coverage specified. [L 1997, c 251, pt of §2]

**§431:10C-116 Challenges to motor vehicle insurance law; intervention by attorney general.** At the request of the commissioner, the attorney general shall intervene in any case before any appellate court in this State in which the constitutionality or validity of this article or any part thereof is at issue, and may appeal to the United States Supreme Court, if necessary, to obtain a final determination of any case. [L 1987, c 347, pt of §2; am L 1997, c 251, §26]

**§431:10C-117 Penalties.**

(a) (1) Any person subject to this article in the capacity of the operator, owner, or registrant of a motor vehicle operated in this State, or registered in this State, who violates any applicable provision of this article, shall be subject to citation for the violation by any county police department in a form and manner approved by the traffic violations bureau of the district court of the first circuit;

(2) Notwithstanding any provision of the Hawaii Penal Code:

(A) Each violation shall be deemed a separate offense and shall be subject to a fine of not less than $100 nor more than $5,000 which shall not be suspended except as provided in subparagraph (B); and

(B) If the person is convicted of not having had a motor vehicle insurance policy in effect at the time the citation was issued, the fine shall be $500 for the first offense and a minimum of $1,500 for each subsequent offense that occurs within a five-year period from any prior offense; provided that the judge:

(i) Shall have the discretion to suspend all or any portion of the fine if the defendant provides proof of having a current motor vehicle insurance policy;

provided further that upon the defendant's request, the judge may grant community service in lieu of the fine, of not less than seventy-five hours and not more than one hundred hours for the first offense, and not less than two hundred hours nor more than two hundred seventy-five hours for the second offense; and

(ii) May grant community service in lieu of the fine for subsequent offenses at the judge's discretion;

(3) In addition to the fine in paragraph (2), the court shall either:

(A) Suspend the driver's license of the driver or of the registered owner for:
(i) Three months for the first conviction; and
(ii) One year for any subsequent offense within a five-year period from a previous offense;
provided that the driver or the registered owner shall not be required to obtain proof of financial responsibility pursuant to section 287-20; or

(B) Require the driver or the registered owner to keep a nonrefundable motor vehicle insurance policy in force for six months;

(4) Any person cited under this section shall have an opportunity to present a good faith defense, including but not limited to lack of knowledge or proof of insurance. The general penalty provision of this section shall not apply to:

(A) Any operator of a motor vehicle owned by another person if the operator's own insurance covers such driving;
(B) Any operator of a motor vehicle owned by that person's employer during the normal scope of that person's employment; or
(C) Any operator of a borrowed motor vehicle if the operator holds a reasonable belief that the subject vehicle is insured;

(5) In the case of multiple convictions for driving without a valid motor vehicle insurance policy within a five-year period from any prior offense, the court, in addition to any other penalty, shall impose the following penalties:

(A) Imprisonment of not more than thirty days;
(B) Suspension or revocation of the motor vehicle registration plates of the vehicle involved;
(C) Impoundment, or impoundment and sale, of the motor vehicle for the costs of storage and other charges incident to seizure of the vehicle, or any other cost involved pursuant to section 431:10C-301; or
(D) Any combination of those penalties; and

(6) Any violation as provided in subsection (a)(2)(B) shall not be deemed to be a traffic infraction as defined by chapter 291D.

(b) Any person, in the capacity of a licensed or unlicensed motor vehicle insurer, self-insurer, producer, or other representative, who violates any provision of this article shall be assessed a civil penalty not to exceed $5,000 for each violation.

(c) Any person, in the capacity of a licensed or unlicensed motor

vehicle insurer, self-insurer, producer, or other representative, who knowingly violates any provision of this article shall be assessed a civil penalty of not less than $3,000 and not to exceed $10,000 for each violation.

(d) (1) Violations of subsections (b) and (c) shall be subject to the construction that each repetition of such act shall constitute a separate violation; and

(2) The imposition of any civil penalty under subsection (a), (b), or (c) shall be in addition to, and shall not in any way limit or affect the application of, any other civil or criminal penalty, or public safety condition or requirement, provided by law. [L 1987, c 347, pt of §2; am L 1988, c 345, §1; am L 1989, c 348, §1; am L 1990, c 167, §1; am L 1993, c 205, §25; am L Sp 1993, c 4, §4; am L 1996, c 20, §1; ree L 1997, c 2, §11 and am c 251, §27; am L 1998, c 231, §2 and c 275, §9; am L 2002, c 155, §69; am L 2006, c 195, §1]

## Case Notes

Applies to repeat offenders and to defendants being sentenced at a single proceeding. 751 F. Supp. 1420.

Borrower of a vehicle cannot assert a good-faith defense without at least inquiring of the owner whether or not the vehicle is insured. 71 H. 178, 787 P.2d 214.

Where State conceded that appellant had borrowed uninsured vehicle from a friend, in order to defeat lack of knowledge defense, State was required to prove beyond reasonable doubt that appellant actually knew that the vehicle was uninsured at the time appellant was operating it. 78 H. 86, 890 P.2d 673.

As §571-1 mandates against treating juvenile adjudications as convictions, appellate court erred in holding that defendant's prior juvenile adjudication of driving without no-fault insurance constituted a conviction for purposes of applying the repeat offender sentencing provisions of this section (1993) to defendant's subsequent offense of driving without no-fault insurance. 92 H. 521, 993 P.2d 555.

Section mandates that an insurer be fined if it violates §431:10C-207 but gives the commissioner some discretion as to the amount of the fine; commissioner's imposition of $3,000 fine was not an abuse of discretion as it satisfied the statutory requirements. 104 H. 261, 88 P.3d 196.

Certified copy of a person's traffic abstract is satisfactory evidence to establish the person's prior no no-fault insurance conviction; State not required to show defendant was counseled at time of prior no no-fault insurance conviction; there was insufficient proof of defendant's prior conviction to support enhanced sentence for no no-fault insurance offense, where record disclosed no evidence to tie defendant with [person with the same name] of the traffic abstract. 9 H. App. 516, 852 P.2d 476.

Pursuant to §431:10C-117(a)(2) (1992) good faith defense and §431:10C-117(a)(2)(C) (1992) reasonable belief defense, borrower of a motor vehicle has a statutory right to reasonably believe that borrowed motor vehicle is insured. If one or more relevant facts reasonably required borrower to inquire, borrower then had a duty to inquire until borrower reasonably believed that motor vehicle was insured. 10 H. App. 519, 879 P.2d 566.

It was the "obvious intention" of the legislature to authorize the retroactive application of the part of Act 167, L 1990, that authorized the sentencing court the discretion to impose a sentence of community service instead of a fine. 77 H. 476 (App.), 888 P.2d 376.

Where defendant was sentenced pursuant to subsection (a)(2), because

the district court may have been unaware of the applicability of quoted parts of §§706-641 and 706-642 and of its discretionary authority to sentence defendant to perform community service rather than to pay the fine, appellate court vacated the part of the sentence ordering defendant to pay a $1,000 fine and remanded that part for resentencing. 77 H. 476 (App.), 888 P.2d 376.

An officer who has grounds to arrest individual for driving without no-fault insurance is required to issue summons or citation in lieu of physically taking defendant to police station or court. 78 H. 98 (App.), 890 P.2d 685.

When trial court revoked driver's suspended sentence, it lacked authority to do so where the State, despite knowledge that driver had been arrested for another no-motor-vehicle-insurance charge, did not move to revoke driver's suspended sentence within the suspended sentence period, and driver was not convicted of the second citation charge until after the suspended sentence period for the first citation had already expired. 106 H. 391 (App.), 105 P.3d 1197.

**[§431:10C-117.5] Additional civil liability.** An insurer whose insured causes death or injury to another person, and that is not entitled to the reduction provided in section 431:10C-301.5, shall be entitled to recover the amount of the covered loss deductible that would have applied from the insured whose conduct resulted in inapplicability of the covered loss deductible. [L 2000, c 70, §1]

**§431:10C-118 Fee in lieu of fine; defense.** (a) Any person bringing an action in tort under this article who was uninsured at the time of the accident shall pay a fee of $1,000 in lieu of any fine which could have been levied as a criminal penalty for failing to obtain the motor vehicle insurance coverage required by this article.

(b) The fee required under subsection (a) shall be paid by the person directly, or deducted from any settlement or verdict received, or both.

(c) No person shall be required to pay the fee in subsection (a) if the person can show proof of having been convicted in a prior criminal proceeding for failing to have motor vehicle insurance coverage on the date of the accident which is the subject of the tort action. [L 1987, c 347, pt of §2; am L 1997, c 251, §28]

**§431:10C-119 Insurer's requirements.** (a) Prior to licensing an insurer to transact a motor vehicle insurance business in this State, the commissioner:

(1) Shall effect a thorough examination of the insurer's business experience, financial soundness, and general reputation as an insurer in this and other states. In the discretion of the commissioner, this examination may include an examination of any or all of the business records of the insurer, and an audit of all or any part of the insurer's motor vehicle insurance business, each to be performed by the commissioner's staff or by independent consultants. No license shall be issued until the commissioner is satisfied as to the business experience, financial solvency, and the economic soundness of the insurer;

(2) Except for a member-owned reciprocal insurer and its wholly owned insurer subsidiaries, as specified in subsection (c), shall require of each insurer, and determine that satisfactory arrangements have been made for, the provision of a complete sales and claims service office in the State; and

(3) Notwithstanding any other requirements of this section or of the insurance code, may require a bond

in a reasonable amount and with deposits or sureties determined in the commissioner's discretion of any applicant for a license hereunder. The commissioner may, at any time, make and enforce such a requirement of any licensed insurer or self-insurer.

(b) The commissioner, prior to issuing a certificate of self-insurance to any person, shall require the applicant to provide for a complete claims service office and an officer for the purpose of service of process in this State.

(c) A member-owned reciprocal insurer and its wholly owned insurer subsidiaries shall make satisfactory arrangements for claims service and adjustment and for policy service of all policies sold or issued to consumers in this State if:

(1) A majority of its members are members of the United States military services, veterans of the United States military services, current or former spouses or dependents of these persons; and

(2) The primary purpose of the insurer is to serve these persons.

The member-owned reciprocal insurer and its wholly owned insurer subsidiaries, upon request by the commissioner, shall provide in writing, specific information as to those arrangements.

(d) The commissioner shall adopt rules to permit any licensed accident and health or sickness insurer to secure a license to engage in the business of motor vehicle insurance to provide only those personal injury protection benefits defined in section 431:10C-103.5(a) and optional major medical coverages. [L 1987, c 347, pt of §2; am L 1997, c 251, §29; am L 1998, c 275, §10; am L 2003, c 212, §83; am L 2004, c 36, §1 and c 122, §41]

**§431:10C-120 Prohibitions, penalty.** (a) No insurer shall issue or offer to issue any policy which the insurer represents is a motor vehicle insurance policy unless such insurer meets the requirements of this article.

(b) Any insurer, any producer, or any representative of an insurer who violates subsection (a) shall be subject to section 431:10C-117. [L 1987, c 347, pt of §2; am L 1989, c 195, §34; am L 1997, c 251, §30; am L 1998, c 275, §11; am L 2001, c 216, §19]

**§431:10C-121 Severability.** (a) Except as provided in subsection (b), if any provision of this article or its application to any person or circumstance is held unconstitutional, the remainder of this article and the application of such provision to other persons or circumstances shall not be affected thereby. It shall be conclusively presumed that the legislature would have enacted the remainder of the article without such invalid or unconstitutional provision.

(b) In the event section 431:10C-306(a) to (d) is held constitutionally invalid, then it is the intent of the legislature that the following sections only shall be voided:

(1) 431:10C-104;

(2) 431:10C-105;

(3) 431:10C-120;

(4) 431:10C-303;

(5) 431:10C-304; and

(6) 431:10C-305.

It shall be conclusively presumed that the legislature would have enacted the remainder of this article without such invalid or unconstitutional provision. [L 1987, c 347, pt of §2; am L 1989, c 195, §35; am L 1997, c 251, §31]

## PART II. RATES AND ADMINISTRATION

**§431:10C-201 Motor vehicle insurance rates generally.** Except as expressly provided in this part, all premium rates for motor vehicle insurance shall comply with the provisions of the rating law contained in article 14. [L 1987, c 347, pt of §2]

**§431:10C-202 Making of motor vehicle insurance rates.** All premium rates for motor vehicle insurance shall be made in accordance with article 14 and the following provisions:

(1) Notwithstanding any other law to the contrary, no insurer shall agree, combine, or conspire with any other private insurer or enter into, become a member of, or participate in any understanding, pool, or trust, to fix, control, or maintain, directly or indirectly, motor vehicle insurance rates. Any violation of this section shall subject the insurer and each of its officers and employees involved to the penalties of chapter 480 without benefit of any exemption otherwise permitted by section 480-11; provided that this paragraph shall not apply to advisory organizations referred to in section 431:14-111 which are not involved in ratemaking under this article.

(2) Notwithstanding any provision in this section to the contrary, the plans and rates for any surcharge or credit included by an insurer as part of the proposed rate filing shall be separately identified. Only reasonable surcharges approved by the commissioner shall be used; provided that no surcharge for the failure to maintain motor vehicle insurance shall be approved by the commissioner unless the insured has previously been convicted of driving without insurance within the preceding three years. Credits shall be deemed reasonable if there is no objection by the commissioner. Insurers shall furnish the prospective insured with a written explanation, in easily understandable language, clearly describing the reason for the surcharge or credit and how the amount of the surcharge or credit is determined. [L 1987, c 347, pt of §2 as superseded by c 349, §7; am L 1990, c 159, §2 and c 218, §2; am L 1992, c 123, §3 and c 124, §3; am L 1997, c 251, §32]

**[§431:10C-202.5] Immediate rate freeze; rate reduction; relief.** (a) No insurer may increase motor vehicle insurance rates between June 3, 1992, and December 31, 1993.

(b) Commencing on January 1, 1993, all authorized insurers transacting motor vehicle insurance in this State shall implement a fifteen per cent rate reduction from the rates on file with the commissioner for all motor vehicle insurance policies in effect on March 1, 1992, and for each new and renewal policy issued thereafter. The reduced rate shall continue to apply to each new and renewal policy for a period of one year.

(c) There shall be no exception to the requirements of this section unless the commissioner, pursuant to an insurer's petition, finds that those requirements will result in imminent danger of insolvency of the insurer. An insurer who contends that a rate required by this section will result in imminent danger of insolvency of the insurer shall designate in its petition the rate it contends is appropriate and shall

state with specificity the factors and data upon which it relies. The insurer shall be permitted to use all generally accepted actuarial techniques in filing any petition pursuant to this subsection. The insurer shall have the burden of proof to actuarially justify any rate increase from those provided for in subsections (a) and (b) and shall furnish all information, facts, and data requested by the commissioner reviewing any rate request.

(d) Effective January 1, 1994, all insurers shall include data on the impact of the provisions of Acts 123 and 124, Session Laws of Hawaii 1992, on all requested rate adjustments. The commissioner shall not approve any rate adjustments that do not contain a statement of the impact of the provisions of Acts 123 and 124, Session Laws of Hawaii 1992, the method used in calculating such impact, and the data used to determine such impact. [L 1992, c 123, pt of §1, §9 and c 124, pt of §1]

**Revision Note**

In subsection (a), "June 3, 1992," substituted for "the effective date of this Act".

In subsection (d), reference to Act 124 added.

**§431:10C-203 Rate filings.** The commissioner may accept from an advisory organization basic standards, manuals of classification, territories, endorsements, forms, and other materials, not dealing with rates, for reference filings by insurers. [L 1987, c 347, pt of §2 as superseded by c 348, §17; am L 1989, c 207, §13; am L 1992, c 124, §4]

**§431:10C-204 REPEALED.** L 1992, c 124, §13.

**§431:10C-205 Rate review: request by aggrieved party.** (a) Any person aggrieved by the application as to such person of any classification, rule, standard, rate, or rating plan made, followed, or adopted by an insurer may make written request to the commissioner to review such application and grant the relief requested. If the commissioner finds that probable cause for the complaint exists or that the complaint charges a violation of this article or any applicable provision of article 14, the commissioner shall conduct a hearing on the complaint. The hearing shall be subject to the procedure provided in section 431:14-118.

(b) If, after a hearing conducted pursuant to subsection (a), the commissioner finds that the complainant is entitled to relief or that any classification, rule, standard, rate, rating territory, or rating plan violates this article or any applicable provisions of article 14, the commissioner shall issue an order granting the complainant's claim for relief or prohibiting the insurer from using such classification, rule, standard, rate, rating territory, or rating plan. The order shall contain the commissioner's findings of fact and conclusions of law, including a specification of the respects in which a violation of this article or article 14 exists and specifying a reasonable time period within which the insurer shall comply with the terms of the order. Any such order shall be subject to judicial review in the manner provided in chapter 91. [L 1987, c 347, pt of §2]

**§431:10C-206 REPEALED.** L 1992, c 124, §14.

**§431:10C-206.5 Group insurance plans.** (a) Notwithstanding section 431:12-104(a), any insurer may issue any insurance coverage on a group plan, without restriction as to the purpose of the group, occupation, or type of group. Group insurance rates shall not be considered to be unfairly discriminatory, if they are averaged broadly among other persons insured under the group plan.

(b) This section is additional to article 12 and other provisions of law, with the exception of section 431:12-104(a), relating to group insurance. [L 1997, c 251, pt of §2; am L 1998, c 275, §13]

**§431:10C-207 Discriminatory practices prohibited.** No insurer shall base any standard or rating plan, in whole or in part, directly or indirectly, upon a person's race, creed, ethnic extraction, age, sex, length of driving experience, credit bureau rating, marital status, or physical handicap. [L 1987, c 347, pt of §2]

**Case Notes**

Section 431:10C-117 mandates that an insurer be fined if it violates this section, but gives the commissioner some discretion as to the amount of the fine; commissioner's imposition of $3,000 fine was not an abuse of discretion as it satisfied the statutory requirements. 104 H. 261, 88 P.3d 196.

This section applies to both rating plans and standards, including underwriting standards; thus, commissioner and trial court correctly concluded that insurer improperly denied plaintiff's application for insurance. 104 H. 261, 88 P.3d 196.

**§431:10C-208 Increase in premiums prohibited.** No premium on any motor vehicle insurance policy shall be increased as a result of any accident if the insured is not at fault in the accident. An accident in which the insured was not at fault shall not be used in any way to affect any subsequent increases, including loss of any discounts, in insurance premiums. [L 1987, c 347, pt of §2; am L 1997, c 251, §33; am L 1998, c 275, §14]

**§431:10C-209 Rate administration.** (a) Except as otherwise provided in this article, the commissioner shall implement and evaluate motor vehicle insurance rates in compliance with article 14.

(b) The commissioner shall order insurers to rebate to policyholders any excessive profit realized by insurers from their operations. [L 1987, c 347, pt of §2]

**§431:10C-209.5 REPEALED.** L 2012, c 258, §6.

**§431:10C-210 Publication of premium information.** (a) Upon the commissioner's request, all motor vehicle insurers shall provide motor vehicle insurance premium information to the commissioner within thirty days of the request.

(b) The commissioner shall publish annually, by electronic or

online publication on the official website of the insurance division, a list of all motor vehicle insurers with representative annual premiums for motor vehicle insurance. The commissioner shall have information on premiums for motor vehicle insurance, which shall be available to the public on request. [L 1987, c 347, pt of §2; am L 1992, c 124, §5; am L 2010, c 116, §1(18); am L 2012, c 258, §2]

**§431:10C-211 Attorney's fees.** (a) A person making a claim for personal injury protection benefits may be allowed an award of a reasonable sum for attorney's fees, and reasonable costs of suit in an action brought by or against an insurer who denies all or part of a claim for benefits under the policy, unless the court upon judicial proceeding or the commissioner upon administrative proceeding determines that the claim was unreasonable, fraudulent, excessive, or frivolous. Reasonable attorney's fees, based upon actual time expended, shall be treated separately from the claim and be paid directly by the insurer to the attorney.

(b) A person who has effected a tort recovery, whether by suit or settlement, and who is sued by the insurer to recover fifty per cent of the personal injury protection benefits paid, under section 431:10C-307, may be allowed reasonable attorney's fees and reasonable costs of suit.

(c) A person suing in tort, as permitted under this article, may enter into any arrangement with an attorney.

(d) An insurer or self-insurer may be allowed an award of a reasonable sum as attorney's fees based upon actual time expended, and all reasonable costs of suit for its defense against a person making claim against the insurer or self-insurer, within the discretion of the court upon judicial proceeding or the commissioner upon administrative proceeding where the claim is determined to be fraudulent or frivolous. Such attorney's fees and all reasonable costs of suit so awarded may be treated as an offset against any benefits due or to become due to the person. [L 1987, c 347, pt of §2; am L 1992, c 124, §6; am L 1997, c 251, §34]

## Cross References

Vexatious litigants, see chapter 634J.

## Case Notes

Plaintiff had a plausible claim to attorney's fees and costs under either subsection (a) or §431:10C-304(5). 685 F. Supp. 2d 1123 (2010).

Where court found that it was reasonable for plaintiff to litigate the issues raised in the action, court awarded plaintiff reasonable attorneys' fees pursuant to subsection (a). 821 F. Supp. 632.

The plain language of subsection (a) (1993) allows an award of reasonable fees and costs to any person, insured or provider, who contests a denial of no-fault benefits for injuries. 90 H. 1, 975 P.2d 211.

Where allowing insurer to seek attorney's fees under §607-14 would have contravened the attorney's fee award scheme set forth in this section, trial court did not abuse its discretion in denying insurer's motion for attorney's fees and costs. 109 H. 537, 128 P.3d 850 (2006).

The assigned claim coverage to which plaintiff was deemed entitled did not constitute a "policy" for purposes of subsection (a); thus, because

an insurer did not deny a claim under a "policy", plaintiff was not entitled to attorney fees under this section. 113 H. 246, 151 P.3d 727 (2006).

Obtaining a remedy on appeal is not required in order to obtain attorney's fees under subsection (a). 129 H. 270, 298 P.3d 1034 (2013).

Petitioner's request for attorney's fees and costs was not unreasonable under subsection (a) because petitioner's underlying claim for personal injury protection benefits based on medical services rendered to the insured had been made before insured's policy limit was reached; inter alia, when petitioner first appealed, it was uncertain whether petitioner would recover on the claim under the circumstances, and, more importantly, there was favorable authority and policy supporting petitioner's position, and thus, petitioner's pursuit of appeal was not irrational or without reason. 129 H. 270, 298 P.3d 1034 (2013).

Under §431:10C-304(5), an award of attorney's fees and costs is mandatory if a claimant prevails in a settlement or suit for no-fault benefits; and under subsection (a), an award of attorney's fees and costs may, in the exercise of a court's or the commissioner's discretion, be awarded to a nonprevailing claimant, as long as the claim is not determined to be unreasonable, fraudulent, excessive, or frivolous. 104 H. 375 (App.), 90 P.3d 267.

Where insurer waived any challenge to insured's status as a real party in interest, insurance commissioner did not abuse discretion in awarding attorney's fees and costs to insured under subsection (a). 108 H. 393 (App.), 120 P.3d 1128 (2005).

**§431:10C-212 Administrative hearing on insurer's denial of claim.**

(a) If a claimant or provider of services objects to the denial of benefits by an insurer or self-insurer pursuant to section 431:10C-304(3)(B) and desires an administrative hearing thereupon, the claimant or provider of services shall file with the commissioner, within sixty days after the date of denial of the claim, the following:

(1) Two copies of the denial;

(2) A written request for review; and

(3) A written statement setting forth specific reasons for the objections.

(b) The commissioner has jurisdiction to review any denial of personal injury protection benefits.

(c) The commissioner shall:

(1) Conduct a hearing in conformity with chapter 91 to review the denial of benefits;

(2) Have all the powers to conduct a hearing as set forth in section 92-16; and

(3) Affirm the denial or reject the denial and order the payment of benefits as the facts may warrant, after granting an opportunity for hearing to the insurer and claimant.

(d) The commissioner may assess the cost of the hearing upon either or both of the parties.

(e) Either party may appeal the final order of the commissioner in the manner provided for by chapter 91. [L 1987, c 347, pt of §2; am L 1992, c 124, §7; am L 1997, c 251, §35]

**Case Notes**

The first party to choose a forum for resolution of no-fault dispute binds the other party to that forum unless the circuit court finds that the parties have entered into a mandatory and binding arbitration agreement. 86 H. 59, 947 P.2d 371.

1992 amendment to subsection (a) applies to claims arising from injuries sustained in accidents occurring before January 1, 1993; thus, provider had standing to contest insurer's denial of no-fault insurance benefits. 90 H. 1, 975 P.2d 211.

**§431:10C-213 Arbitration.** (a) A claimant, insurer, or provider of services may submit any dispute relating to a motor vehicle insurance policy to an arbitrator by filing a written request with the clerk of the circuit court in the circuit where the accident occurred.

(b) The administrative judge of each circuit court shall maintain a current list of persons qualified and willing to act as arbitrators and shall, within ten days of the date of filing of a request for arbitration, appoint an arbitrator from such list to hear and determine the claim.

(c) Except as otherwise provided herein, the arbitration shall be in accordance with and governed by the provisions of chapter 658A.

(d) Any fee or cost of the arbitrator shall be borne equally by the parties unless otherwise allocated by the arbitrator.

(e) An appeal may be taken from any judgment of the arbitrator to the circuit court in the manner provided for in rule 72 of the Hawaii Rules of Civil Procedure. [L 1987, c 347, pt of §2; am L 1992, c 124, §8; am L 1997, c 251, §36; am L 2001, c 265, §4]

**Case Notes**

Hawaii's public policy strongly favors arbitration when dispute centers on automobile insurance policy. 769 F. Supp. 1135.

The first party to choose a forum for resolution of no-fault dispute binds the other party to that forum unless the circuit court finds that the parties have entered into a mandatory and binding arbitration agreement. 86 H. 59, 947 P.2d 371.

Where plaintiff and defendant's insurer did not have a written agreement in compliance with §658-1, this section did not by itself provide independent authority to compel arbitration. 86 H. 59, 947 P.2d 371.

**§431:10C-213.5 Binding arbitration.** (a) A claimant or defendant shall have the option to elect arbitration to resolve a claim in tort that is covered by motor vehicle liability insurance.

(b) A claimant or defendant may submit any dispute relating to a tort claim to binding arbitration by either filing a written request with the clerk of the circuit court in the circuit where the accident occurred or by agreement.

(c) A claimant or defendant shall have the opportunity to decline arbitration.

(d) Except as otherwise provided herein, arbitration shall be in accordance with and governed by chapter 658A.

(e) Fees and costs of arbitration shall be borne equally by the parties, unless otherwise agreed to by the parties.

(f) Collection of any arbitration award issued under this section shall be limited to the applicable liability policy limit, unless the insured tortfeasor otherwise agrees.

(g) The amount of an arbitration award under this section shall not be binding on a subsequent underinsured motorist claim. [L 1998, c 275, §3; am L 2000, c 181, §1; am L 2001, c 265, §4]

**§431:10C-214 Administration.** In order to carry out the provisions and fulfill the purpose of this article, the commissioner shall:

(1) Consult with representatives of the private insurance business, such other persons, public and consumer organizations, and agencies of the federal, state or local governments as the commissioner deems necessary;

(2) Adopt, amend and repeal such rules, pursuant to chapter 91, as the commissioner deems necessary to carrying out and fulfilling the purposes of this article, and to establishing standards for the prompt, fair and equitable disposition of all claims arising out of motor vehicle accidents; and

(3) Appoint such personnel as necessary for the performance of the commissioner's functions under this article. All personnel appointed under this section shall be subject to chapter 76. [L 1987, c 347, pt of §2; am L 2000, c 253, §150]

**§431:10C-215 Inspection and audit.** (a) In addition to the right and duty of examination under article 2, the commissioner shall have the right and the duty of visitation, inspection and audit of all business records, including internal memoranda, audits and correspondence related in any way to the insurer's motor vehicle insurance business in this State.

(b) The commissioner shall, in the commissioner's discretion, cause an audit to be made of all or any segment of the motor vehicle insurance books and business records of any insurer by the staff of the division or by an independent contract examiner. A copy of every audit, internal or external, performed by any insurer of any aspect of its motor vehicle books and business records shall be submitted immediately upon completion to the commissioner.

(c) The commissioner shall assess and collect from each insurer, self-insurer, and from every applicant for a certificate of self-insurance or a license to transact a motor vehicle insurance and optional additional insurance business in this State, such portion of the full cost of every audit, inspection, examination, visitation, and other services related to motor vehicle insurance required by this or any other article, or performed by the commissioner in the commissioner's discretion under this article or this code, as the commissioner deems equitable in the rendering of the service. Assessments collected shall be paid into the compliance resolution fund.

(d) (1) Each insurer licensed to transact motor vehicle insurance or optional additional insurance business in this State shall provide the commissioner with periodic reports on every aspect of the motor vehicle insurance and the optional additional insurance business the insurer transacts in this State, including, but not limited to reports on the investment, reserve, reinsurance, loss and profit experience, ratemaking and schedules, claims received and paid; and

(2) Each insurer subject to this section shall, not less frequently than quarterly, maintain a report of the details of each claim received, claim paid, application for and sale of a motor vehicle insurance policy, each termination and renewal refusal notice posted, and each cancellation and refusal to renew effected on both

motor vehicle insurance and optional additional insurance policy transactions. The insurer shall make available and submit a report to the commissioner at the commissioner's request.

(e) Any insurer failing to report information in the manner and within the time required by the commissioner, or failing fully to cooperate with the commissioner and the commissioner's staff in the fulfillment of their duties under this article and this code shall be subject to the penalty provided in section 431:14-117. [L 1987, c 347, pt of §2; am L 1997, c 251, §37; am L 1998, c 275, §15; am L 2003, c 212, §84; am L 2010, c 116, §1(19)]

**§431:10C-216 Annual review.** The commissioner shall periodically review and evaluate the motor vehicle insurance program described in this article, including an annual review of the premium rates, benefit payments and insurers' loss experience. [L 1987, c 347, pt of §2]

## PART III. COVERAGES AND RIGHTS

### Cross References

Arbitration; binding arbitration, see §§431:10C-213 and 213.5.

### Law Journals and Reviews

Tort and Insurance "Reform" in a Common Law Court. 14 UH L. Rev. 55.

**§431:10C-301 Required motor vehicle policy coverage.** (a) An insurance policy covering a motor vehicle shall provide:

(1) Coverage specified in section 431:10C-304; and

(2) Insurance to pay on behalf of the owner or any operator of the insured motor vehicle using the motor vehicle with a reasonable belief that the person is entitled to operate the motor vehicle, sums which the owner or operator may legally be obligated to pay for injury, death, or damage to property of others, except property owned by, being transported by, or in the charge of the insured, which arise out of the ownership, operation, maintenance, or use of the motor vehicle; provided that in the case of a U-drive motor vehicle, insurance to pay on behalf of the renter or any operator of the insured motor vehicle using the motor vehicle with the express permission of the renter or lessee, sums which the renter or operator may be legally obligated to pay for damage or destruction of property of others (except property owned by, being transported by, or in the charge of the renter or operator) arising out of the operation or use of the motor vehicle unless the motor vehicle is reported stolen by the owner within three days of notification of the incident; provided that the insurer and owner of a U-drive vehicle shall have the right of subrogation against the renter and operator for breach of the rental contract between owner and renter; and provided further that, in the event that any motor vehicle offered for rental or lease is involved in an accident, the lessor shall provide all information it has or obtains relevant to the accident to all other involved parties upon their request, including but not limited to information about the lessee, and the driver of the vehicle if other than the lessee.

(b) A motor vehicle insurance policy shall include:

(1) Liability coverage of not less than $20,000 per person, with an aggregate limit of $40,000 per accident, for all damages arising out of accidental harm sustained as a result of any one accident and arising out of ownership, maintenance, use, loading, or unloading of a motor vehicle;

(2) Liability coverage of not less than $10,000 for all damages arising out of damage to or destruction of property including motor vehicles and including the loss of use thereof, but not including property owned by,

being transported by, or in the charge of the insured, as a result of any one accident arising out of ownership, maintenance, use, loading, or unloading, of the insured vehicle;

(3) With respect to any motor vehicle registered or principally garaged in this State, liability coverage provided therein or supplemental thereto, in limits for bodily injury or death set forth in paragraph (1), under provisions filed with and approved by the commissioner, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, or disease, including death, resulting therefrom; provided that the coverage required under this paragraph shall not be applicable where any named insured in the policy shall reject the coverage in writing; and

(4) Coverage for loss resulting from bodily injury or death suffered by any person legally entitled to recover damages from owners or operators of underinsured motor vehicles. An insurer may offer the underinsured motorist coverage required by this paragraph in the same manner as uninsured motorist coverage; provided that the offer of both shall:

(A) Be conspicuously displayed so as to be readily noticeable by the insured;
(B) Set forth the premium for the coverage adjacent to the offer in a manner that the premium is clearly identifiable with the offer and may be easily subtracted from the total premium to determine the premium payment due in the event the insured elects not to purchase the option; and
(C) Provide for written rejection of the coverage by requiring the insured to affix the insured's signature in a location adjacent to or directly below the offer.

(c) The stacking or aggregating of uninsured motorist coverage or underinsured motorist coverage is prohibited, except as provided in subsection (d).

(d) An insurer shall offer the insured the opportunity to purchase uninsured motorist coverage and underinsured motorist coverage by offering the following options with each motor vehicle insurance policy:

(1) The option to stack uninsured motorist coverage and underinsured motorist coverage; and

(2) The option to select uninsured motorist coverage and underinsured motorist coverage, whichever is applicable, up to but not greater than the bodily injury liability coverage limits in the insured's policy.

These offers are to be made when a motor vehicle insurance policy is first applied for or issued. For any existing policies, an insurer shall offer such coverage at the first renewal after January 1, 1993. Once an insured has been provided the opportunity to purchase or reject the coverages in writing under the options, no further offer is required to be included with any renewal or replacement policy issued to the insured.

(e) If uninsured motorist coverage or underinsured motorist coverage is rejected, pursuant to section 431:10C-301(b):

(1) The offers required by section 431:10C-301(d) are not required to be made;

(2) No further offers or notice of the availability of uninsured motorist coverage and underinsured motorist coverage are required to be made in connection with any renewal or replacement policy; and

(3) The written rejections required by section 431:10C-301(b) shall be presumptive evidence of the insured's decision to reject the options. [L 1987, c 347, pt of §2; am L 1988, c 306, §1; am L 1992, c 123, §4, c 124, §9, and c 221, §1; am L 1993, c 205, §26; am L Sp 1993, c 4, §5; am L 1997, c 251, §38; am L 1998, c 275, §16]

## Law Journals and Reviews

Nobody I Know Should Have $35,000 B.I. Limits. 23 HBJ 89.

Key Issues in Hawai‘i Insurance Law Answered by the Moon Court. 33 UH L. Rev. 779 (2011).

## Case Notes

Discussed, where insurer not legally obligated to pay uninsured motorist benefits claimed where accident occurred in Thailand, a country outside of motor vehicle insurance policy's territorial limit. 134 F. Supp. 2d 1159.

Hawaii law applied to the California policy in effect at the time of the insured's accident in Hawaii. Hawaii law allowing stacking of uninsured/underinsured motorist benefits and prohibiting an insurer from offsetting benefits received from other parties was fundamental, and Hawaii had a materially greater interest than California in having its laws applied in interpreting the insurance policy. 903 F. Supp. 2d 1049 (2012).

Neither the addition of the named insureds' third and fourth vehicles nor the addition of their daughter as a covered driver required insurer to make a new offer of uninsured and underinsured motorist coverage to insureds. 911 F. Supp. 2d 947 (2012).

Whether or not: (1) insurer intelligibly advised named insured of the nature of uninsured motorist and underinsured motorist coverage, and (2) insurer apprised named insured that such coverage was available for a relatively modest increase in premium, were issues of material fact. 911 F. Supp. 2d 947 (2012).

Pursuant to subsection (b)(3), insurance coverage for uninsured motorists is "optional coverage". 76 H. 304, 875 P.2d 921.

Underinsured motorist coverage was subject to stacking. 77 H. 362, 884 P.2d 1138.

Defendant was not a permissive user of insured vehicle and was therefore not a "covered person" under insurance contract. 78 H. 249, 891 P.2d 1041.

Named insured under an automobile liability insurance policy, who is injured by hit-and-run driver, can be entitled to uninsured motorist benefits thereunder when the named insured is operating a motorcycle at the time of the named insured's accident. 78 H. 325, 893 P.2d 176.

Car rental agreement not contract for insurance and not source of customer's entitlement to insurance coverage; customer statutorily entitled to minimum motor vehicle insurance coverage required by this section. 82 H. 351, 922 P.2d 964.

Car rental company, as self-insurer, not subject to subsection (b)(3) and (4); thus, not required to provide uninsured or underinsured motorist coverage to permissive users of its vehicles. 82 H. 466, 923 P.2d 408.

Mandatory uninsured motorist offer requirements of subsection (b)(3) apply to the minimum requirements of a "no-fault policy" as specified in subsection (a). 82 H. 466, 923 P.2d 408.

Insurer's offer to stack benefits legally insufficient where offer did not clearly convey that insureds could have obtained same amount of coverage at lower premium by selecting stacking option and failed to inform insureds that stacking was available for a relatively modest increase in premium. 87 H. 307, 955 P.2d 100.

Section requires that insurer obtain written rejection of stacked coverage; insurer's offer of coverage inconsistent with requirement as offer required insured to affirmatively select, rather than affirmatively

reject, stacking option. 87 H. 307, 955 P.2d 100.

Though insurer was required under this section to offer stacking option at time of renewal of policy, insurer's failure to do so was irrelevant where policy was not in effect at time of accident. 87 H. 307, 955 P.2d 100.

An underinsured motorist carrier's grounds for denying underinsured motorist benefits under a consent-to-settle provision in an underinsured motorist policy must be reasonable, in good faith, and within the bounds of the intent underlying subsection (b)(4). 90 H. 302, 978 P.2d 740.

Exhaustion clauses in underinsured motorist policies requiring insured to exhaust tortfeasor's insurance prior to applying for underinsured motorist benefits are void as against public policy. 90 H. 302, 978 P.2d 740.

It is unreasonable for an underinsured motorist insurance carrier to precondition its refusal to consent to settle upon the failure of the insured to achieve a settlement exhausting the tortfeasor's policy limits. 90 H. 302, 978 P.2d 740.

When an insured makes a material change to an existing policy after a valid rejection of coverage, the resulting policy is not a renewal or replacement policy within the meaning of subsection (d), and a new offer of coverage is required; whether a material change was made is a fact specific determination based on the totality of the circumstances that includes consideration of the public policies underlying Hawaii's motor vehicle insurance code. 93 H. 210, 998 P.2d 490.

Trial court correctly ruled that insured was not entitled to uninsured motorist benefits where insured's injuries resulting from being shot from an adjacent parked car did not arise from the operation, maintenance, or use of a motor vehicle. 103 H. 263, 81 P.3d 1178.

Insurer's refusal to consent to settle in order to protect its subrogation rights, in light of its investigation of factors that would render subrogation more or less favorable to insurer, was reasonable; however, having withheld its consent, insurer had to put itself in the position of insured's subrogee by paying insured the amount of the settlement offer. 111 H. 160, 140 P.3d 393 (2006).

Under the Hawaii motor vehicle insurance statutory scheme, no requirement exists that an injured party exhaust the liability policies of all joint tortfeasors before making a claim against his or her uninsured motorist policy. 88 H. 77 (App.), 961 P.2d 1171.

Denial of coverage did not violate subsection (b)(4) where policy did not provide coverage for non-named insureds who are injured while not occupying a covered automobile but clearly provided UIM coverage to persons who are injured while occupying a covered automobile. 88 H. 122 (App.), 962 P.2d 1004.

Where injured employee was a permissive user of the company vehicle of the named insured, was using the truck during the course of employee's employment to get to and from the jobsite where employee was injured and to store and transport the equipment that employee was using as part of employee's duties at the time employee was injured, employee demonstrated "some connection with the insured vehicle", and was thus an insured person who was entitled to uninsured motorist coverage. 118 H. 123 (App.), 185 P.3d 871 (2008).

Construing the language of §431:10C-103 and this section governing uninsured motorist (UM) and underinsured motorist (UIM) insurance according to their plain and commonly understood meaning and in pari materia with §§663-10.9 and 663-11, UM and UIM policies must provide coverage for all damages which an insured is legally entitled to recover from the owner or operator of an uninsured or underinsured motor vehicle,

which necessarily encompasses damages for which the owner or operator of an uninsured or underinsured motor vehicle is jointly and severally liable pursuant to §§663-10.9 and 663-11. 120 H. 329 (App.), 205 P.3d 594 (2009).

To obtain underinsured motorist (UIM) coverage in Hawaii, the liability for damages must exceed the total amount of bodily injury liability limits applicable at the time of the loss and the policy limits for uninsured motorist coverage and payments or settlements are not part of that analysis; thus, trial court correctly determined that the joint and several "damages imposed by law" against the driver exceeded the cumulative limits of driver's bodily injury policies, driver met the statutory definition of an UIM, and the insurer therefore was obligated to pay victim UIM benefits to compensate victim for the difference. 120 H. 329 (App.), 205 P.3d 594 (2009).

Where the "other insurance" clause contained in insurer's policy created a priority of coverage among multiple insurers, and did not limit or reduce insurer's liability for uninsured motorist payments to insured, the provision was valid and enforceable under Hawaii law, and the circuit court did not err in denying insured's motion for partial summary judgment. 120 H. 329 (App.), 205 P.3d 594 (2009).

Discussed: 77 H. 117, 883 P.2d 38; 86 H. 511, 950 P.2d 695.

Mentioned: 807 F. Supp. 98.

**§431:10C-301.5 Covered loss deductible.** Whenever a person effects a recovery for bodily injury, whether by suit, arbitration, or settlement, and it is determined that the person is entitled to recover damages, the judgment, settlement, or award shall be reduced by $5,000 or the amount of personal injury protection benefits incurred, whichever is greater, up to the maximum limit. The covered loss deductible shall not include benefits paid or incurred under any optional additional coverage, benefits paid under any public assistance program, or benefits paid or incurred under chapter 386. [L 1997, c 251, pt of §2; am L 1998, c 275, §17; am L 2004, c 174, §2; am L 2012, c 32, §1]

**Case Notes**

The covered loss deductible provision of this section applied to the insureds' recovery of bodily injury damages under their uninsured motorist coverage with insurer. 103 H. 142, 80 P.3d 321.

Where defendant failed to (1) raise the covered loss deductible statute during the arbitration proceedings, (2) apply to the arbitration administrator or the arbitration judge to reduce the awards, or (3) file a notice of appeal and request a trial de novo, pursuant to Hawaii Arbitration Rules rule 21, the arbitration awards were entered as unappealable final judgments, which the trial court was precluded from modifying or vacating. 105 H. 93, 94 P.3d 648.

Applying the covered loss deductible under this section to plaintiff's recovery of underinsured motorist benefits did not violate plaintiff's constitutional right to substantive due process as the legislature's policy determination to enact this section to reduce one of the costs of the motor vehicle insurance system was expressly within the constitutional purview of the legislature. 106 H. 511, 107 P.3d 440.

The covered loss deductible applies to underinsured motorist coverage. 106 H. 511, 107 P.3d 440.

This section mandates that the "award shall be reduced by the amount of

personal injury protection (PIP) benefits"; as this section does not state that the award should be reduced after apportionment by the amount of PIP benefits, the covered loss deductible is to be deducted from the "total damages" awarded by the trier of fact prior to apportionment of the damages; thus, circuit court erred when it subtracted the covered loss deductible from the jury's damage award after apportioning the damages. 124 H. 236 (App.), 240 P.3d 899 (2010).

**§431:10C-302 Required optional additional insurance.** (a) In addition to the motor vehicle insurance coverages described in section 431:10C-301, every insurer issuing a motor vehicle insurance policy shall make available to the insured the following optional insurance under the following conditions. Every insurer issuing a commercial motor vehicle insurance policy shall make available to the insured the following optional insurance, except for those benefits under paragraphs (4), (5), (9), (10), and (11) under the following conditions:

(1) At the option of the insured, provisions covering loss resulting from damage to the insured's motor vehicle with such deductibles, including but not limited to collision and comprehensive deductibles of $50, $100, $250, $500, $1,000, $1,500, and $2,000, at appropriately reduced premium rates, as the commissioner, by rule, shall provide;

(2) At the option of the insured, compensation to the insured, the insured's spouse, any dependents, or any occupants of the insured's vehicle for damages not covered by personal injury protection benefits;

(3) Additional coverages and benefits with respect to any injury or any other loss from motor vehicle accidents or from operation of a motor vehicle for which the insurer may provide for aggregate limits with respect to such additional coverage so long as the basic liability coverages provided are not less than those required by section 431:10C-301(b)(1) and (2);

(4) At the option of the insured, an option in writing for coverage for wage loss benefits for monthly earnings loss for injury arising out of a motor vehicle accident. Any change in the wage loss benefits coverage selected by an insured shall apply only to benefits arising out of motor vehicle accidents occurring after the date the change becomes effective. Coverage shall be offered in multiples of $500 a month/$3,000 per accident per person, from $500 a month/$3,000 per accident to $2,000 a month/$12,000 per accident; however, nothing shall prevent an insurer from making available higher limits of coverage;

(5) An option in writing for minimum coverage for death benefits for death arising out of a motor vehicle accident in an amount of $25,000, to be paid to the surviving spouse, for the benefit of the spouse and dependent children, or if there are no surviving spouse or dependent children, then to the estate. Coverage shall also be made available for increased death benefits in increments of $25,000 up to $100,000; however, nothing shall prevent an insurer from making available higher limits of coverage. At the option of the insured, coverage for funeral expenses of $2,000 shall be made available;

(6) Terms, conditions, exclusions, and deductible clauses, coverages, and benefits which:

(A) Are consistent with the required provisions of the policy;
(B) Limit the variety of coverage available so as to give buyers of insurance reasonable opportunity to compare the cost of insuring with various insurers; and
(C) Are approved by the commissioner as fair and equitable;

(7) At appropriately reduced premium rates, deductibles applicable only to claims of an insured in the amounts of $100, $300, $500, and $1,000 from all personal injury protection benefits otherwise payable; provided that if two or more insureds to whom the deductible is applicable under the contract of insurance are injured in the same accident, the aggregate amount of the deductible applicable to all of them shall not exceed

the specified deductible, which amount where necessary shall be allocated equally among them;

(8) Every insurer shall fully disclose the availability of all required and optional coverages and deductibles, including the nature and amounts, at the issuance or delivery of the policy; or, for a policy already issued on January 1, 1998, disclosure shall be made at the first renewal after January 1, 1998. The insurer shall also disclose at issuance or renewal, as applicable, the effect on premium rates and savings of each option and deductible. Further offers or disclosures thereafter shall be required to be included with every other renewal or replacement policy. All elections of coverages, options, and deductibles by a named insured shall be binding upon additional insureds covered under the named insured's policy. The purpose of this paragraph is to inform insureds or prospective insureds of the coverages under this article;

(9) (A) An insurer may make available, and provide at the option of the named insured, the benefits described in section 431:10C-103.5(a) through managed care providers such as a health maintenance organization or a preferred provider organization. The option may include conditions and limitations to coverage, including deductibles and coinsurance requirements, as approved by the commissioner. The commissioner shall approve those conditions and limitations which are substantially comparable to or exceed the coverage provided under section 431:10C-103.6;

(B) An insurer may make available, and provide at the option of the named insured, deductible and coinsurance arrangements whereby the recipient of care, treatment, services, products, expenses, or accommodations shares in the payment obligation;

(C) No deductible or coinsurance under a policy covered under section 431:10C-302(a)(9)(A) or (B) shall be applied with respect to care, treatment, services, products, or accommodation provided or expenses incurred by an insured during the first twenty-four hours in which emergency treatment has been provided or until the insured patient's emergency medical condition is stabilized, whichever is longer;

(D) (i) The optional coverage prescribed in section 431:10C-302(a)(9)(A) and (B) shall apply only to the named insured, resident spouse, or resident relative; and

(ii) "Resident relative" means a person who, at the time of the accident, is related by blood, marriage, or adoption to the named insured or resident spouse and who resides in the named insured's household, even if temporarily living elsewhere, and any ward or foster child who usually resides with the named insured, even if living elsewhere;

(E) An agreement made under section 431:10C-302(a)(9) must be a voluntary agreement between the insured and the insurer, and no insurer shall require an insured to agree to those policy provisions as a condition of providing insurance coverage. Requiring an agreement as a precondition to the provision of insurance shall constitute an unfair insurance practice and shall be subject to the provisions, remedies, and penalties provided in article 13; and

(F) An insurer providing the coverages authorized in section 431:10C-302(a)(9)(A) and (B) shall demonstrate in rate filings submitted to the commissioner the savings to the insured to be realized under the plan;

(10) An insurer shall make available optional coverage for naturopathic, acupuncture, nonmedical remedial care, and treatment rendered in accordance with the teachings, faith, or belief of any group which relies upon spiritual means through prayer for healing; and

(11) An insurer may make available optional coverage for chiropractic treatment in addition to chiropractic treatment provided under section 431:10C-103.6 for not more than the lesser of the following:

(A) Thirty additional visits at no more than $75 a visit; or
(B) Treatment as defined by the Hawaii Chiropractic Association guidelines in effect on January 25, 1997.

The commissioner shall adopt rules, including policy limits, terms, and conditions as necessary to implement the requirements of this section.

(b) In accordance with the rules adopted by the commissioner, a policy of insurance described in this section shall contain a provision specifying the periods within which claims may be filed and action may be brought against the insurer. [L 1987, c 347, pt of §2; am L 1988, c 306, §2; am L 1992, c 124, §10; am L 1997, c 251, §39; am L 1998, c 275, §18]

**Case Notes**

Trial court erred in granting summary judgment in favor of insurer because this section required insurer to offer death benefits coverage for death arising out of all motor vehicle accidents, regardless of whether a motorcycle was involved. 107 H. 227, 112 P.3d 713 (2005).

Inter-policy stacking of applicable wage loss coverages must be permitted for each covered accident; insurer's "non-duplication of benefits" clause, which purported to limit wage loss benefits of insurer's two policies, was invalid to the extent that it impaired coverage of actual wage loss. 103 H. 181 (App.), 80 P.3d 1002.

Circuit court did not err in granting insured summary judgment where, under the plain language of insured's policy and Act 251, L 1997 amendments to this section, no per accident cap on wage loss benefits was incorporated into this section, and amendments by Act 275, L 1998 did not disclose a legislative intent to have adopted, in 1997, a cap on overall wage loss benefits; thus, insured was entitled to wage loss benefits that "shall terminate upon insured's death". 124 H. 426 (App.), 246 P.3d 358 (2010).

Cited: 77 H. 39, 881 P.2d 526.

**§431:10C-302.5 Managed care option.** (a) An insurer may offer, and provide at the option of the named insured, the personal injury protection benefits through managed care providers such as a health maintenance organization or preferred provider organization. The option may include conditions and limitations to coverage, including deductibles and coinsurance requirements, as approved by the commissioner. The commissioner shall approve those conditions and limitations if the benefits are substantially comparable to or exceed the requirements of section 431:10C-103.5.

(b) An insurer offering the coverages authorized under subsection (a) shall demonstrate in rate filings submitted to the commissioner the savings to the insured to be realized under subsection (a). [L 1997, c 251, pt of §2; am L 1998, c 275, §19]

**§431:10C-303 Right to personal injury protection benefits.** (a) If

the accident causing accidental harm occurs in this State, every person insured under this article, and such person's survivors, suffering loss from accidental harm arising out of the operation, maintenance, or use of a motor vehicle, has a right to personal injury protection benefits.

(b) If the accident causing accidental harm occurs outside this State, the following persons and their survivors suffering loss from accidental harm arising out of the operation, maintenance, or use of a motor vehicle, have a right to personal injury protection benefits as defined in section 431:10C-103.5(a):

(1) Insureds as defined in section 431:10C-103; and

(2) The driver and other occupants of an insured vehicle, other than a vehicle which is regularly used in the course of the business of transporting persons or property and which is one of five or more vehicles under common ownership. [L 1987, c 347, pt of §2; am L 1997, c 251, §40]

## Case Notes

Injury and subsequent death of automobile passenger shot by person who walked up to stopped vehicle did not arise out of use of motor vehicle. 776 F. Supp. 1432.

Right to no-fault benefits is not absolute. 73 H. 552, 836 P.2d 1074.

As motorcycles are excluded from the definition of "motor vehicle" under §431:10C-103, appellant's accident with a motorcycle was not a "motor vehicle accident" under the definition set forth in §431:10C-103; appellant was thus not entitled to no-fault benefits under subsection (a) (1993). 91 H. 299 (App.), 983 P.2d 200.

**§431:10C-303.5 U-drive insurance policy; primary.** (a) A U-drive motor vehicle insurance policy shall be primary; provided that its bodily injury and property damage liability coverages shall be secondary to the operator's or renter's motor vehicle insurance policy if:

(1) The U-drive rental business provides any claimant or person sustaining accidental harm or damages, as a result of the operation of the rental vehicle, the identity and address of the operator or renter, along with any information available to the U-drive rental business as to the identity and address of any insurer under any liability policies applicable to the operator or renter; provided that the U-drive rental business shall make reasonable efforts to obtain such information;

(2) A suit may be filed and service upon the responsible operator or renter can be effectuated; and

(3) An insurer responds on behalf of the operator or renter to a claim or suit.

(b) In cases where the U-drive motor vehicle insurance policy is primary because of:

(1) A failure of a renter or operator to cooperate with the U-drive rental business in providing the information described in subsection (a)(1);

(2) The failure to file suit and effectuate service as described in subsection (a)(2); or

(3) The failure of an insurer to respond as described in subsection (a)(3) or defend a claim or pay required benefits or a judgment;

the U-drive rental business may recover from the renter, operator, or insurer, the sums the U-drive rental business expended in payments or benefits, along with reasonable attorneys' fees and expenses. [L 1997, c

251, pt of §2; am L 1998, c 275, §20]

**Case Notes**

Even if certain defendants were secondarily liable, this statute seemed to preclude such a finding until after plaintiff had prosecuted claims against the vehicle renter's auto insurance company, the primary source of coverage for bodily injury and property damages. Plaintiff's bodily injury and property damage claims against those defendants should be dismissed without prejudice; plaintiff must first pursue an action against the insured vehicle renter. 255 F. Supp. 2d 1149.

Rent-a-car company's rental agreement provision, which attempted to shift primary responsibility for providing minimum insurance coverage to the renter's personal insurance policy, violated the public policy enumerated in this chapter. 88 H. 274, 965 P.2d 1274.

The owner of a vehicle has the primary obligation to provide minimum coverage for the owned vehicle and this obligation may not be avoided through a unilateral contract with a permissive user of the vehicle. 88 H. 274, 965 P.2d 1274.

Where section does not expressly indicate an intent to be applied retroactively and retroactive application would have increased obligations of permissive user's insurance company, enactment of this section has no effect on causes of action arising before its effective date of January 1, 1998. 88 H. 274, 965 P.2d 1274.

**§431:10C-304 Obligation to pay personal injury protection benefits.** For purposes of this section, the term "personal injury protection insurer" includes personal injury protection self-insurers. Every personal injury protection insurer shall provide personal injury protection benefits for accidental harm as follows:

(1) Except as otherwise provided in section 431:10C-305(d), in the case of injury arising out of a motor vehicle accident, the insurer shall pay, without regard to fault, to the provider of services on behalf of the following persons who sustain accidental harm as a result of the operation, maintenance, or use of the vehicle, an amount equal to the personal injury protection benefits as defined in section 431:10C-103.5(a) payable for expenses to that person as a result of the injury:

(A) Any person, including the owner, operator, occupant, or user of the insured motor vehicle;
(B) Any pedestrian (including a bicyclist); or
(C) Any user or operator of a moped as defined in section 249-1;

provided that this paragraph shall not apply in the case of injury to or death of any operator or passenger of a motorcycle or motor scooter as defined in section 286-2 arising out of a motor vehicle accident, unless expressly provided for in the motor vehicle policy;

(2) Payment of personal injury protection benefits shall be made as the benefits accrue, except that in the case of death, payment of benefits under section 431:10C-302(a)(5) may be made immediately in a lump sum payment, at the option of the beneficiary;

(3) (A) Payment of personal injury protection benefits shall be made within thirty days after the insurer has received reasonable proof of the fact and amount of benefits accrued, and demand for payment thereof. All providers must produce descriptions of the service provided in conformity with applicable fee schedule codes;

(B) If the insurer elects to deny a claim for benefits in whole or in part, the insurer shall, within thirty days, notify the claimant in writing of the denial and the reasons for the denial. The denial notice shall be prepared and mailed by the insurer in triplicate copies and be in a format approved by the commissioner. In the case of benefits for services specified in section 431:10C-103.5(a) the insurer shall also mail a copy of the denial to the provider; and

(C) If the insurer cannot pay or deny the claim for benefits because additional information or loss documentation is needed, the insurer shall, within the thirty days, forward to the claimant an itemized list of all the required documents. In the case of benefits for services specified in section 431:10C-103.5(a) the insurer shall also forward the list to the service provider;

(4) Amounts of benefits which are unpaid thirty days after the insurer has received reasonable proof of the fact and the amount of benefits accrued, and demand for payment thereof, after the expiration of the thirty days, shall bear interest at the rate of one and one-half per cent per month;

(5) No part of personal injury protection benefits paid shall be applied in any manner as attorney's fees in the case of injury or death for which the benefits are paid. The insurer shall pay, subject to section 431:10C-211, in addition to the personal injury protection benefits due, all attorney's fees and costs of settlement or suit necessary to effect the payment of any or all personal injury protection benefits found due under the contract. Any contract in violation of this provision shall be illegal and unenforceable. It shall constitute an unlawful and unethical act for any attorney to solicit, enter into, or knowingly accept benefits under any contract;

(6) Disputes between the provider and the insurer over the amount of a charge or the correct fee or procedure code to be used under the workers' compensation supplemental medical fee schedule shall be governed by section 431:10C-308.5; and

(7) Any insurer who violates this section shall be subject to section 431:10C-117(b) and (c). [L 1987, c 347, pt of §2; am L 1992, c 124, §11; am L 1993, c 6, §20 and c 205, §27; am L 1997, c 251, §41; am L 1998, c 275, §21; am L 2000, c 138, §1]

## Case Notes

Where plaintiff alleged that defendant insurance company refused to pay claims for personal injury protection benefits, (1) defendant's motion to dismiss certain counts of the first amended complaint denied in part and granted in part; among other things, counts one to four of plaintiff's "first claim" stated a claim for relief that was authorized under this section; and (2) plaintiff's cross motion for summary judgment and adjudication or preliminary injunction denied. 685 F. Supp. 2d 1123 (2010).

Disputed issue of material fact existed as to whether or not the information requested by defendant insurer from plaintiff personal injury protection company was necessary and reasonable; defendant insurer was entitled to do some investigation to determine whether claimed benefits are appropriate and reasonable. 732 F. Supp. 2d 1107 (2010).

Section entitles motorcycle passenger to claim no-fault benefits against automobile driver's policy for passenger's injuries received in accident between driver's vehicle and motorcycle. 81 H. 302, 916 P.2d 1203.

Term "any person" in paragraph (1)(A)(i) includes motorcycle

passengers. 81 H. 302, 916 P.2d 1203.

In light of the unambiguous mandatory language of paragraph (3)(B), an insurer is required to provide written notice of its denial--in whole or in part--of the claim for benefits; written notice to the claimant is required where the denial or partial denial relates to the treatment service and/or the charges therefor; where the denial or partial denial involves treatment services, the insurer must also provide written notice to the provider. 109 H. 185, 124 P.3d 930 (2005).

Where insurer's denial of plaintiff's claim for no-fault benefits was based upon an open question of law--whether "the reasons" as used in paragraph (3)(B) means "all reasons"--there was no bad faith on the part of insurer for not having stated all the reasons for its denial of plaintiff's claim. 109 H. 537, 128 P.3d 850 (2006).

Hawaii's no-fault legislative scheme did not establish doctor's status as a third party beneficiary as a matter of law. 116 H. 159, 172 P.3d 471 (2007).

Paragraph (1)(B) (1987) created a statutory right to survivors' loss benefits. 88 H. 345 (App.), 966 P.2d 1071.

Pursuant to paragraph (1)(B) (1987) and §431:10C-103(10)(B) (1987), upon the death of an insured, the insurer is obligated to provide the insured's survivor a survivor's loss benefit of up to either (1) $15,000 where the insured has purchased only the basic no-fault coverage, or (2) the expanded limits of no-fault benefits where the insured has contracted for it under an optional additional coverage. 88 H. 345 (App.), 966 P.2d 1071.

The plain language of paragraph (1) requires a causal connection between a motor vehicle accident and any injury for which a claim for no-fault insurance benefits is made. 101 H. 21 (App.), 61 P.3d 532.

Insurer violated the time requirements of paragraph (3)(C) (1993) when it delayed granting or denying insured's claim for no-fault benefits pending (1) receipt of answers from insured's treating physicians to insurer's questions regarding the underlying cause of the medical condition that required insured to undergo bypass surgery a few days after a motor vehicle accident, and (2) insured's undergoing two independent medical examinations; however, the commissioner wrongly concluded that insurer's violation of these time requirements procedurally barred insurer from contesting the substantive merits of insured's claim. 101 H. 311 (App.), 67 P.3d 810.

Under paragraph (5), an award of attorney's fees and costs is mandatory if a claimant prevails in a settlement or suit for no-fault benefits; and under §431:10C-211(a), an award of attorney's fees and costs may, in the exercise of a court's or the commissioner's discretion, be awarded to a nonprevailing claimant, as long as the claim is not determined to be unreasonable, fraudulent, excessive, or frivolous. 104 H. 375 (App.), 90 P.3d 267.

Paragraph (3)(B) (1993) applies to billing disputes and this section's notice requirement is triggered by a partial denial of claims in the form of reduced or partial payments by an insurer; thus, trial court erred in finding that insurer was not required to issue a formal notice of denial of benefits pursuant to paragraph (3)(B) (1993) after it made both reduced and partial payments on physician's claims. 117 H. 477 (App.), 184 P.3d 792 (2008).

Paragraph (4) (1993) is applicable when a payment due is delayed in conjunction with a billing dispute; thus, physician was entitled to interest on the balance withheld by insurer thirty days after physician submitted physician's billing statements and demand for payment; insurer was not permitted to withhold payment for an indeterminate period of

time, without interest, while it sought additional information from physician. 117 H. 477 (App.), 184 P.3d 792 (2008).

The doctrine of equitable tolling cannot be applied to expand the two-year statute of limitations period in §431:10C-315 (1993) based solely on an issuer's failure to provide a formal notice of denial required pursuant to paragraph (3) (1993) in conjunction with a reduced or partial payment. 117 H. 502 (App.), 184 P.3d 817 (2008).

**§431:10C-305 Source of payment.**

(a) (1) A claim for personal injury protection benefits for accidental harm of a person who is not an occupant of any motor vehicle involved in a motor vehicle accident may be made against the insurer of any involved vehicle; and

(2) The insurer against whom the claim is asserted shall process and pay the claim as if wholly responsible, but the insurer shall thereafter be entitled to recover from the insurer of all other involved vehicles proportionate contribution for the benefits paid and the cost of processing the claim.

(b) (1) Except as provided in paragraph (2), personal injury protection benefits shall be paid primarily from the following sources in the following conditions:

(A) The insurance on the vehicle occupied by the injured person at the time of the accident; or
(B) The insurance on the vehicle which caused accidental harm if the injured person is a pedestrian (including a bicyclist).

If there is no insurance on the vehicle, any other motor vehicle insurance applicable to the injured person shall apply. No person shall recover personal injury protection benefits from more than one insurer for accidental harm as a result of the same accident;

(2) All personal injury protection benefits shall be paid secondarily and net of any benefits a person is entitled to receive because of the accidental harm from workers' compensation laws; provided that:

(A) The total amount a person is entitled to receive for monthly earnings loss under this article shall be limited to the amount of any applicable coverage under section 431:10C-302, without any deduction of any amount received as compensation for lost earnings under any workers' compensation law;
(B) The aggregate of the payments from both sources shall not exceed eighty per cent of the person's monthly earnings as provided in section 431:10C-302(a)(4). However, if the person's employer provides both workers' compensation and personal injury protection payments, the aggregate shall not exceed the person's net monthly earnings (computed by subtracting the total of federal and state income taxes and employee social security contributions from the gross monthly earnings), provided that the workers' compensation payments shall not be less than required by chapter 386; and
(C) This section shall not apply to benefits payable to a surviving spouse and any surviving dependent as provided under section 431:10C-304.

If the person does not collect such benefits under the workers' compensation laws by reason of the contest of this right to so collect by the person or organization responsible for payment thereof, the injured person, if otherwise eligible, shall, nevertheless, be entitled to receive personal injury protection benefits and, upon payment thereof, the personal injury protection insurer shall be subrogated to the injured person's rights to collect such benefits.

(c) (1) If a temporary substitute vehicle is made available to a customer by an auto repair shop registered with the motor vehicle repair industry board or a motor vehicle dealer licensed by the motor vehicle industry licensing board, while the shop or dealer repairs or services the customer's insured motor vehicle, the motor vehicle insurance policy of the customer's insured motor vehicle shall be primary over the policy on the temporary substitute vehicle; and

(2) In the event that a customer's insured motor vehicle is operated by a registered repair shop in the course of service or repair, or to verify repairs, the motor vehicle insurance policy of the registered repair shop shall be primary over the policy on the customer's insured motor vehicle.

(d) The following persons are not eligible to receive payment of personal injury protection benefits:

(1) Occupants of a motor vehicle other than the insured motor vehicle;

(2) Operator or user of a motor vehicle engaging in criminal conduct which causes any loss; or

(3) Operator of a motorcycle or motor scooter as defined in section 286-2.

This subsection shall not preclude recovery in other capacities under a motor vehicle insurance policy covering a vehicle which the person did not occupy at the time of the accident. [L 1987, c 347, pt of §2; am L 1989, c 208, §4; am L 1991, c 149, §1; am L 1997, c 251, §42]

**Case Notes**

Section does not toll §431:10C-315's statute of limitations; section requires workers' compensation claim to be paid prior to any no-fault benefits payments. 794 F. Supp. 1012.

Owned vehicle exclusion in policy is valid because it is consistent with section and legislative intent of no-fault law. 73 H. 552, 836 P.2d 1074.

**[§431:10C-305.5] Right to reimbursement of deductible paid; when.** If an insured is involved in an accident with an uninsured motorist and the insured paid a deductible amount for damages incurred in that accident, and if the insurer recovers any money from the uninsured motorist, the insurer shall reimburse the insured, provided that:

(1) The amount recovered shall be divided equally between the insured and the insurer;

(2) The amount of the insured's reimbursement shall not exceed the deductible paid; and

(3) If the amount of damages exceeds $2,500, the insurer shall:

(A) Pay the full amount of the deductible to the insured; or
(B) Initiate proceedings against the uninsured motorist to recover damages. [L 1988, c 21, §1]

**§431:10C-306 Abolition of tort liability.** (a) Except as provided in subsection (b), this article abolishes tort liability of the following

persons with respect to accidental harm arising from motor vehicle accidents occurring in this State:

(1) Owner, operator, or user of an insured motor vehicle; or

(2) Operator or user of an uninsured motor vehicle who operates or uses such vehicle without reason to believe it to be an uninsured motor vehicle.

(b) Tort liability is not abolished as to the following persons, their personal representatives, or their legal guardians in the following circumstances:

(1) Death occurs to the person in such a motor vehicle accident;

(2) Injury occurs to the person which consists, in whole or in part, in a significant permanent loss of use of a part or function of the body;

(3) Injury occurs to the person which consists of a permanent and serious disfigurement which results in subjection of the injured person to mental or emotional suffering; or

(4) Injury occurs to the person in a motor vehicle accident and as a result of such injury that the personal injury protection benefits incurred by such person equal or exceed $5,000; provided that in calculating this amount:

(A) The following shall be included:
(i) Personal injury protection benefits incurred by, paid to or payable to, or on behalf of, an eligible injured person including amounts paid directly by or on behalf of the eligible insured because of the accidental harm or similar benefits under social security, worker's compensation, or public assistance laws;
(ii) The applicable amounts of deductible or copayment paid or incurred;
(iii) Amounts paid by or on behalf of an injured person who is not entitled to personal injury protection benefits, by health insurance or other funds; provided that payment in excess of the charges or services allowable under this chapter shall not be included;
(iv) Where an eligible injured person receives coverage on other than a fee for service basis including, but not limited to, a health maintenance organization operating on a capitation basis, the value of services provided shall be determined in accordance with the fee schedules allowable under this chapter for purposes of threshold determination;
(B) When a person has optional coverage, benefits received in excess of the maximum basic personal injury protection limits set forth in section 431:10C-103.5 shall not be included.

(c) Subsections (a) and (b) shall apply whether or not the injured person is entitled to receive personal injury protection benefits. The party against whom the presumption under this section is directed shall have the burden of proof to rebut the presumption.

(d) No claim may be made for benefits under the uninsured motorist coverage by an injured person against an insurer who has paid or is liable to pay motor vehicle insurance benefits to the injured person

unless the claim meets the requirements of this article.

(e) No provision of this article shall be construed to exonerate, or in any manner to limit:

(1) The liability of any person in the business of manufacturing, retailing, repairing, servicing, or otherwise maintaining motor vehicles, arising from a defect in a motor vehicle caused, or not corrected, by an act or omission in the manufacturing, retailing, repairing, servicing, or other maintenance of a vehicle in the course of the person's business;

(2) The criminal or civil liability, including special and general damages, of any person who, in the maintenance, operation, or use of any motor vehicle:

(A) Intentionally causes injury or damage to a person or property;
(B) Engages in criminal conduct that causes injury or damage to person or property;
(C) Engages in conduct resulting in punitive or exemplary damages; or
(D) Causes death or injury to another person in connection with the accident while operating the vehicle in violation of section 291E-61 or section 291-4 or 291-7, as those sections were in effect on or before December 31, 2001.

(f) No provision of this section shall be construed to abolish tort liability with respect to property damage arising from motor vehicle accidents. [L 1987, c 347, pt of §2; am L 1997, c 251, §43; am L 1998, c 275, §§22, 23; am L 2001, c 157, §31]

## Law Journals and Reviews

Key Issues in Hawai'i Insurance Law Answered by the Moon Court. 33 UH L. Rev. 779 (2011).

## Case Notes

Section (pre-1997) does not violate constitutional right to the equal protection of the laws as applied to persons ineligible for no-fault benefits. 87 H. 297, 955 P.2d 90.

Plaintiff did not satisfy minimum level of qualifying expenses necessary to maintain action under subsection (b)(2) (1993) where plaintiff did not present: (1) evidence that medical expenses plaintiff claimed in motor vehicle tort lawsuit were paid, thereby triggering statutory presumption that they were reasonable and necessary; nor (2) expert testimony establishing that the expenses were reasonable and necessary. 88 H. 251, 965 P.2d 793.

Where insured was neither involved in the car accident nor witnessed the accident involving insured's son, insured was precluded from recovering for any emotional distress under subsection (b) and First Insurance Co. of Hawaii v. Lawrence. 108 H. 380, 120 P.3d 1115 (2005).

Where plaintiffs' claim did not accrue until the quantum of the medical care they actually received exceeded the medical-rehabilitative limit set forth in subsection (b)(2) (1993), and plaintiff apparently exceeded that limit, §662-4 afforded plaintiffs two years from the accrual of their claim within which to file their lawsuit; as plaintiffs' claim had accrued by the time they filed their complaint but not more than two years prior, the complaint was timely under §662-4; thus, trial court properly denied defendant's motion to dismiss. 113 H. 459, 153 P.3d 1144 (2007).

Trial court erred in entering judgment for defendant as subsection (b)(2) does not require that jury return verdict in excess of medical-rehabilitative limit established by §431:10C-308, but only requires that "amount paid or accrued" exceeds this limit. 80 H. 188 (App.), 907 P.2d 774.

**§431:10C-307 Reimbursement of duplicate benefits.** Whenever any person effects a tort liability recovery for accidental harm, whether by suit or settlement, which duplicates personal injury protection benefits already paid under the provisions of this article, the motor vehicle insurer shall be reimbursed fifty per cent of the personal injury protection benefits paid to or on behalf of the person receiving the duplicate benefits up to the maximum limit. [L 1987, c 347, pt of §2; am L 1989, c 83, §1; am L 1997, c 251, §44; am L 1998, c 275, §24]

**Case Notes**

Cited: 73 H. 403, 833 P.2d 890.
Discussed: 76 H. 304, 875 P.2d 921.

**§431:10C-307.7 REPEALED.** L 2009, c 149, §10.

**Cross References**

Insurance fraud, see §§431:2-401 to 431:2-410.

**§431:10C-307.8 REPEALED.** L 2009, c 149, §11.

**§431:10C-308 REPEALED.** L 1997, c 251, §58.

**§431:10C-308.5 Limitation on charges.** (a) As used in this article, the term "workers' compensation supplemental medical fee schedule" means the schedule adopted and as may be amended by the director of labor and industrial relations for workers' compensation cases under chapter 386, establishing fees and frequency of treatment guidelines. References in the workers' compensation supplemental medical fee schedule to "the employer", "the director", and "the industrial injury", shall be respectively construed as references to "the insurer", "the commissioner", and "the injury covered by personal injury protection benefits" for purposes of this article.

(b) The charges and frequency of treatment for services specified in section 431:10C-103.5(a), except for emergency services provided within seventy-two hours following a motor vehicle accident resulting in injury, shall not exceed the charges and frequency of treatment permissible under the workers' compensation supplemental medical fee schedule. Charges for independent medical examinations, including record reviews, physical examinations, history taking, and reports, to be conducted by a licensed Hawaii provider unless the insured consents to an out-of-state provider, shall not exceed the charges permissible under the appropriate codes in the workers' compensation supplemental medical fee schedule. The workers' compensation supplemental medical fee schedule

shall not apply to independent medical examinations conducted by out-of-state providers if the charges for the examination are reasonable. The independent medical examiner shall be selected by mutual agreement between the insurer and claimant; provided that if no agreement is reached, the selection may be submitted to the commissioner, arbitration or circuit court. The independent medical examiner shall be of the same specialty as the provider whose treatment is being reviewed, unless otherwise agreed by the insurer and claimant. All records and charges relating to an independent medical examination shall be made available to the claimant upon request. The commissioner may adopt administrative rules relating to fees or frequency of treatment for injuries covered by personal injury protection benefits. If adopted, these administrative rules shall prevail to the extent that they are inconsistent with the workers' compensation supplemental medical fee schedule; provided that the fees set forth in the administrative rules adopted by the commissioner shall not exceed the charges permissible under sections 386-21 and 386-21.7.

(c) Charges for services for which no fee is set by the workers' compensation supplemental medical fee schedule or other administrative rules adopted by the commissioner shall be limited to eighty per cent of the provider's usual and customary charges for these services.

(d) Services for which no frequency of treatment guidelines are set forth in the workers' compensation supplemental medical fee schedule or other administrative rules adopted by the commissioner shall be deemed appropriate and reasonable expenses necessarily incurred if so determined by a provider.

(e) In the event of a dispute between the provider and the insurer over the amount of a charge or the correct fee or procedure code to be used under the workers' compensation supplemental medical fee schedule, the insurer shall:

(1) Pay all undisputed charges within thirty days after the insurer has received reasonable proof of the fact and amount of benefits accrued and demand for payment thereof; and

(2) Negotiate in good faith with the provider on the disputed charges for a period up to sixty days after the insurer has received reasonable proof of the fact and amount of benefits accrued and demand for payment thereof.

If the provider and the insurer are unable to resolve the dispute after a period of sixty days pursuant to paragraph (2), the provider, insurer, or claimant may submit the dispute to the commissioner, arbitration, or court of competent jurisdiction. The parties shall include documentation of the efforts of the insurer and the provider to reach a negotiated resolution of the dispute. This section shall not be subject to the requirements of section 431:10C-304(3) with respect to all disputes about the amount of a charge or the correct fee and procedure code to be used under the workers' compensation supplemental medical fee schedule. An insurer who disputes the amount of a charge or the correct fee or procedure code under this section shall not be deemed to have denied a claim for benefits under section 431:10C-304(3); provided that the insurer shall pay what the insurer believes is the amount owed and shall furnish a written explanation of any adjustments to the provider and to the claimant at no charge, if requested. The provider, claimant, or insurer may submit any dispute involving the amount of a charge or the correct fee or procedure code to the commissioner, to arbitration, or to a court of competent jurisdiction.

(f) The provider of services described in section 431:10C-103.5(a)

shall not bill the insured directly for those services but shall bill the insurer for a determination of the amount payable. The provider shall not bill or otherwise attempt to collect from the insured the difference between the provider's full charge and the amount paid by the insurer.

(g) A health care provider shall be compensated by the insurer for preparing reports documenting the need for treatments which exceed the workers' compensation supplemental medical fee schedule in accordance with the fee schedule for special reports. The health care provider may assess the cost of preparing a report to the insurer at no more than $20 per page up to a maximum of $75 for each report. [L 1992, c 123, pt of §1; am L 1997, c 251, §45; am L 1998, c 275, §§26, 27; am L 2000, c 138, §2; am L 2001, c 55, §20; am L 2006, c 198, §2; am L 2014, c 231, §3]

**Case Notes**

Fee schedule referenced in this section was intended to apply to medical services rendered as a result of motor vehicle accidents and paid by a no-fault insurer. 73 F. Supp. 2d 1189.

Independent medical examination (IME) provisions in subsection (b) do not apply to a record review performed in isolation, without other accompanying procedures necessary to complete an IME, particularly an in-person examination. 402 F. Supp. 2d 1157 (2005).

Plaintiff had not pled a claim under subsection (e), where plaintiff had not acknowledged that it received any partial payment from defendant insurance company. 685 F. Supp. 2d 1123 (2010).

This section (1993), which referred to the worker compensation treatment schedules adopted by the director of labor and industrial relations in the Hawaii administrative rules (HAR) as the schedules governing payments to no-fault benefit providers under motor vehicle insurance policies, must be construed as having generally incorporated the worker compensation fee schedules as they may have been adopted and amended from time to time; thus, after the director repealed HAR chapter 12-13 and adopted HAR chapter 12-15 in 1996, the latter became the fee schedule governing payments under this section. 105 H. 362, 98 P.3d 233.

An actual examination, physical or otherwise, is an essential component of an "independent medical examination" within the meaning of subsection (b); thus, where physician retained by insurer did not actually examine insured but instead limited the evaluation to a review of insured's records, physician did not perform an independent medical examination within the meaning of subsection (b) and insured did not violate subsection (b) when it declined to seek insured's consent in selecting physician to review insured's records. 119 H. 109, 194 P.3d 1071 (2008).

Insurer did not violate this section by selecting physician to review insured's record without insured's approval where, in the context of subsection (b), a "record reviewer" is not an independent medical examiner. 117 H. 465 (App.), 184 P.3d 780 (2008).

The circuit court did not err by failing to limit plaintiff's recovery for medical expenses to what plaintiff had already received in personal injury protection (PIP) benefits as this section limits the payment of PIP benefits to payments permitted under the workers' compensation schedules and does not preclude a plaintiff injured in an automobile accident from receiving special damages beyond what plaintiff received in PIP benefits. 124 H. 236 (App.), 240 P.3d 899 (2010).

Based on the clarification provided by Act 198, L 2006 and its legislative history, insured had standing and was a real party in interest who was entitled to pursue insured's administrative action which challenged insurer's refusal to pay insured's medical provider for

acupuncture treatments provided to insured. 124 H. 415 (App.), 245 P.3d 488 (2011).

Cited: 732 F. Supp. 2d 1107 (2010).

**§431:10C-308.6 REPEALED.** L 1997, c 251, §59.

**§431:10C-308.7 Client-patient referrals, health care provider practices prohibited.** (a) An attorney or a law firm of which the attorney is a member or by which the attorney is employed may not establish a pattern of consistently referring clients to the same health care provider as a result of any accidental harm which is subject to benefits under this article, and a health care provider may not establish a pattern of consistently referring patients to the same attorney or law firm as a result of any accidental harm which is subject to benefits under this article. Any attorney, or any attorney from the law firm of which the attorney is a member or by which the attorney is employed, and that health care provider engaged in such pattern shall be presumed to be in violation of this section.

As used in this section, "law firm" means any sole proprietorship, partnership, corporation, or other entity having members or employees who engage in the practice of law in this State.

(b) No health care provider shall engage in, or agree or offer to engage in, fee splitting. For the purposes of this subsection, "fee splitting" means the payment, or acceptance of payment, by a health care provider, of any portion of a health care fee, or a commission, in return for the referral of a patient for any service or treatment for which personal injury protection benefits are provided under this chapter.

(c) No health care provider shall refer, for any service or treatment authorized under this chapter, a patient to any entity in which the referring provider has a financial interest unless the referring provider has disclosed that financial interest to the patient.

For the purposes of this section "financial interest" shall mean an ownership or investment interest through debt, equity, or any other means. "Financial interest" does not refer to salary or other compensation paid to physicians by a health maintenance organization, or any compensation arrangement involving payment by a group practice which contracts with a health maintenance organization to a physician in the same group practice or entity affiliated with the health maintenance organization for services provided to a member of the health maintenance organization.

(d) The health care provider shall make the disclosure required by this section in advance and in writing, and shall obtain the signature of the patient and retain the disclosure form for a period of two years. The health care provider shall include in the disclosure a statement indicating that the patient is free to choose a different health care provider.

(e) The regulated industries complaints office, department of commerce and consumer affairs, shall refer reports of any attorney in violation of this section to the appropriate professional licensing or regulatory body, for investigation and disciplinary action, including the suspension or revocation of the attorney's license to practice.

(f) The regulated industries complaints office, department of commerce and consumer affairs, may initiate investigations and disciplinary action to enforce this section regarding any reports of

health care provider referrals of persons eligible for benefits under this article that may violate this section.

(g) For the purposes of this section, the term "health care provider" means any person who is licensed to provide health care services pursuant to chapters 436E, 442, 448, 452, 453, 455, 457G, 459, 461J, 463E, and 465. [L 1992, c 123, pt of §1; am L Sp 1993, c 4, §6; am L 1995, c 23, §1; am L 1997, c 251, §46; am L 2009, c 11, §51]

**§431:10C-309 Total loss motor vehicle claims.** When a motor vehicle insurance policy provides for the adjustment and settlement of an insured's motor vehicle's total losses on the basis of actual cash value or replacement, the insurer shall follow either the replacement method set forth in section 431:10C-310 or the cash settlement method set forth in section 431:10C-311. [L 1987, c 347, pt of §2; am L 1997, c 251, §47]

**§431:10C-310 Total loss motor vehicle claims: replacement.** When an insurer elects under section 431:10C-309 to offer the insured a replacement vehicle as defined in section 431:10C-103, the insurer shall comply with the following requirements:

(1) The claim file, which is maintained by the insurer, shall contain a description of the replacement vehicle, including the vehicle identification number and a schedule of options;

(2) Replacement vehicles of the current model plus the three previous model years shall be purchased through motor vehicle dealers licensed under chapter 437. This requirement may be waived in writing by the insured. The signed waiver shall be maintained in the insurer's claim file;

(3) If the insurer offers a replacement vehicle to the insured and the insured rejects the offer and elects a cash settlement instead of the replacement vehicle, the insurer need pay only the amount it would have otherwise paid on the replacement vehicle. Evidence of the insured's rejection shall be apparent in the file; and

(4) If the insurer offers a replacement vehicle to the insured and the insured rejects the offer and wants another vehicle substantially similar in value, the insurer need pay only the amount it would have otherwise paid on the replacement vehicle. The insurer shall maintain in the claim file the insured's written waiver that the acceptance of another vehicle is of the insured's own free will and choice. [L 1987, c 347, pt of §2; am L 1997, c 251, §48]

**§431:10C-311 Total loss motor vehicle claims: cash settlement.** (a) When an insurer elects under section 431:10C-309 to offer the insured a cash settlement for a total loss motor vehicle claim, the following shall apply:

(1) The cash settlement shall be based upon the retail value of the motor vehicle as determined from a source or sources which are reflective of the market value of the total loss vehicle.

(2) The use of dealer quotations (when the vehicle is available at the quoting dealer's lot) and newspaper advertisements may be used in lieu of the source generally used by the insurer, if the claim file reflects that the vehicle was not quoted in the source generally used by the insurer or the source was not reflective of the market value. Dealer quotations and newspaper advertisements shall not be considered sole sources reflective of market values. When dealer quotations are used, the vehicle identification number shall be contained in the insured's claim file;

(3) Estimates from at least three licensed dealers may be used when vehicles are not quoted in the source

usually used by the insurer and are not available for replacement. Dealer estimates shall take into consideration the condition of the insured vehicle prior to the loss; and

(4) The documentation of the determination of the total loss vehicle market value shall be maintained in the insurer's claim file.

(b) If within thirty days of the receipt of the settlement by the insured (i) the insured cannot purchase a comparable vehicle of like kind and quality for the market value determined by the insurer before applicable deductions, and (ii) the insured has located, but not purchased, a comparable vehicle of like kind and quality in excess of such market value, the following procedure shall apply:

(1) The insurer shall locate a comparable vehicle of like kind and quality for the insured for the market value determined by the insurer at the time of settlement. Any comparable vehicle shall be available through licensed dealers;

(2) The insurer shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured;

(3) The insurer may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or at common law; or

(4) The insurer shall provide written notice to the insured at the time of settlement that if within thirty days of the receipt of the settlement by the insured, the insured cannot purchase a comparable vehicle of like kind and quality for the market value determined by the insurer before applicable deductions and the insured has located, but not purchased a comparable vehicle of like kind and quality in excess of such market value, the insurer shall reopen its claim file.

(c) Deductions of the kind commonly referred to as "get ready to go" and "dealer prep" or dealer preparation charges are prohibited. [L 1987, c 347, pt of §2]

**§431:10C-312 Payment of excise tax and certificate of ownership fee.** (a) When a replacement vehicle is provided under section 431:10C-310 or section 431:10C-311, the insurer shall pay the applicable general excise tax and ownership fee as follows:

(1) If a cash settlement is provided, and if within thirty days of the receipt of the settlement by the insured, the insured has purchased a vehicle, the insurer shall reimburse the insured for the applicable general excise tax and certificate of ownership fee incurred on account of the purchase of the vehicle, but not exceeding the amount payable on account of the value of the total loss vehicle.

(2) If the insured purchases a vehicle with a market value less than the amount of the settlement, then the insurer shall reimburse only the amount of the applicable general excise tax and certificate of ownership fee incurred by the insured.

(b) If the insured cannot substantiate the purchase and the payment of the taxes and fee, by submission to the insurer of appropriate documentation within thirty-three days after the receipt of settlement, the insurer shall not be required to reimburse the insured for the taxes or fee.

(c) In lieu of the reimbursement procedure set out in subsection (a), the insurer may directly pay the required amounts of general excise

taxes and certificate of ownership fee to the insured at the time of settlement.

(d) Written notice of the payment procedure outlined in this section shall be communicated to the insured at the time of settlement, together with any form required by the insurer for applying for the reimbursement. [L 1987, c 347, pt of §2]

**§431:10C-313 Insurer practices regarding loss of use, storage and towing, and betterment.** (a) In motor vehicle property damage liability claims in which liability is reasonably clear, the insurer shall pay for the reasonable and necessary costs, in direct proportion to the extent of its liability, incurred in the rental of another motor vehicle as long as the loss of use claim is submitted and substantiated.

(b) (1) The insurer shall provide reasonable notice to an insured prior to termination of payment for motor vehicle storage charges and document the notice in the claim file. Sufficient notice to the insured to allow the insured to remove the vehicle from storage prior to the termination of payment shall constitute reasonable notice.

(2) The insurer shall pay any and all reasonable towing charges, irrespective of the towing company used by the insured, unless the insurer has provided the insured with the name of a specific towing company prior to the insured's use of another towing company. Any determination of reasonable towing charges shall consider policy coverage as well as the cost and distances involved in each claim.

(3) An insurer shall make no advance charge deductions for storage and towing charges unless excessive charges have resulted from the insured's own actions. The insurer shall itemize each advance charge deduction and maintain in its claim file documentation of the reasons and dollar amounts involved in each deduction.

(c) Betterment deductions are allowable only if the deductions:

(1) Reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the insured vehicle;

(2) Are for prior wear and tear, missing parts and rust damage that is reflective of the general overall condition of the vehicle considering its age; provided that any deductions for this type of damage shall not exceed $500; and

(3) Are measurable, itemized, specified as to dollar amount, and documented in the insurer's claim file.

(d) No insurer shall require the insured or claimant to supply parts for replacement. [L 1987, c 347, pt of §2]

**[§431:10C-313.5] Preferred repair provider.** An insurer may have a preferred repair provider program. All insurers having such a program shall:

(1) Make appropriate rate filings with the insurance commissioner to reflect the reduced premiums; and

(2) Offer a choice of no less than two preferred repair providers to the claimant, if available. [L 1997, c 251, pt of §2]

**[§431:10C-313.6] Original equipment manufacturer's and like kind and quality parts.** (a) An insurer shall make available a choice to the insured of authorizing a repair provider to utilize a like kind and

quality part of an equal or better quality than the original equipment manufacturer part if such part is available or an original equipment manufacturer part for motor vehicle body repair work. If the insured or claimant chooses the use of an original equipment manufacturer part, the insured or claimant shall pay the additional cost of the original equipment manufacturer part that is in excess of the equivalent like kind and quality part, unless original equipment parts are required by the vehicle manufacturer's warranty.

(b) A like kind and quality part under subsection (a), of an equal or better quality than the original equipment manufacturer part, shall carry a guarantee in writing for the quality of the like kind and quality part for not less than ninety days or for the same guarantee period as the original equipment manufacturer part, whichever is longer. The guarantee shall be provided by the insurer.

(c) Like kind and quality parts, certified or approved by governmental or industry organizations, shall be utilized if available. [L 1997, c 251, pt of §2]

**§431:10C-314 Jurisdiction.** Any person may bring suit for breach of any contractual obligation assumed by an insurer under a policy of insurance containing such mandatory or optional provisions in any state court of competent jurisdiction. [L 1987, c 347, pt of §2]

**Case Notes**

The first party to choose a forum for resolution of no-fault dispute binds the other party to that forum unless the circuit court finds that the parties have entered into a mandatory and binding arbitration agreement. 86 H. 59, 947 P.2d 371.

**§431:10C-315 Statute of limitations.** (a) No suit shall be brought on any contract providing motor vehicle insurance benefits or any contract providing optional additional coverage more than the later of:

(1) Two years from the date of the motor vehicle accident upon which the claim is based;

(2) Two years after the last payment of motor vehicle insurance benefits;

(3) Two years after the entry of a final order in arbitration;

(4) Two years after the entry of a final judgment in, or dismissal with prejudice of, a tort action arising out of a motor vehicle accident, where a cause of action for insurer bad faith arises out of the tort action; or

(5) Two years after payment of liability coverage, for underinsured motorist claims.

(b) No suit arising out of a motor vehicle accident shall be brought in tort more than the later of:

(1) Two years after the date of the motor vehicle accident upon which the claim is based;

(2) Two years after the date of the last payment of motor vehicle insurance or optional additional benefits; or

(3) Two years after the date of the last payment of workers' compensation or public assistance benefits arising from the motor vehicle accident. [L 1987, c 347, pt of §2; am L 1997, c 251, §49; am L 1998, c 275, §28]

## Case Notes

Section requires suit for breach of contract to be filed within two years after receipt by claimant of last benefit payment. 794 F. Supp. 1012.

Summary judgment granted in favor of defendant with respect to any claim seeking to recover underinsured motorist benefits under automobile insurance policy, where any claim regarding underinsured motorist benefits, including the bad faith denial thereof, was barred by the limitations period set forth in this section (pre-1997 amendment). 11 F. Supp. 2d 1204.

Controlling date for the purpose of calculating the statute of limitations for plaintiff's claims of tortious breach of contract and bad faith denial of insurance benefits was two years after the last payment of motor vehicle insurance benefits; the date of plaintiff's receipt of payment, within three days of the date on which the payment was mailed, was the date on which the statute of limitations began to run. 520 F. Supp. 2d 1212 (2007).

Based on the plain language of subsection (a)(2) (1993), plaintiff's claim for no-fault benefits was not barred, where the last payment of no-fault or optional additional benefits was made not more than two years before plaintiff filed complaint against insurer. 109 H. 537, 128 P.3d 850 (2006).

Where the question of whether the underinsured motorist benefits settlement from non-party insurer would trigger the two-year statute of limitations under subsection (a) (1993) for plaintiff's claim against defendant insurer was an open question of law until this case, there was no bad faith on the part of defendant insurer for having denied plaintiff's claim for no-fault benefits on the basis of the statute of limitations. 109 H. 537, 128 P.3d 850 (2006).

Where plaintiff's negligence action was filed more than two years after insurance company made its lump sum payment to plaintiff in full satisfaction of the release, plaintiff's suit was time-barred. 105 H. 66 (App.), 93 P.3d 1173.

The doctrine of equitable tolling cannot be applied to expand the two-year statute of limitations period in this section (1993) based solely on an issuer's failure to provide a formal notice of denial required pursuant to §431:10C-304(3) (1993) in conjunction with a reduced or partial payment. 117 H. 502 (App.), 184 P.3d 817 (2008).

# PART IV. JOINT UNDERWRITING PLAN

## Subpart A. Participation and Administration

**§431:10C-401 Participation.** (a) A joint underwriting plan is established consisting of all insurers authorized to write and engage in writing motor vehicle insurance in this State, except those insurers writing motor vehicle insurance exclusively under section 431:10C-106.

(b) Each insurer shall be a member of the plan and shall maintain membership as a condition of its licensure to transact such insurance in this State. [L 1987, c 347, pt of §2; am L 1989, c 195, §36]

## Case Notes

Petitioner, who was assigned by the state insurance joint underwriting program bureau to respondent under the assigned claim procedure, was owed a duty of good faith by respondent given that: (1) under the assigned claims procedure, respondent owed the same rights and obligations to petitioner as respondent would owe to an insured to whom respondent had issued a motor vehicle mandatory public liability and property insurance policy; and (2) respondent's good faith covenant implied in motor vehicle policies applied to claimants under the assigned claim procedure irrespective of the absence of a written insurance policy. 129 H. 478, 304 P.3d 619 (2013).

**§431:10C-402 Bureau.** (a) The commissioner shall establish and maintain a joint underwriting plan bureau in the insurance division to receive, assign and supervise the servicing of all assigned claims and all applications for joint underwriting plan coverage.

(b) The commissioner shall adopt regulations for the operation of the bureau, the assignment of applications for joint underwriting plan coverage and assigned claims, and the inspection, supervision and maintenance of this service on a fair and equitable basis in accordance with this article. [L 1987, c 347, pt of §2]

**§431:10C-403 Bureau's duties.** The bureau shall promptly assign each claim and application, and notify the claimant or applicant of the identity and address of the assignee of the claim or application. Claims and applications shall be assigned so as to minimize inconvenience to claimants and applicants. The assignee, thereafter, has rights and obligations as if it had issued motor vehicle mandatory public liability and property damage policies complying with this article applicable to the accidental harm or other damage, or, in the case of financial inability of a motor vehicle insurer or self-insurer to perform its obligations, as if the assignee had written the applicable motor vehicle insurance policy, undertaken the self-insurance, or lawfully obligated itself to pay motor vehicle insurance benefits. [L 1987, c 347, pt of §2; am L 1997, c 251, §50; am L 1998, c 275, §29]

**Case Notes**

Petitioner, who was assigned by the state insurance joint underwriting program bureau to respondent under the assigned claim procedure, was owed a duty of good faith by respondent given that: (1) under the assigned claims procedure, respondent owed the same rights and obligations to petitioner as respondent would owe to an insured to whom respondent had issued a motor vehicle mandatory public liability and property insurance policy; and (2) respondent's good faith covenant implied in motor vehicle policies applied to claimants under the assigned claim procedure irrespective of the absence of a written insurance policy. 129 H. 478, 304 P.3d 619 (2013).

**§431:10C-404 Allocation of costs.** All costs incurred in the operation of the joint underwriting plan bureau and the operation of the plan, including administrative, staff, consultative costs as provided in section 431:10C-215, and claims paid, other than assigned claims as provided in section 431:10C-408(d), shall be allocated fairly and

equitably among the plan members. [L 1987, c 347, pt of §2]

**§431:10C-405 Board of governors.** (a) The commissioner shall establish within the bureau, a board of governors for the purpose of providing expertise and consultation on all matters pertaining to the operation of the bureau and the joint underwriting plan. The board shall be composed of:

(1) Five persons from, and members or representatives of, nationally organized insurers or their domestic insurer affiliates;

(2) One person to represent insurance producers;

(3) Two members, each a self-insurer under this article, and nominated by all the certified self-insurers in the State;

(4) Two members, not affiliated with the foregoing organizations, nominated by such nonaffiliated insurers; and

(5) Two members each, to be selected by the commissioner or nominated by each of the classifications provided for in section 431:10C-407(b).

(b) The commissioner shall provide, after consultation with the board, in the budget of the bureau, funds sufficient to reimburse each member of the board for the actual costs of transportation, overnight housing, food, and other incidental costs of attending to the business and meetings of the board. Otherwise, the members shall serve without compensation.

(c) The board shall elect its chairperson and vice chairperson annually. The first meeting of the board shall be convened by the commissioner within sixty days of the effective date of this article. Thereafter, the board shall meet at its discretion but not less frequently than quarterly. [L 1987, c 347, pt of §2; gen ch 1993; am L 2003, c 212, §85]

**§431:10C-406 Regulations, review, and appellate procedure.** (a) The commissioner shall adopt all necessary and appropriate rules for the execution of the commissioner's duties under this part as provided for in chapter 91.

(b) Any final ruling or disposition by the bureau, or by any assigned insurer or by a self-insurer, shall be appealed to the commissioner. Administrative review, and the regulations promulgated therefor by the commissioner, shall conform to chapter 91.

(c) Judicial review shall be available to any person aggrieved as provided in chapter 91.

(d) The provisions of all other parts of this article apply to the joint underwriting plan, whether direct reference is made or not, unless in conflict with the provisions of this part. [L 1987, c 347, pt of §2; am L 1998, c 275, §30]

Subpart B. Coverages and Assignment of Claims

**§431:10C-407 Classifications.** (a) The commissioner shall establish classifications of eligible persons and uses for which the joint underwriting plan shall provide both the required motor vehicle

insurance policies and any optional additional insurance an eligible person or user applies for. The commissioner shall, by rule, establish, implement, and supervise the joint underwriting plan, through the bureau, assuring that insurance for motor vehicles will be conveniently and expeditiously afforded, subject only to payment or provision for payment of the premium, to all applicants for insurance required by this part to provide insurance for payment of bodily injury and property damage liability insurance, or optional additional benefits, and who cannot reasonably obtain insurance at rates not in excess of those applicable to applicants under the plan, or who otherwise are in good faith entitled to, but unable to obtain, the insurance through ordinary methods.

(b) The plan shall provide all personal injury protection benefits and services and bodily injury and property damage liability coverages to the limits and coverages specified in this article for all classes of persons, motor vehicles, and motor vehicle uses specified in this part upon the payment of premiums as provided in subpart C, as follows:

(1) The plan shall provide personal injury protection benefits and policies for each of the following classes, and each class shall be able to secure a personal injury protection and bodily injury and property damage liability policy through the plan:

(A) All motor vehicles owned by licensed assigned risk drivers as the commissioner, by rules, shall define. The commissioner shall regulate the class in accordance with the general practice of the industry, the applicable results, if any, of the commissioner's examination of the motor vehicle insurers' business records and experience, and any applicable and scientifically credible governmental or academic studies of the multi-accident or high-risk motor vehicle driver;

(B) All motor vehicles owned by licensed drivers convicted within the thirty-six months immediately preceding the date of application, in any jurisdiction of any one or more of the offenses of, or of the offenses cognate to:

(i) Heedless and careless driving;

(ii) Driving while license suspended or revoked;

(iii) Leaving the scene of an accident;

(iv) Manslaughter, if resulting from the operation of a motor vehicle;

(v) Operating a vehicle under the influence of an intoxicant as provided in section 291E-61; or

(vi) Driving under the influence of an intoxicating liquor as provided in section 291-4 or any drug as provided in section 291-7, as those sections were in effect on or before December 31, 2001;

(C) All commercial uses, first class, defined as any commercial use engaged in the transport of passengers for hire or gratuity;

(D) All commercial uses, second class, defined as any commercial, business, or institutional use other than the transport of passengers as described in subparagraph (C) or the exclusive use of a vehicle for domestic-household-familial purposes; and

(E) All other motor vehicles, not classified under subparagraph (A), (B), (C), or (D), owned by licensed drivers who are unable to obtain motor vehicle insurance policies and optional additional insurance through

ordinary methods;

(2) The plan shall provide personal injury protection benefits and bodily injury and property damage policies for all classes of persons, motor vehicles, and motor vehicle uses, at the premiums specified under subpart C, at the option of the owners, for the following classes, which the commissioner, by rules, shall further define and regulate:

(A) All licensed drivers, or unlicensed permanently disabled individuals unable to operate their motor vehicles, who are receiving public assistance benefits consisting of direct cash payments, or who received public assistance benefits in the form of medical services prior to July 1, 1994, and are still receiving the benefits, through the department of human services, or benefits from the Supplemental Security Income program under the Social Security Administration; provided that the licensed drivers, or unlicensed permanently disabled individuals unable to operate their motor vehicles, are the sole registered owners of the motor vehicles to be insured; provided further that not more than one vehicle per public assistance unit shall be insured under this part, unless extra vehicles are approved by the department of human services as being necessary for medical or employment purposes; provided further that the motor vehicle to be insured shall be used strictly for personal purposes, and not for commercial purposes;

(B) Any licensed physically handicapped driver, including drivers with any auditory limitation; and

(C) Any licensed driver who is a minor under foster care and whose parents are unable to pay for the minor's motor vehicle insurance as provided in [section 346-17.3].

Each category of driver/owner under subparagraphs (A), (B), and (C) may secure motor vehicle insurance coverage through the plan at the individual's option; provided any previous motor vehicle insurance policy has expired or has been canceled. Any person becoming eligible for plan coverage under subparagraph (A) shall first exhaust all paid coverage under any motor vehicle insurance policy then in force before becoming eligible for plan coverage.

Any person eligible or becoming eligible under rules adopted by the commissioner under subparagraph (B) or (C) may at any time elect coverage under the plan and terminate any prior private insurer's coverage.

A certificate shall be issued by the department of human services indicating that the person is a bona fide public assistance recipient as defined in subparagraph (A). The certificate shall be deemed a policy for the purposes of this chapter upon the issuance of a valid motor vehicle insurance identification card pursuant to section 431:10C-107; and

(3) Under the joint underwriting plan, the required motor vehicle policy coverages as provided in section 431:10C-301 shall be offered by every insurer to each eligible applicant assigned by the bureau. In addition, uninsured motorist and underinsured motorist coverages shall be offered in conformance with section 431:10C-301, and optional additional coverages shall be offered in conformance with section 431:10C-302, for each class except the class defined in paragraph (2)(A), as the commissioner, by rules, shall provide.

(c) The commissioner may further refine the definitions of the classifications provided for in subsection (b). [L 1987, c 347, pt of §2; am L 1990, c 253, §2; am L 1993, c 205, §29; am L Sp 1993, c 4, §7; am L 1994, c 225, §1; am L 1997, c 251, §51; am L 1998, c 275, §31; am L 1999, c 142, §3; am L 2001, c 157, §32; am L 2006, c 289, §4]

**§431:10C-408 Assigned claims.** (a) Each person sustaining accidental harm, or such person's legal representative, may, except as provided in subsection (b), obtain the motor vehicle insurance benefits through the plan whenever:

(1) No liability or uninsured motorist insurance benefits under motor vehicle insurance policies are applicable to the accidental harm;

(2) No such insurance benefits applicable to the accidental harm can be identified; or

(3) The only identifiable insurance benefits under motor vehicle insurance policies applicable to the accidental harm will not be paid in full because of financial inability of one or more self-insurers or insurers to fulfill their obligations.

(b) A person, or such person's legal representative, shall be disqualified from receiving benefits through the plan if:

(1) Such person is disqualified for criminal conduct under section 431:10C-305(d) from receiving the motor vehicle insurance benefits; or

(2) Such person was:

(A) The owner or registrant of the motor vehicle at the time of the motor vehicle's involvement in the accident out of which such person's accidental harm arose;
(B) The operator or any passenger of such a vehicle at such time with reason to believe that such vehicle was an uninsured motor vehicle.

(c) Any person eligible for benefits under this part, and who becomes eligible to file a claim or an action against the mandatory bodily injury liability or property damage liability policies, shall, upon the bureau's determination of eligibility, be entitled to:

(1) The full personal injury protection benefits as if the victim had been covered as an insured at the time of the accident producing the accidental harm, but not including an owner, operator, or passenger of a motorcycle or motor scooter, as defined in section 286-2, or a pedestrian incurring accidental harm arising out of a motorcycle or motor scooter accident, as defined in section 431:10G-101; and

(2) The rights of claim and action against the insurer, assigned under section 431:10C-403, with reference to the mandatory bodily injury liability policy for accidental harm, and with reference to the mandatory property damage liability policy for property damage sustained.

Any claims of an eligible assigned claimant against either mandatory bodily injury liability or property damage liability policies, or the basic personal injury protection policy, shall be filed with the insurer assigned and shall be subject to all applicable conditions and provisions of this subpart and subpart A, except that the date of notification of the assignment shall, where applicable, be substituted for the date of the accident for purposes of section 431:10C-315.

(d) By rules adopted by the commissioner, each self-insurer shall be assessed its equitable proration of all costs and claims paid under this part annually. No claim shall be assigned to any self-insurer for servicing. Proration for insurers and self-insurers shall be founded upon a pro rata distribution for each premium dollar actually or theoretically received. Self-insurers shall be assessed that prorated

amount based upon the total premium cost for the coverage and vehicles stated in its certificate of self-insurance, as if the self-insurer had sold the coverage at the premium rates applicable under subpart C.

(e) If a person qualifies for assignment or benefits under this part, the joint underwriting plan or any insurer to whom the claim is assigned by the plan shall be subrogated to the rights of the person and shall have a claim for relief or a cause of action, separate from that of the persons, to the extent that:

(1) It has paid personal injury protection benefits; and

(2) Elements of damage compensated for by the plan, with reference to the mandatory motor vehicle insurance or bodily injury policies and to the mandatory property damage policy for property damage sustained, are paid. [L 1987, c 347, pt of §2; am L 1989, c 208, §5; am L 1993, c 205, §30; am L 1997, c 251, §52; am L 1998, c 275, §32; am L 2001, c 14, §1]

**Case Notes**

Where assignee insurer made no offer of uninsured motorist coverage to insured public assistance recipient, assignee insurer did not demonstrate an "applicable" and "identifiable" alternative to insured's assigned claim so as to relieve the assignee insurer under this section of the duty to compensate insured. 112 H. 184, 145 P.3d 727 (2006).

Petitioner, who was assigned by the state insurance joint underwriting program bureau to respondent under the assigned claim procedure, was owed a duty of good faith by respondent given that: (1) under the assigned claims procedure, respondent owed the same rights and obligations to petitioner as respondent would owe to an insured to whom respondent had issued a motor vehicle mandatory public liability and property insurance policy; and (2) respondent's good faith covenant implied in motor vehicle policies applied to claimants under the assigned claim procedure irrespective of the absence of a written insurance policy. 129 H. 478, 304 P.3d 619 (2013).

Subpart C. Rates

**§431:10C-409 Establishment and criteria.** The commissioner shall, after consultation with the board, establish and promulgate the rating rules, classification standards and rules, rates, rating plans, territories, and policy forms for use in the provision of all motor vehicle insurance issued under the joint underwriting plan, in accordance with the following provisions:

(1) Rates shall not be excessive, inadequate or unfairly discriminatory.

(2) Consideration shall be given to the following:

(A) The plan's past and prospective loss experience within the State;
(B) Contingencies in the administration of motor vehicle insurance sold;
(C) Past and prospective expenses in the sale and administration of motor vehicle insurance;
(D) Income from investments of premiums and other proceeds received on account of joint underwriting plan motor

vehicle insurance sold; and

(E) All other factors demonstrated to be relevant by a current actuarially sound study of the definable risks involved.

(3) The commissioner may:

(A) Establish rating territories and group risks by classifications for the establishing of rates and minimum premiums;

(B) Provide for, by regulation, a uniform classification of risks and rating territories for the various coverages;

(C) Modify classification rates to produce rates in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks including vehicles, occupations, past traffic convictions, and involvement in past accidents, provided they are established to have a demonstrable effect upon losses or expense; and

(D) Ensure that no standard or rating plan shall be based, in whole or in part, directly or indirectly, upon a person's race, creed, ethnic extraction, age, sex, length of driving experience, credit bureau rating, marital status, or physical handicap. [L 1987, c 347, pt of §2; am L Sp 1993, c 4, §8]

**§431:10C-410 Schedules.** The commissioner shall:

(1) Set rate schedules periodically, but not less frequently than annually, for all classes in accordance with this part and the criteria in paragraph (3), so that the total premium income, from all plan motor vehicle insurance, when combined with the investment income, shall annually fund the costs of all joint underwriting plan classes, the joint underwriting assigned claims plan, and the administration of the plans;

(2) Prior to setting rates in accordance with paragraph (1), hold a public hearing on the proposed rates to afford all interested persons an opportunity to be heard. Notice shall be published and the hearing shall be held in accordance with chapter 91;

(3) Establish rates for the following classes within the following restrictions:

(A) For the licensed public assistance driver, as defined in section 431:10C-407(b)(2)(A), or the licensed foster care driver, as defined in section 431:10C-407(b)(2)(C), no premium shall be assessed for the mandatory minimum personal injury protection, bodily injury, or property damage coverages; and all policies shall conform to section 431:10C-407(b)(2); and

(B) For the licensed physically handicapped driver, including drivers with any auditory limitation, defined in section 431:10C-407, no rate shall be set higher than that assessed a comparable driver without limitation, except that a higher rate may be surcharged under any applicable standard conforming with section 431:10C-409(3); and

(4) Set various systems and schedules of rates based upon the risks involved, the experience with various exposures, uses, and drivers, and may include the establishment of surcharges for specific risks, drivers, and uses for each of the enumerated classes except the classes limited under paragraph (3). [L 1987, c 347, pt of

§2; am L 1997, c 251, §53; am L 1998, c 275, §33; am L 2006, c 289, §5]

**§431:10C-411 Optional additional coverages.** The commissioner shall, in the same manner as in section 431:10C-410, set rates for any optional additional coverages the plan shall offer. [L 1987, c 347, pt of §2]

**§431:10C-412 Adjustment and refund.** The commissioner may:

(1) Adjust any rate to reflect any excess premiums charged during any premium year, or in any subsequent premium year; and

(2) Order a refund to any class. [L 1987, c 347, pt of §2]

## PART V. MOTORCYCLES AND MOTOR SCOOTERS--REPEALED

**§§431:10C-501 to 504 REPEALED.** L 1989, c 208, §6.

### Cross References

For present provisions, see article 10G, this chapter.

## [PART VI. SELF-INSURER REQUIREMENTS]

**[§431:10C-601] Agreement.** The applicant shall execute and file with the commissioner an agreement in a form prescribed by the commissioner, that if certified as a self-insurer the applicant shall:

(1) Permit the commissioner or an authorized representative to inspect and copy records and provide them copies of records pertaining to the self-insurer's financial condition, processing and payment of claims, and any other matters pertinent to the administration and enforcement of this article; and

(2) Provide all mandatory benefits required under this article and comply with all requirements of articles 10C and 13, and with the rules and directives of the commissioner, including, but not limited to, those relating to processing and payment of assessments and fees. [L 2000, c 24, pt of §3]

**§431:10C-602 Surety bond or deposit of security; proof of financial ability.** An applicant for self-insurance shall:

(1) (A) File with the commissioner and maintain a bond of a surety company authorized to do business in the State, conditioned for the payment of benefits and amounts as would be payable if the applicant were insured under a motor vehicle insurance policy as prescribed in this article. The bond shall be in the form and penal sum acceptable to the commissioner, but in no event shall be less than $300,000, and shall provide that the bond may not be canceled or otherwise terminated until two years have elapsed from the last day the applicant was self-insured, unless the commissioner has given prior written consent. It shall be undertaken and may be enforced in the name of "Commissioner of Insurance, State of Hawaii".

The surety company may not cancel the bond for the period of certification; or

(B) Deposit with the commissioner cash or those securities as may be legally purchased for investment by insurance companies under this chapter and evidence satisfactory to the commissioner that there are no unsatisfied judgments against the applicant. As used herein, "cash" includes an irrevocable letter of credit issued by a federally insured financial institution whose principal office is located in this State. Prior to the issuance of a certificate of self-insurance the securities and cash, if appropriate, shall be registered in the name of the "Commissioner of Insurance, State of Hawaii". The deposit shall be held to satisfy claims for personal injury protection benefits and liability coverage as prescribed in this article. The commissioner shall deposit the cash or securities with the director of finance. The applicant shall execute an agreement satisfactory in form to the commissioner with respect to the deposit. The cash or market value of the securities deposited shall be in an amount determined by the commissioner to afford security substantially equivalent to that afforded under a motor vehicle insurance policy, but in no event less than $300,000 and shall provide that the cash or securities shall not be withdrawn until two years have elapsed from the last day the applicant was self-insured, unless the commissioner has given prior written consent; and

(2) Furnish the commissioner satisfactory proof of the applicant's solvency and financial ability to timely pay benefits and amounts as would be payable if the applicant were insured under this article. The commissioner shall consider the assets, liabilities, profit, loss records, and liquidity of the applicant, the number of vehicles involved, the exposure, and other factors appropriate to determining whether the applicant qualifies as a self-insurer. [L 2000, c 24, pt of §3; am L 2004, c 122, §42]

**[§431:10C-603] Proof of ability to process and pay claims promptly.** An applicant for self-insurance shall submit proof satisfactory to the commissioner that the applicant has retained an adjuster licensed under this chapter to provide a complete claims service to process and promptly pay claims in accordance with this article and article 13. During the period that the applicant is self-insured, the applicant shall immediately refer all claims to the adjuster for processing. From time to time, the commissioner may require a self-insurer to show that the self-insurer is continuing to maintain an effective claims service. [L 2000, c 24, pt of §3]

**[§431:10C-604] Issuance of certificate of self-insurance.** The commissioner shall issue a certificate of self-insurance if:

(1) The applicant has provided the bond, cash, or securities and proof of qualification as a self-insurer affording security substantially equivalent to that afforded under a motor vehicle insurance policy; and

(2) The commissioner is satisfied that in case of injury, death, or property damage, any claimant would have the same rights against the self-insurer as the claimant would have had if a motor vehicle insurance policy was applicable. [L 2000, c 24, pt of §3]

**[§431:10C-605] Duty to notify commissioner.** A self-insurer shall notify the commissioner in writing of any change in status of any motor vehicle which is self-insured, such as a transfer, sale, removal from the State, or any additional motor vehicle which the self-insurer desires to self-insure within ten working days after the change is effected. [L 2000, c 24, pt of §3]

**[§431:10C-606] Duration of certification.** A certificate of self-insurance is valid for a period of one year from the date of issuance and may be renewed annually. [L 2000, c 24, pt of §3]

**[§431:10C-607] Revocation of certificate of self-insurance.** The commissioner may revoke a certificate of self-insurance for good cause at any time after providing notice and the opportunity for a hearing in accordance with chapter 91. Failure to comply with this article, rules, orders, or directives of the commissioner, or to pay any lawful fee or assessment is cause for revocation. Upon a revocation, the owner of any self-insured motor vehicle shall not operate or permit operation of the vehicle in the State until the owner has obtained insurance or has received a new certificate of self-insurance from the commissioner. [L 2000, c 24, pt of §3]

**[§431:10C-608] Termination of self-insurer status and withdrawal of security deposit.** (a) A person who terminates the person's status as a self-insurer or whose certificate of self-insurance has been revoked and who obtains a motor vehicle insurance policy for any formerly self-insured motor vehicle or shows that the person does not own any motor vehicle, may apply to the commissioner for the return of the person's security deposit or cancellation of the surety bond.

(b) After a lapse of twenty-four months from termination or revocation of self-insurer status and proof satisfactory to the commissioner that all claims have been fully adjudicated and paid, that all allotments and assessments have been paid, and that the owner has complied with the applicable provisions of this article, rules, orders, and directives of the commissioner, and provisions of the self-insurer's agreement, the commissioner may release the securities deposited or permit the cancellation of the bond. [L 2000, c 24, pt of §3]

## [PART VII.] TRANSPORTATION NETWORK COMPANIES

### Note

Part effective September 1, 2016, and repealed September 1, 2021. L 2016, c 236, §6.

Annual study and report to 2017-2021 legislature by insurance commissioner on impact of L 2016, c 236 on personal motor vehicle insurance policy rates in the State (repealed September 1, 2021). L 2016, c 236, §§3, 6.

**[§431:10C-701] Definitions.** As used in this part:

"Personal vehicle" means a vehicle that is:

(1) Used by a transportation network company driver to provide a prearranged ride;

(2) Owned, leased, or otherwise authorized for use by the transportation network company driver; and

(3) Not a taxicab, limousine, or other for-hire vehicle.

"Prearranged ride" means the provision of transportation by a transportation network company driver to a passenger, beginning when a transportation network company driver accepts a passenger's request for a ride through a digital network or software application service controlled by a transportation network company, continuing while the transportation network company driver transports the requesting passenger, and ending when the requesting passenger, or the last passenger from the requesting passenger's party, departs from the personal vehicle. A prearranged ride shall not include transportation provided through a ridesharing arrangement, as defined in section 279G-1; use of a taxicab, limousine, or other for-hire vehicle; or a regional transportation provider.

"Transportation network company" means an entity that uses a digital network or software application service to connect passengers to transportation network company drivers; provided that the entity:

(1) Does not own, control, operate, or manage the personal vehicles used by transportation network company drivers; and

(2) Is not a taxicab association or a for-hire vehicle owner.

"Transportation network company driver" means an individual who operates a personal vehicle used to transport a passenger between points chosen by the passenger and prearranged through a transportation network company and that is:

(1) Owned, leased, or otherwise authorized for use by the individual;

(2) Not a taxicab or for-hire vehicle; and

(3) Used to provide prearranged rides to passengers.

[L 2016, c 236, pt of §2]

**[§431:10C-702] Relation to other laws.** Solely for the purposes of this article, neither a transportation network company nor a transportation network company driver shall be deemed to be a common carrier by motor vehicle, a contract carrier by motor vehicle, a motor carrier as defined in section 271-4, a taxicab, or a for-hire vehicle service. [L 2016, c 236, pt of §2]

**[§431:10C-703] Transportation network company and transportation network company driver; disclosure; limitations; insurance requirements.** (a) Upon entering into an agreement with a transportation network company driver, a transportation network company shall immediately disclose the following in writing to the transportation network company driver:

(1) The insurance coverage and limits of liability that the transportation network company provides when the transportation network company driver uses a personal vehicle while engaged in a prearranged ride; and

(2) That the transportation network company driver's personal motor vehicle insurance policy might not provide any required or optional coverage when the transportation network company driver uses a personal vehicle while engaged in a prearranged ride.

(b) On or before September 1, 2016, and thereafter, a transportation network company driver or transportation network company on the transportation network company driver's behalf shall maintain a primary motor vehicle insurance policy that recognizes that the transportation network company driver is a transportation network company driver or otherwise uses a personal vehicle to transport passengers for compensation and covers the transportation network company driver:

(1) While the transportation network company driver is logged onto the transportation network company's digital network or software application service; and

(2) While the transportation network company driver is engaged in a prearranged ride.

(c) The following motor vehicle insurance requirements shall apply while a participating transportation network company driver is logged onto the transportation network company's digital network or software application service and is available to receive transportation requests but is not engaged in a prearranged ride:

(1) Primary motor vehicle liability insurance in the amount of at least $50,000 for death and bodily injury per person, $100,000 for death and bodily injury per accident, and $25,000 for property damage per accident, costs of defense outside of all such limits;

(2) Personal injury protection coverage that meets the minimum coverage amount where required by section 431:10C-103.5; and

(3) The coverage requirements of this subsection may be satisfied by any of the following:

(A) A motor vehicle insurance policy maintained by the transportation network company driver;
(B) A motor vehicle insurance policy maintained by the transportation network company; or
(C) Any combination of subparagraphs (A) and (B).

(d) The following motor vehicle insurance requirements shall apply while a transportation network company driver is engaged in a prearranged ride:

(1) Primary motor vehicle liability insurance that provides at least $1,000,000 for death, bodily injury, and property damage per accident, costs of defense outside such limits;

(2) Personal injury protection coverage that meets the minimum coverage amount where required by section 431:10C-103.5; and

(3) The coverage requirements of this subsection may be satisfied by any of the following:

(A) A motor vehicle insurance policy maintained by the transportation network company driver;
(B) A motor vehicle insurance policy maintained by the transportation network company; or
(C) Any combination of subparagraphs (A) and (B).

(e) If insurance maintained pursuant to subsection (c) or (d) has lapsed or does not provide the required coverage, the transportation

network company insurer shall provide the coverage required by this section beginning with the first dollar of a claim and shall have the duty to defend the claim.

(f) Insurers providing the motor vehicle insurance policies pursuant to this section shall offer the following optional coverages, which any named insured may elect to reject or purchase:

(1) Uninsured and underinsured motorist coverages for the transportation network company driver and passengers, as provided in section 431:10C-301, which shall be equal to the primary liability limits specified in subsections (c) and (d); provided that uninsured and underinsured motorist coverage offers shall also provide for written rejection of the coverages as provided in section 431:10C-301;

(2) Uninsured and underinsured motorist coverage stacking options as provided in section 431:10C-301; provided that the offer of the stacking options shall also provide for written rejection as provided in section 431:10C-301; and

(3) An offer of required optional additional insurance coverages as provided in section 431:10C-302.

(g) In the event the only named insured under the motor vehicle insurance policy issued pursuant to this section is the transportation network company, the insurer or the transportation network company shall:

(1) Disclose the coverages in writing to the transportation network company driver;

(2) Disclose to the transportation network company driver in writing that all optional coverages available may not have been purchased under sections 431:10C-301 and 431:10C-302; and

(3) Obtain a written acknowledgment from the transportation network company driver of receipt of the written disclosures required in paragraphs (1) and (2).

The standard disclosure forms used in paragraphs (1) and (2), and every modification of such forms intended to be used, must be filed with the commissioner within fifteen days of providing such disclosure to the transportation network company driver. The insurer shall also send to the transportation network company driver every modified disclosure form within fifteen days of the filing of such modified disclosure form and comply with paragraph (3). Such disclosures and acknowledgment may be sent and received by electronic means.

(h) Coverage under an insurance policy maintained by the transportation network company shall not be dependent on a personal motor vehicle insurer first denying a claim nor shall a personal motor vehicle insurance policy be required to first deny a claim.

(i) Insurance required by this section may be placed with an insurer licensed under section 431:3-203 or with a surplus lines insurer eligible under section 431:8-301 that has a credit rating of no less than A minus from A.M. Best or A from Demotech or similar rating from another rating agency recognized by the insurance division.

(j) Insurance satisfying the requirements of this section shall be deemed to satisfy the financial responsibility requirement for a motor vehicle under chapter 287, the motor vehicle safety responsibility act.

(k) A transportation network company driver shall carry proof of coverage that meets the requirements of subsections (c) and (d) at all times during the transportation network company driver's use of a personal vehicle in connection with a transportation network company's digital network or software application service. In the event of an accident, a transportation network company driver shall provide this insurance coverage information to the directly interested parties, motor vehicle insurers, and investigating police officers, upon request. Upon

such request, a transportation network company driver shall also disclose to directly interested parties, motor vehicle insurers, and investigating police officers whether the transportation network company driver was logged on to the transportation network company's digital network or software application service or engaged in a prearranged ride at the time of the accident.

(l) Unless specified in the personal motor vehicle insurance policy or endorsement, nothing in this section shall be construed to require a personal motor vehicle insurance policy maintained by a transportation network company driver to provide primary or excess coverage while engaged in a prearranged ride. While the transportation network company driver is engaged in a prearranged ride, and notwithstanding any other law to the contrary, the following shall apply:

(1) The transportation network company driver's or the vehicle owner's personal motor vehicle insurance policy shall not be required to provide any coverage to any person or entity unless the policy expressly provides for that coverage while the driver is engaged in a prearranged ride, with or without a separate charge, or the policy contains an amendment or endorsement to provide coverage while the driver is engaged in a prearranged ride, for which a separately stated premium may be charged; and

(2) The transportation network company driver's or the vehicle owner's personal motor vehicle insurance policy shall not be required to provide a duty to defend or indemnify the driver's activities in connection with the transportation network company, unless the policy expressly provides otherwise while the driver is engaged in a prearranged ride, with or without a separate charge, or the policy contains an amendment or endorsement to provide coverage while the driver is engaged in a prearranged ride, for which a separately stated premium may be charged.

(m) This section shall not restrict any motor vehicle insurance policy coverage applicable to a passenger or pedestrian, other than the limitations in the transportation network company driver's or the vehicle owner's personal motor vehicle insurance policy described in subsection (l).

(n) Notwithstanding any other law to the contrary, a personal motor vehicle insurer may, at its discretion, offer a motor vehicle liability insurance policy, or an amendment or endorsement to an existing policy that covers a private passenger vehicle, station wagon type vehicle, sport utility vehicle, or similar type of vehicle with a passenger capacity of eight persons or less, including the driver, while the driver is logged onto the transportation network company's digital network or software application service, or while engaged in a prearranged ride, if the policy expressly provides for coverage while the driver is logged onto the transportation network company's digital network or software application service or engaged in prearranged rides, with or without a separate charge, or the policy contains an amendment or an endorsement to provide coverage while the driver is logged onto the transportation network company's digital network or software application service or engaged in a prearranged ride, for which a separately stated premium may be charged.

(o) Notwithstanding any other law affecting whether one or more policies of insurance that may apply with respect to an occurrence is primary or excess, this section shall determine the obligations under insurance policies issued to transportation network companies and, if applicable, transportation network company drivers. [L 2016, c 236, pt of §2]

**[§431:10C-704] Records.** (a) A transportation network company

shall maintain:

(1) Global positioning system records and electronic records for each period while a transportation network company driver is logged onto the transportation network company's digital network or software application service or is engaged in a prearranged ride for at least five years from the date each prearranged ride was provided; and

(2) Transportation network company driver records at least until the five-year anniversary of the date on which a transportation network company driver's activation on the transportation network company digital network or software application service has ended.

(b) Records maintained under this section shall be made readily available for purposes of an accident investigation pursuant to section 431:10C-703(k) or resolving any other dispute related to transportation network company drivers while they are logged onto the transportation network company's digital network or software application service or while they are engaged in a prearranged ride, no later than ten days after receipt of a written request for such record. [L 2016, c 236, pt of §2]

**[§431:10C-705] Disclaimers, waiver of liability, and indemnity agreements invalid.** None of the following agreements between a transportation network company or transportation network company driver and a passenger shall be valid or enforceable in this State:

(1) A disclaimer of liability of a transportation network company or transportation network company driver;

(2) A waiver, before the occurrence of an accident, of any claim or right to file a lawsuit by a passenger against a transportation network company or transportation network company driver; or

(3) An agreement by the passenger to defend, indemnify, or hold harmless a transportation network company or transportation network company driver. [L 2016, c 236, pt of §2]

# ARTICLE 10D
# LIFE INSURANCE AND ANNUITIES

## Cross References

Civil relief for state military forces, see chapter 657D.
Risk-based capital for insurers, see §§431:3-401 to 414.

## PART I. INDIVIDUAL LIFE INSURANCE, ANNUITIES AND PURE ENDOWMENT CONTRACTS

**§431:10D-101 Scope.** This part applies to contracts of life insurance and annuities other than group life insurance, group annuities and except as provided in section 431:10D-302, other than industrial life insurance. [L 1987, c 347, pt of §2]

**§431:10D-102 Standard provisions required.** (a) No policy of life

insurance shall be delivered or issued for delivery in this State unless it contains in substance all of the following provisions:

(1) Grace period. A grace period of thirty days shall be allowed during which the policy shall continue in full force. If a claim arises under the policy during the grace period and before an overdue premium is paid, the amount of such premium may be deducted from the policy proceeds.

(2) Entire contract. The policy, or the policy and the application therefor, shall constitute the entire contract between the parties. All statements contained in the application shall, in the absence of fraud, be deemed representations and not warranties. The application shall not constitute a part of the entire contract unless a copy of the application is endorsed upon or attached to the policy when issued.

(3) Incontestability. The policy, exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means, shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two years from its date of issue.

(4) Misstatement of age. If the age of the insured or of any other person whose age is considered in determining the premium has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

(5) Reinstatement. The policy will be reinstated at any time within three years from the date of premium default, unless the policy has been surrendered for its cash surrender value or unless the paid-up term insurance has expired, upon:

(A) Written application for reinstatement;
(B) The production of evidence of insurability satisfactory to the insurer;
(C) The payment of all premiums in arrears; and
(D) The payment or reinstatement of any other indebtedness to the insurer upon the policy, all with interest at a rate not exceeding six per cent a year compounded annually.

(6) Participation in surplus.

(A) In participating policies, that beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, accruing on the policy anniversary or other dividend date specified in the policy. Except as hereinafter provided, any dividend becoming payable shall at the option of the party entitled to elect such option be either:
(i) Payable in cash, or
(ii) Applied to any one of the other dividend options as may be provided by the policy.
(B) If any other dividend options are provided, the policy shall state which option shall be automatically effective if the party shall not have elected some other option before the expiration of the period not less than thirty days following the date on which the dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning of [subparagraph] (A)(i) even though the policy provides that payment of the dividend is to be deferred for a specified period, provided such period does not exceed six years from the date of apportionment, and that interest will be added to the dividend at a specified rate. If a policy

provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under the nonforfeiture provision shall be applied in the manner set forth in the policy.

(7) Table of installments. A table showing the amounts of the guaranteed installments in instances where the policy provides that the proceeds may be payable in installments which are determinable prior to maturity of the policy.

(8) Policy loan.

(A) (i) In the case of policies issued prior to the operative date of the Standard Nonforfeiture Law (section 431:10D-104), a provision that after the policy has been in force three full years, the insurer at any time, while the policy is in force, will:

(I) Advance on proper assignment or pledge of the policy and on the sole security thereof, at a specified rate of interest, a sum equal to or, at the option of the insured, less than the reserve at the end of the current policy year on the policy and on any dividend additions thereto, computed according to a mortality table, interest rate, and method of valuation permitted by section 431:5-307, less a sum of not more than two and one-half per cent of the amount insured by the policy and of any dividend additions thereto; and

(II) Deduct from the loan value any existing indebtedness on the policy and any unpaid balance of the premium for the current policy year, and may collect interest in advance on the loan to the end of the current policy year.

The policy may further provide that the loan may be deferred for not exceeding six months after the application is made.

(ii) This subsection shall not be required in term insurance, nor shall it apply to temporary insurance or pure endowment insurance, issued or granted in exchange for lapsed or surrendered policies.

(B) (i) In the case of policies issued on or after the operative date of the Standard Nonforfeiture Law (section 431:10D-104), a provision that after the policy has a cash surrender value and while no premium is in default, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, at a rate of interest not exceeding eight per cent a year, an amount at the option of the party entitled thereto, not to exceed the loan value less any prior indebtedness on the policy. If the policy shall provide for a rate of return in excess of six per cent a year, the commissioner may require of the insurers that the holders of such policies will benefit through higher dividends or lower premiums. The policy shall also

provide for a loan value at least equal to the cash surrender value of the policy without indebtedness at the end of the then current policy year, less any unpaid balance of the premium for the current policy year, and less interest on the loan to the end of the current policy year. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six months after application is made.

(ii) The policy may also provide that if interest on any indebtedness is not paid when due, it shall then be added to the existing indebtedness and shall bear interest at the same rate, and that if and when the total indebtedness on the policy including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void.

(iii) This subsection shall not apply to term policies nor to term insurance benefits provided by rider or supplemental policy provisions.

(9) Nonforfeiture benefits and cash surrender values.

(A) (i) In the case of policies issued prior to the operative date of the Standard Nonforfeiture Law (section 431:10D-104), a provision that in event of default in premium payments, after premiums shall have been paid for three years, the insured shall be entitled to a stipulated form of insurance the net value of which shall be at least equal to the reserve at the date of default on the policy and on dividend additions thereto, if any, computed according to a mortality table, interest rate, and method of valuation permitted by section 431:5-307, less a percentage (not more than two and one-half) of the amount insured by the policy and of existing dividend additions thereto, if any, and less any existing indebtedness to the insurer on or secured by the policy; provided that:

(I) If the benefits under the policy are calculated according to a more modern table than the American Experience Table of Mortality, the value of any extended term insurance, with accompanying pure endowment, if any, may be calculated according to rates of mortality not exceeding one hundred thirty per cent of the rates according to such more modern table;

(II) The policy may be surrendered to the insurer at its home office within one month of date of default for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as aforesaid; and

(III) The insurer may defer payment for not more than six months after the application is made.

(ii) The policy shall also contain a provision specifying the options to which the policyholder is entitled in

the event of default in a premium payment after three full annual premiums have been paid.

(iii) The policy shall also contain a table showing in figures the loan values and the options available under the policy each year upon default in premium payments, during at least the first twenty years of the policy or during the premium paying period if less than twenty years.

(iv) A provision may be inserted in the policy that in event of default in a premium payment before the options become available, the reserve on any dividend additions then in force may at the option of the insurer be paid in cash or applied as a net premium to the purchase of paid-up term insurance for any amount not in excess of the face of the original policy.

(v) This subsection shall not be required in term insurance of twenty years or less.

(B) In the case of policies issued on or after the operative date of the Standard Nonforfeiture Law (section 431:10D-104), a provision for nonforfeiture benefits and cash surrender values in accordance with the requirements of section 431:10D-104.

(b) Any of the provisions or portions of [subsection (a)](1) through (9) not applicable to single premium policies shall to that extent not be incorporated therein. This section shall not apply to:

(1) Any provision of a life insurance policy relating to disability benefits;

(2) Additional benefits in the event of death by accident or accidental means;

(3) Annuities; or

(4) Pure endowment contracts. [L 1987, c 347, pt of §2; am L 2004, c 122, §43]

**§431:10D-103 Policy loan interest rates for policies issued after June 22, 1982.** (a) For the purposes of this section:

(1) The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

(2) The term policy includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(3) The term policyholder includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

(4) The term policy loan includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due.

(b) Policies issued on or after June 22, 1982, shall provide for maximum policy loan interest rates as follows:

(1) A provision permitting a maximum interest rate of not more than eight per cent per annum; or

(2) A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law.

Insurers issuing policies with interest rates as provided in subsection (b)(2) shall make available policies with interest rates as provided in subsection (b)(1).

(c) The rate of interest charged on a policy loan made under subsection (b)(2) shall not exceed the higher of the following:

(1) The Moody's Corporate Bond Yield Average-Monthly Average Corporate, as published by Moody's Investors Service, Inc. or any successor thereto, for the calendar month ending two months before the date on which the rate is determined; or

(2) The rate used to compute the cash surrender values under the policy during the applicable period plus one per cent per annum;

In the event that the Moody's Corporate Bond Yield Average-Monthly Average Corporate is no longer published by Moody's Investors Service, Inc., a substantially similar average, approved by rule adopted by the commissioner, shall be substituted.

(d) If the maximum rate of interest is determined pursuant to subsection (b)(2), the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy. The maximum rate for each policy shall be determined at regular intervals at least once every twelve months, but not more frequently than once in any three-month period. At the intervals specified in the policy, the rate being charged shall be reduced whenever such reduction as determined under subsection (b)(2) would decrease that rate by one-half per cent or more per annum.

(e) The life insurer shall:

(1) Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(2) Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in paragraph (3); and

(3) Send to policyholders with loans reasonable advance notice of any increase in the rate.

(f) No policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(g) The substance of the pertinent provisions of subsections (a) through (d) shall be set forth in the policies to which they apply. [L 1987, c 347, pt of §2; am L 2004, c 122, §44]

**§431:10D-104 Standard nonforfeiture law for life insurance.** (a) This section shall be known as the Standard Nonforfeiture Law for Life Insurance.

(b) With regard to nonforfeiture benefits of life insurance:

(1) In the case of policies issued on or after the operative date of this section as defined in subsection (i), no policy of life insurance, except as stated in subsection (h), shall be delivered or issued for delivery in this State unless it contains in substance the following provisions, or corresponding provisions that in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with subsection (g):

(A) That, in the event of default in any premium payment, the

company shall grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, of an amount as may be hereinafter specified. In lieu of the stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request no later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(B) That, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company shall pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of an amount as may be hereinafter specified.

(C) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make the election elects another available option not later than sixty days after the due date of the premium in default.

(D) That, if the policy has been paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit that became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company shall pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of an amount as may be hereinafter specified.

(E) In the case of policies that cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, the values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(F) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the jurisdiction in which

the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that the method of computation has been filed with the insurance supervisory official of the jurisdiction in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and a paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which values and benefits are consecutively shown in the policy.

(2) Any of the provisions in paragraph (1) or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(3) The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

(c) With regard to the computation of cash surrender value:

(1) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, regardless of subsection (b), shall be an amount not less than the excess, if any, of the present value, on the anniversary, of the future guaranteed benefits that would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(A) The then present value of the adjusted premiums as defined in subsection (e) corresponding to premiums that would have fallen due on and after the anniversary; and
(B) The amount of any indebtedness to the company on the policy.

(2) For any policy issued on or after the operative date of subsection (e)(8) that provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph (1) shall be an amount not less than the sum of the cash surrender value for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and the cash surrender value as defined in paragraph (1) for a policy that provides only the benefits otherwise provided by the rider or supplemental policy provision.

(3) For any family policy issued on or after the operative date of subsection (e)(8) that defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's seventy-first birthday, the cash surrender value referred to in paragraph (1) shall be an amount not less than the sum of the cash surrender value for an otherwise similar policy issued at the same age without term insurance on the life of the spouse and the cash surrender value as defined in paragraph (1) for a policy that provides only the benefits otherwise provided by term insurance on the life of the spouse.

(4) Any cash surrender value available within thirty days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, regardless of subsection (b), shall be an amount not less than the present value, on the anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(d) With regard to the computation of paid-up nonforfeiture benefits, for any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy

anniversary shall be such that its present value as of the anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value that would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(e) With regard to the calculation of adjusted premiums:

(1) This section shall not apply to policies issued on or after the operative date of paragraph (8). Except as provided in paragraph (4), the adjusted premiums for any policy shall be calculated on an annual basis and shall be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards of the present value at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(A) The then present value of the future guaranteed benefits provided for by the policy;
(B) Two per cent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy;
(C) Forty per cent of the adjusted premium for the first policy year; and
(D) Twenty-five per cent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

(2) In applying the percentages specified in paragraph (1)(C) and (D), no adjusted premium shall be deemed to exceed four per cent of the amount of insurance or level amount equivalent. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(3) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent level amount for the purpose of this subsection shall be deemed to be the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the inception of the insurance as the benefits under the policy.

(4) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to:

(A) The adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits, increased, during the period for which premiums for the term insurance benefits are payable, by
(B) The adjusted premiums for the term insurance.

The foregoing amounts in subparagraphs (A) and (B) being calculated separately and as specified in paragraphs (1) and (3), except that, for the purposes of paragraph (1)(B), (C), and (D), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in paragraph (1)(B) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in subparagraph (A).

(5) Except as otherwise provided in paragraphs (6) and (7), all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table; provided that for any category of ordinary

insurance issued on female risks, adjusted premiums and present values may be calculated according to any age not more than three years younger than the actual age of the insured and the calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half per cent a year, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits.

In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred thirty per cent of the rates of mortality according to the applicable table.

For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on any other table of mortality as may be specified by the company and approved by the commissioner.

(6) This paragraph shall not apply to ordinary policies issued on or after the operative date of paragraph (8). In the case of ordinary policies issued on or after the operative date of this paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that the rate of interest shall not exceed three and one-half per cent a year, except that:

(A) A rate of interest not exceeding four per cent a year may be used for policies issued after June 1, 1976, and prior to June 1, 1979;
(B) A rate of interest not exceeding five and one-half per cent a year may be used for policies issued on or after June 1, 1979; and
(C) For any single premium whole life or endowment insurance policy, a rate of interest not exceeding six and one-half per cent a year may be used.

For any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured.

In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table.

For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After June 1, 1959, any company may file with the commissioner a written notice of its election to comply with this paragraph after a specified date before January 1, 1966. After the filing of such notice, upon the specified date (which shall be the operative date of this paragraph for that company), this paragraph shall become operative with respect to the ordinary policies thereafter issued by the company. If a company makes no such election, the operative date of this paragraph for the company shall be January 1, 1966.

(7) This paragraph shall not apply to industrial policies issued on or after the operative date of paragraph (8). In the case of industrial policies issued on or after the operative date of this paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that the rate of interest shall not exceed three and one-half per cent a year, except that:

(A) A rate of interest not exceeding four per cent a year may be used for policies issued on or after June 1, 1976, and

prior to June 1, 1979;

(B) A rate of interest not exceeding five and one-half per cent a year may be used for policies issued on or after June 1, 1979; and

(C) For any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half per cent a year may be used.

In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table.

For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After May 8, 1965, any company may file with the commissioner a written notice of its election to comply with this paragraph after a specified date before January 1, 1968. After the filing of the notice, upon the specified date (which shall be the operative date of this paragraph for that company), this paragraph shall become operative with respect to the industrial policies thereafter issued by the company. If a company makes no such election, the operative date of this paragraph for the company shall be January 1, 1968.

(8) (A) This paragraph shall apply to all policies issued on or after the operative date of this paragraph. Except as provided in subparagraph (G), the adjusted premiums for any policy shall be calculated on an annual basis and shall be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

(i) The then present value of the future guaranteed benefits provided for by the policy;

(ii) One per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(iii) One hundred twenty-five per cent of the nonforfeiture net level premium as hereinafter defined.

In applying the percentage specified in clause (iii), no nonforfeiture net level premium shall be deemed to exceed four per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this paragraph shall be the date as of which the rated age of the insured is determined.

(B) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

(C) In the case of policies that cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or that provide an option for changes in

benefits or premiums, other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefit or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(D) Except as otherwise provided in subparagraph (G), the recalculated future adjusted premiums for any policy shall be the uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all the future adjusted premiums shall be equal to the excess of the sum of:

(i) The then present value of the then future guaranteed benefits provided for by the policy; and

(ii) The additional expense allowance, if any, over the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(E) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

(i) One per cent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

(ii) One hundred twenty-five per cent of the increase, if positive, in the nonforfeiture net level premium.

(F) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing the value defined in clause (i) by the value defined in clause (ii):

(i) The nonforfeiture net level premium applicable prior to the charge times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the charges on which a premium would have fallen due had the change not occurred, plus the present value of the increase in future guaranteed benefits provided for by the policy; and

(ii) The present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of charge on which a premium falls due.

(G) Notwithstanding any other provision of this paragraph to the contrary, in the case of a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(H) All adjusted premiums and present values referred to in this section shall: for all policies of ordinary insurance be calculated on the basis of either the Commissioners 1980 Standard Ordinary Mortality Table or, at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this paragraph for policies issued in that calendar year; provided that:

(i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding nonforfeiture interest rate, as defined in this paragraph, for policies issued in the immediately preceding calendar year;

(ii) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, regardless of subsection (b), shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any;

(iii) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

(iv) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance;

(v) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables;

(vi) For policies issued prior to the operative date of the valuation manual, any commissioners standard

ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table.

For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner approves by rule any commissioners standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual; and

(vii) For policies issued prior to the operative date of the valuation manual, any commissioners standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner approves by rule any commissioners standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(I) As used in this paragraph, "nonforfeiture interest rate" means:

(i) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five per cent of the calendar year statutory

valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearer one quarter of one per cent; provided that the nonforfeiture interest rate shall not be less than four per cent; and

(ii) For policies issued on or after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be as provided by the valuation manual.

(J) Notwithstanding any other provision in this chapter to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(K) After the effective date of this paragraph, any company may file with the commissioner a written notice of its election to comply with this paragraph after a specified date before January 1, 1989, which shall be the operative date of this paragraph for the company. If a company makes no election, the operative date of this paragraph for the company shall be January 1, 1989.

(L) In the case of any plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on estimates of future experience, or in the case of any plan of life insurance that is of such a nature that minimum values cannot be determined by the methods described in this subsection and subsections (b) to (d), then:

(i) The commissioner shall be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsections (b) to (d) and this subsection;

(ii) The commissioner shall be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(iii) The cash surrender values and paid-up nonforfeiture benefits provided by the plan shall not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by rules adopted by the commissioner.

(f) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (c), (d), and (e) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding subsection (c) to the contrary,

additional benefits payable:

(1) In the event of death or dismemberment by accident or accidental means;

(2) In the event of total and permanent disability;

(3) As reversionary annuity or deferred reversionary annuity benefits;

(4) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply;

(5) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child; and

(6) As other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits,

shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(g) This subsection, in addition to all other applicable subsections, shall apply to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount that does not differ by more than two-tenths of one per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of the greater of zero and the basic cash value hereinafter specified, and the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value shall be equal to the present value, on the anniversary, of the future guaranteed benefits that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums that would have fallen due on and after the anniversary. The effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (c) or (e)(1), (2), (3), (4), and (5), whichever is applicable, shall be the same as are the effects specified in subsection (c) or (e)(1), (2), (3), (4), and (5), whichever is applicable, on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (e)(1), (2), (3), (4), and (5) or subsection (e)(8), whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, the percentage:

(1) Shall be the same for each policy year between the second policy anniversary and the later of:

(A) The fifth policy anniversary; and

(B) The first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one

per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(2) Shall be such that no percentage after the later of the two policy anniversaries specified in paragraph (1) may apply to fewer than five consecutive policy years.

No basic cash value may be less than the value that would be obtained if the adjusted premiums for the policy, as defined in subsection (e)(8), were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (b), (c), (d), (e)(8), and (f). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed in subsection (f)(1) to (6) shall conform with the principles of this subsection.

(h) This section shall not apply to any of the following:

(1) Reinsurance;

(2) Group insurance;

(3) Pure endowment;

(4) Annuity or reversionary annuity contract;

(5) Term policy uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy;

(6) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsection (e), is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy;

(7) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year calculated as specified in subsections (c), (d), and (e), exceeds two and one-half per cent of the amount of insurance at the beginning of the policy year; and

(8) Policy that shall be delivered outside this State through a producer or other representative of the company issuing the policy.

For purposes of determining the applicability of this section, the

age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(i) After January 1, 1956, any company may file with the commissioner a written notice of its election to comply with this section after a specified date within six months from January 1, 1956. After the filing of the notice, then upon the specified date (which shall be the operative date for the company), this section shall become operative with respect to the policies thereafter issued by the company. If a company makes no election, the operative date of this section for the company shall be six months from January 1, 1956.

(j) As used in this section, "operative date of the valuation manual" means the January 1 of the first calendar year that the valuation manual, as defined in section 431:5-307(t), is effective. [L 1987, c 347, pt of §2; am L 2003, c 212, §86; am L 2004, c 122, §45; am L 2014, c 234, §5]

**§431:10D-105 Annuities and pure endowment contracts; standard provisions required.** (a) No annuity or pure endowment contract shall be delivered or issued for delivery in this State unless it contains in substance each of the provisions set forth below:

(1) Grace period. There shall be a grace period of not fewer than thirty days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer, to an interest charge at a rate to be specified in the contract, but not exceeding six per cent a year, for the number of days elapsing before such payment, during which period of grace the contract shall continue in full force. However, if a claim arises under the contract on account of death prior to the expiration of the grace period and before the overdue payment to the insurer of the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

(2) Incontestability. If any statements, other than those relating to age, sex, and identity, are required as a condition to issuing an annuity or pure endowment contract, subject to paragraph (4), the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two years from its date of issue, except for nonpayment of stipulated payments to the insurer. At the option of the insurer, the contract may also except any provisions relative to benefits in the event of disability and any provisions that grant insurance specifically against death by accident or accidental means.

(3) Entire contract. The contract shall constitute the entire contract between the parties, or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

(4) Misstatement of age or sex. If the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefit accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex; and that if the insurer makes or has made any overpayment on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding six per cent a year, may be charged against the current or next succeeding payment to be made by the insurer under the contract.

(5) Dividends. In participating contracts the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract except that at the option of the insurer the participation may be deferred to the end of the third contract year.

(6) Reinstatement. The contract may be reinstated at any time within one year from the date of default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue

stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated, with interest thereon at a rate to be specified in the contract but not exceeding six per cent a year compounded annually. In cases where applicable, the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

(b) Provisions of this section shall not apply to:

(1) Reversionary annuities or survivorship annuities;

(2) Contracts for annuities included in, or upon the lives of beneficiaries under, life insurance policies; or

(3) Single premium annuities or single premium pure endowment contracts. [L 1987, c 347, pt of §2; am L 2004, c 122, §46]

**§431:10D-106 Reversionary annuities; standard provisions required.** (a) No contract for a reversionary annuity shall be delivered or issued for delivery in this State unless it contains in substance the following:

(1) Provisions specified in subsection (a)(1) to (5) of section 431:10D-105, except that under subsection (a)(1) of section 431:10D-105 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue or deferred payment in lieu of providing for a deduction of such payments from an amount payable upon a settlement under the contract.

(2) Provision that the contract may be reinstated at any time within three years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract be paid, or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding six per cent a year compounded annually.

(b) Any of the provisions not applicable to single premium annuities shall not, to that extent, be incorporated therein.

(c) This section shall not apply to annuities included in life insurance policies. [L 1987, c 347, pt of §2]

**§431:10D-107 Standard nonforfeiture law; individual deferred annuities.** *[This section is effective July 1, 2006 but may be applied to annuity contracts on a contract form-by-contract form basis beginning July 1, 2004. L 2004, c 15, §4(2), (3).]* (a) This section shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

(b) This section shall not apply to:

(1) Any reinsurance;

(2) Group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as amended;

(3) Any premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity; or

(4) Any contract which shall be delivered outside this State through a producer or other representative of the insurer issuing the contract.

(c) In the case of contracts issued on or after July 1, 2006, no contract of annuity, except as stated in subsection (b), shall be delivered or issued for delivery in this State unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contract holder upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the insurer will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (g), (h), (i), (j), and (l);

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay in lieu of any paid-up annuity benefit a cash surrender benefit of the amount as specified in subsections (g), (h), (j), and (l). The insurer shall reserve the right to defer the payment of the cash surrender benefit for a period not exceeding six months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered, and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract, or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid would be less than $20 monthly, the insurer may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by the payment shall be relieved of any further obligation under the contract.

(d) The minimum values as specified in subsections (g), (h), (i), (j), and (l), of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this subsection. The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to that time at rates of interest as indicated in subsection (e) of the net considerations paid prior to that time, decreased by the sum of:

(1) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest as indicated in subsection (e);

(2) An annual contract charge of $50, accumulated at rates of interest as indicated in subsection (e);

(3) Any premium tax paid by the insurer for the contract, accumulated at rates of interest as indicated in subsection (e); and

(4) The amount of any indebtedness to the company on the contract, including interest due and accrued.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and five-tenths per cent of the gross considerations credited to the contract during the contract year.

(e) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three per cent a year and the following, which shall be specified in the contract if the interest rate will be reset:

(1) The five-year constant maturity treasury rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one per cent, specified in the contract not later than fifteen months prior to the contract issue date or redetermination date under paragraph (4);

(2) Reduced by one hundred twenty-five basis points;

(3) Where the resulting interest rate is not less than one per cent; and

(4) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. As used in this paragraph, "basis" means the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

(f) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subsection (e)(2) by up to an additional one hundred basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each subsequent redetermination date, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction. The commissioner may adopt rules to implement this subsection and provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

(g) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(h) For contracts which provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, the present value being calculated on the basis of an interest rate not more than one per cent higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the insurer on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under these

contracts shall be at least equal to the cash surrender benefit.

(i) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, the present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any existing additional amounts credited by the insurer to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(j) For the purpose of determining the benefits calculated under subsections (h) and (i), in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be the latest date for which election shall be permitted by the contract, but shall not be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(k) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that the benefits are not provided.

(l) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled consideration beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(m) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding subsections (g), (h), (i), (j), and (l), additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this section. The inclusion of additional benefits shall not be required in any paid-up benefits, unless these additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits. [L 1987, c 347, pt of §2; am L 2002, c 155, §70 and c 210, §1; am L 2004, c 15, §2]

**§431:10D-108 Limitation of liability.** (a) No policy of life insurance shall be delivered or issued for delivery in this State if it contains a provision limiting to less than three years the time within which an action at law or in equity may be commenced after the cause of action shall accrue.

(b) No policy of life insurance shall be delivered or issued for delivery in this State if it contains a provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that the policy may contain provisions excluding or restricting coverage as specified therein in event of death under any one or more of the following circumstances:

(1) Death as a result directly or indirectly of war, declared or undeclared, or of any act or hazard of such war;

(2) Death as a result of aviation under conditions specified in the policy;

(3) Death as a result of a specified hazardous occupation or occupations;

(4) Death while the insured is a resident outside of the United States and Canada; or

(5) Death within two years from the date of issue of the policy as a result of suicide, while sane or insane.

(c) A policy which contains any exclusion or restriction pursuant to subsection (b) shall also provide that in the event of death under circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the valuation method prescribed in the minimum standard required by law upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits (or if the policy provides no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy) with adjustment for indebtedness or dividend credit.

(d) This section shall not apply to annuities and pure endowment contracts, or to any provision of a life insurance policy relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(e) An insurer may specify conditions pertaining to subsections (a), (b) and (c) which in the commissioner's opinion are more favorable to the policyholder. [L 1987, c 347, pt of §2]

**§431:10D-109 Scope of incontestable clauses.** A clause in any policy of life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not the restrictions or exclusions are excepted in the clause. [L 1987, c 347, pt of §2]

**§431:10D-110 Incontestability after reinstatement.** The reinstatement of any policy of life insurance or contract of annuity delivered or issued for delivery in this State may be contestable on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement as the policy provides with respect to contestability after original issuance.

[L 1987, c 347, pt of §2]

**§431:10D-111 Premium deposits.** (a) A life insurer may, under policy provisions or agreements, contract for and accept premium deposits in addition to the regular premiums specified in the policy, for the purpose of paying future premiums, to facilitate conversion of the policy, or to increase the benefits of the policy, according to this section.

(b) The unused accumulation from such deposits shall be held and accounted for as a premium deposit fund, and the policy or agreement shall provide for the manner of application of the premium deposit fund to the payment of premiums otherwise in default and for the disposition of the fund if it is not sufficient to pay the next premium.

(c) Such fund shall:

(1) Be available upon surrender of the policy, in addition to the cash surrender value;

(2) Be payable upon the insured's death or upon maturity of the policy; and

(3) Be paid to the insured whenever the cash surrender value together with the premium deposit fund equals or exceeds the amount of insurance provided by the policy, unless the amount of the deposit does not exceed that which may be required to facilitate conversion of the policy to another plan in accordance with its terms.

(d) No part of the premium deposit fund shall be paid to the insured during the continuance of the policy except at such times and in such amounts as is specified in the policy or in the deposit agreement. [L 1987, c 347, pt of §2; am L 2010, c 116, §1(20)]

**§431:10D-112 Policy settlements.** Any life insurer shall have the power to hold under agreement the proceeds of any policy issued by it, upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries, and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as set forth in the policy or as agreed to in writing by the insurer and the policyholder. Upon maturity of a policy in the event the policyholder has made no such agreement, the insurer shall have the power to hold the proceeds of the policy under an agreement with the beneficiaries. The insurer shall not be required to segregate funds so held but may hold them as part of its general assets. [L 1987, c 347, pt of §2]

**§431:10D-113 Indebtedness deducted from proceeds.** In determining the amount due under any life insurance policy issued, deduction may be made of:

(1) Any unpaid premiums or installments thereof for the current policy year due under the terms of the policy, and

(2) The amount of principal and accrued interest of any policy loan or other indebtedness against the policy then remaining unpaid, such principal increased by unpaid interest and compounded as provided in this part. [L 1987, c 347, pt of §2]

**§431:10D-114 Miscellaneous proceeds.** Upon the death of the insured

and except as is otherwise expressly provided by the policy or premium deposit agreement, a life insurer may pay to the surviving spouse, children, beneficiary, or person other than the insured's estate, appearing to the insurer to be equitably entitled to such payment, sums then held by it and comprising:

(1) Premiums paid in advance, if such premiums did not fall due prior to the death, or funds held on deposit for the payment of future premiums.

(2) Dividends theretofore declared on the policy and held by the insurer under the insured's option.

(3) Dividends becoming payable on or after the death of the insured. [L 1987, c 347, pt of §2]

**§431:10D-115 Dealing in dividends.** No life insurer nor any of its representatives, producers, or affiliates, shall buy, take by assignment other than in connection with policy loans, or otherwise deal or traffic in any rights to dividends existing under participating life insurance policies issued by the insurer. [L 1987, c 347, pt of §2; am L 2002, c 155, §71]

**§431:10D-116 Prohibited policy plans.** No life insurer shall issue for delivery or deliver in this State any life insurance policy:

(1) Issued under any plan for the segregation of policyholders into mathematical groups and providing benefits for a surviving policyholder of a group arising out of the death of another policyholder of such group, or under any other similar plan.

(2) Providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination of the policies of other policyholders, whether by death or otherwise. [L 1987, c 347, pt of §2]

**§431:10D-117 Life franchise plan.** Insurance may be issued pursuant to the provisions of this part on a franchise plan under the terms of which life insurance and annuities, other than group life insurance, group annuities and industrial life insurance, is issued to:

(1) Two or more employees of any corporation, co-partnership, or individual employer or any governmental corporation, agency or department thereof; or

(2) Ten or more members, employees, or employees of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two years where such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance.

Such persons, with or without their dependents, may be issued the same form of an individual policy varying only as to premium, amounts, and kinds of coverage applied for by such persons under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association for its members, or by some designated person acting on behalf of such employer or association. The term employees as used in this section shall be deemed to include the officers, managers and employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. No individual may become insured for more than $20,000 under this plan. [L 1987, c 347,

pt of §2]

**§431:10D-118 Variable contracts.** (a) A domestic life insurance company may, by or pursuant to resolution of its board of directors, establish one or more separate accounts, and may allocate thereto amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance or annuities (and benefits incidental thereto), payable in fixed or variable amounts or both, subject to the following:

(1) The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains or losses of the company.

(2) Except as hereinafter provided, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this State governing the investments of life insurance companies; provided that to the extent that the company's reserve liability with regard to (A) benefits guaranteed as to amount and duration, and (B) funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be, except as the commissioner may otherwise approve, invested, in accordance with the laws of this State governing the investments of life insurance companies. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(3) Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; provided that unless otherwise approved by the commissioner, a portion of the assets of such separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in [subparagraphs] (A) and (B) of subsection (a)(2), if any, shall be valued in accordance with the rules otherwise applicable to the company's assets.

(4) Amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. That portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

(5) No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (A) by a transfer of cash, or (B) by a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the commissioner. The commissioner may approve other transfers among such accounts, if in the commissioner's opinion, such transfers would not be inequitable.

(6) To the extent such company deems it necessary to comply with any applicable federal or state laws, such company, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account.

(b) (1) Any variable contract providing benefits payable in variable amounts delivered or issued for delivery in this State shall contain a statement of the essential features of the procedures to be followed by the

insurance company in determining the dollar amount of such variable benefits. Any such contract, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

(2) Variable contracts delivered or issued for delivery in this State may include as an incidental benefit provision for payment on death during the deferred period of an amount not in excess of the greater of the sum of the premiums or stipulated payments paid under the contract or the value of the contract at time of death. Any such provision shall not be deemed to be life insurance and therefore not subject to the provisions of this code governing life insurance carriers. A provision for any other benefit on death during the deferred period shall be subject to such insurance provisions.

(c) No company shall deliver or issue for delivery within this State contracts under this section unless it is licensed or organized to do a life insurance or annuity business in this State, and the commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this State. In this connection, the commissioner shall consider among other things:

(1) The history and financial condition of the company;

(2) The character, responsibility and fitness of the officers and directors of the company; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable contracts.

A company which issues variable contracts and which is a subsidiary of, or affiliated through common management or ownership with, another life insurance company authorized to do business in this State shall be deemed to have met the provisions of this subsection if either it or the parent or affiliated company meets the requirements of this subsection.

(d) Notwithstanding any other provision of law, the commissioner shall have sole and exclusive authority to regulate the issuance and sale of variable contracts and to provide for licensing of persons selling such contracts, and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of this section.

(e) The provisions of section 431:10D-101 through section 431:10D-106 and section 431:10D-109 shall be inapplicable to variable contracts, nor shall any provision in this code requiring contracts to be participating be deemed applicable to variable contracts. The commissioner, by regulation, may require that any individual variable contract, delivered or issued for delivery in this State, contain provisions as to grace period, reinstatement or nonforfeiture which are appropriate to a variable contract. Except as otherwise provided in this section, all pertinent provisions of this code shall apply to separate accounts and contracts relating thereto. The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees. [L 1987, c 347, pt of §2]

## PART II. GROUP LIFE INSURANCE

**§431:10D-201 Group life insurance requirements.** (a) Except as provided in subsection (b), no policy of group life insurance shall be delivered in this State unless it conforms to one of the descriptions as provided in this article.

(b) Subsection (a) shall not apply to contracts of life insurance insuring only individuals:

(1) Related by marriage, by blood, or by legal adoption; or

(2) Having a common interest through ownership of a business enterprise, or of a substantial legal interest or equity in the business enterprise, and who are actively engaged in its management; or

(3) Otherwise having an insurable interest in each other's lives. [L 1987, c 347, pt of §2]

**§431:10D-202 Employee groups.** (a) The lives of a group of individuals may be insured under a policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustee is deemed the policyholder, insuring employees of the employer for the benefit of persons other than the employer; provided that if the entire cost of the insurance has been borne by the employer and the employer uses the benefits for the purpose of purchasing employer securities distributed to employees from a pension, profit sharing, stock bonus, or employee stock ownership plan which has been qualified under section 401 of the Internal Revenue Code, benefits may be made payable to the employer.

(b) Issuance of group life insurance policies shall be subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term employees shall include:

(A) The employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships, or partnerships, if the business of the employer and of such affiliated corporations, proprietorships, or partnerships is under common control;
(B) The individual proprietor or partners, if the employer is an individual proprietor or a partnership; and
(C) Retired employees.

No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless the individual is actively engaged in and devotes a substantial part of the individual's time to the conduct of the business of the proprietorship or partnership;

(2) The premium for the policy may be paid entirely by the employer, or by funds paid entirely by the insured employees, or by funds contributed by both the employer and the insured employees. Except as provided in paragraph (3), a policy on which no part of the premium is to be derived from funds contributed by the insured employees shall insure all eligible employees, except those who reject such coverage in writing;

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer; and

(4) The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the employer or trustees. [L 1987, c 347, pt of §2; am L 1988, c 330, §3; gen ch 1992; am L 2004, c 122, §47; am L 2008, c 155, §2]

**§431:10D-203 Debtor groups.** The lives of a group of individuals may be insured under a policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees, or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors, subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors or all of any class or classes thereof. The policy may provide that the term debtors shall include:

(A) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;
(B) The debtors of one or more subsidiary corporations; and
(C) The debtors of one or more affiliated corporations, proprietorships, or partnerships, if the business of the policyholder and the affiliate is under common control;

(2) The premiums for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premiums is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible from insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five per cent of the then eligible debtors elect to pay the required charges. Except as provided in paragraph (3), a policy on which no part of the premium is to be derived from the collection of such identifiable charges shall insure all eligible debtors;

(3) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer;

(4) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly, or may reasonably be expected to receive at least one hundred new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five per cent of the new entrants become insured;

(5) The amount of the insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor, except that if the sole purpose of the loan is to provide future advances to the debtor to meet education or education-related expenses of the debtor, the debtor's spouse, children or other dependents, the amount of insurance may equal, but may not exceed, the total amount of the described expenses forecast at the time of entry into the loan agreement with the creditor, less the amount of all repayments by the debtor. In the case of revolving loan or revolving charge accounts, the insurance shall at no time exceed the unpaid indebtedness;

(6) The insurance shall 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, whenever the amount of insurance exceeds the unpaid indebtedness, any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate; and

(7) Payment by the debtor insured under any such group life insurance contract of an amount not in excess of the premium charged the creditor by the insurer for such insurance pertaining to the debtor, shall not be deemed to constitute a charge upon a loan in violation of any banking or usury law or any law regulating installment sales. [L 1987, c 347, pt of §2; am L 2004, c 122, §48]

**§431:10D-204 Labor union groups.** The lives of a group of

individuals may be insured under a policy issued to a labor union, which shall be deemed the policyholder, to insure members of the union for the benefit of persons other than the union or any of its officials, representatives, or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof;

(2) The premium for the policy shall be paid either wholly from the union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. No policy may be issued on which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance. A policy on which part of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force only if at least seventy-five per cent of the then eligible members, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. Except as provided in paragraph (3), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance shall insure all eligible members, except those who reject such coverage in writing;

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(4) The policy shall cover at least twenty-five members at date of issue; and

(5) The amount of insurance under the policy shall be based upon some plan precluding individual selection either by the members or by the union. [L 1987, c 347, pt of §2; am L 2004, c 122, §49]

**§431:10D-205 Trustee groups.** The lives of a group of individuals may be insured under a policy issued to the trustees of a fund established by two or more employers or by one or more labor unions, or by one or more employers and one or more labor unions which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof. The policy may provide that the term employees shall include:

(A) The employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships, or partnerships if the business of the employer and the affiliated corporations, proprietorships or partnerships are under common control;
(B) The individual proprietor or partners if the employer is an individual proprietor or a partnership;
(C) Retired employees; and
(D) The trustees or their employees, or both, if their duties are principally connected with the trusteeship.

No director of a corporate employer shall be eligible for insurance under the policy unless the person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless the individual proprietor or partner is actively engaged in and devotes a substantial part of the individual proprietor's or partner's time to the conduct of the business of the proprietorship or partnership.

(2) The premium for the policy shall be paid wholly from funds contributed by the employer or employers of the insured persons, or by the union or unions, or by both, or, except in the case of a policy issued to the trustees of a fund established wholly by two or more employers, partly from those funds and partly from funds contributed by the insured persons. No policy may be issued to the trustees of a fund established wholly by two or more employers on which any part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance. A policy on which part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance may be placed in force only if at least seventy-five per cent of the then eligible persons, excluding any as to whom evidence of insurability is not satisfactory to the insurer, elect to make the required contributions. Except as provided in paragraph (3), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject that coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) The policy must cover at date of issue at least twenty-five persons and not less than an average of four persons per employer unit; and if the fund is established by the members of an association of employers the policy may be issued only if:

(A) Either:
  (i) The participating employers constitute at date of issue at least thirty-three and one-third per cent of those employer members whose employees are not already covered for group life insurance, or
  (ii) The total number of persons covered at date of issue exceeds two hundred; and
(B) The policy shall not require that, if a participating employer discontinues membership in the association, the insurance of the employer's employees shall cease solely by reason of the discontinuance.

(5) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions. [L 1987, c 347, pt of §2; am L 1990, c 38, §1]

**§431:10D-206 Agent groups.** The lives of a group of individuals may be insured under a policy issued to a principal, or if such principal is a life insurer, by or to such principal covering when issued not less than twenty-five agents of the principal, subject to the following requirements:

(1) The agents eligible for insurance under the policy shall be those who are under contract to render personal services for the principal for a commission or other fixed or ascertainable compensation.

(2) The policy must insure either all of the agents or all of any class or classes thereof, except that if a policy is intended to insure several such classes it may be issued to insure any such class of which seventy-five per cent are covered and extended to other classes as seventy-five per cent thereof express the desire to be covered.

(3) The premium on the policy shall be paid by the principal or by the principal and the agents jointly. When the premium is paid by the principal and agents jointly and the benefits of the policy are offered to all eligible agents, the policy, when issued, must insure not less than seventy-five per cent of the agents.

(4) The amounts of insurance shall be based upon some plan which will preclude individual selection.

(5) The insurance shall be for the benefit of persons other than the principal.

(6) The policy shall terminate if, subsequent to issue the number of agents insured falls below twenty-five lives or seventy-five per cent of the number eligible and the contribution of the agents, if the premiums are on a renewable term insurance basis, exceed $1 per month per $1,000 of insurance coverage plus any additional premium per $1,000 of insurance coverage charged to cover one or more hazardous occupations.

(7) For the purpose of this section the term agents shall be deemed to include producers and salespersons. [L 1987, c 347, pt of §2; gen ch 1993; am L 2002, c 155, §72]

**§431:10D-207 Public employee association groups.** The lives of a group of individuals may be insured under a policy issued to an association of public employees, which shall be deemed the policyholder, to insure members of the association for the benefit of persons other than the association or any of its officials, subject to the following requirements:

(1) The association shall have been formed for purposes other than obtaining insurance and have when the policy is placed in force, a membership in the classes eligible for insurance of not less than seventy-five per cent of the number of employees eligible for membership in such classes;

(2) The members eligible for insurance under the policy shall be all of the members of the association, or all of any class or classes thereof;

(3) The premium for the policy shall be paid either from the association's own funds or from charges collected from the insured members specifically for the insurance, or from both. Any charges collected from the insured members specifically for the insurance, and the dues of the association if they include the cost of insurance, may be collected through deductions by the employer from the salaries of the members. The deductions from salary may be paid by the employer to the association or directly to the insurer. No policy may be placed in force unless and until at least seventy-five per cent of the then eligible members of the association, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have authorized their employer to make the required deductions from salary, or have otherwise assigned pay or arranged for payment of their individual contributions to the association. Except as provided in paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance shall insure all eligible members, except those who reject such coverage in writing;

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(5) Charges collected from the insured members specifically for the insurance, and the dues of the association if they include the cost of insurance, may be determined according to each attained age or in not fewer than four reasonably spaced attained age groups. This provision, however, shall not preclude an average rate for the whole group with charges to the individual members based on a schedule of insurance graded by rank, salary bracket, or by length of service or seniority;

(6) The policy shall cover at least twenty-five persons at date of issue; and

(7) The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the members or by the association.

As used in this section, "public employees" means employees of the United States government, any state, any political subdivision, instrumentality, department, bureau, board, or commission of the United States government or any state, or the national guard as an association in nature under its existing form. [L 1987, c 347, pt of §2; am L 2004, c 122, §50]

**§431:10D-208 Mutual benefit society groups.** The lives of a group of individuals may be insured under a policy issued to a mutual benefit society, which shall be deemed the policyholder, to insure members of the society for the benefit of persons other than the society or any of its officials, subject to the following requirements:

(1) The society must have been formed for purposes other than obtaining insurance and have, when the policy is placed in force, a membership in the classes eligible for insurance of not less than seventy-five per cent of the number of persons eligible for membership in such classes;

(2) The members eligible for insurance under the policy shall be all of the members of the society, or all of any class or classes thereof;

(3) The premium for the policy shall be paid either from the society's own funds or from charges collected from the insured members specifically for the insurance, or from both. No policy may be placed in force unless and until at least seventy-five per cent of the then eligible members of the society, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have arranged for payment of their individual contributions to the society. Except as provided in paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members;

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(5) Charges collected from the insured members specially for the insurance, and the dues of the society if they include the cost of insurance, may be determined according to each attained age or in not less than four reasonably spaced attained age groups;

(6) The policy must cover at least twenty-five persons at date of issue; and

(7) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the society.

As used in this section, the term "mutual benefit society" has the same meaning as that ascribed to it in section 432:1-104. Any mutual benefit society participating in an insurance program under this section shall be exempted from the requirements of chapter 432 relative to the management or operation of its death or accident and health or sickness benefit funds with respect to the insurance program. [L 1987, c 347, pt of §2; am L 2003, c 212, §87]

**§431:10D-209 Professional association groups.** The lives of a group of individuals may be insured under a policy issued to an association of professional persons, which shall be deemed the policyholder, to insure members of the association for the benefit of persons other than the association or any of its officials, subject to the following requirements:

(1) The association shall have been formed for purposes other than obtaining insurance and have when the policy is placed in force, a membership in the classes eligible for insurance of not less than seventy-five per cent of the number of professional persons eligible for membership in such classes;

(2) The members eligible for insurance under the policy shall be all of the members of the association, or all of any class or classes thereof;

(3) The premium for the policy shall be paid either from the association's own funds or from charges

collected from the insured members specifically for the insurance, or from both. No policy may be placed in force unless and until at least seventy-five per cent of the then eligible members of the association, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have arranged for payment of their individual contributions to the association. Except as provided in paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance shall insure all eligible members;

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(5) Charges collected from the insured members specifically for the insurance, and the dues of the association if they include the cost of insurance, may be determined according to each attained age or in not fewer than four reasonably spaced attained age groups;

(6) The policy shall cover at least twenty-five persons at date of issue; and

(7) The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the members or by the association.

As used in this section, "professional persons" means persons practicing a profession requiring examination and licensing under chapters 448, 453, 464, 466, and 605. [L 1987, c 347, pt of §2; am L 2004, c 122, §51]

**§431:10D-210 Occupation, industry, or trade association groups.** The lives of a group of individuals may be insured under a policy issued to an association of individuals belonging to a single occupation, industry, or trade association, which shall be deemed the policyholder, to insure members of the association for the benefit of persons other than the association or any of its officials, subject to the following requirements:

(1) The association must have been formed for purposes other than obtaining insurance.

(2) The members eligible for insurance under the policy shall be all of the members of the association.

(3) The premium for the policy shall be paid either from the association's own funds or from charges collected from the insured members specifically for the insurance, or from both. No policy may be placed in force unless and until at least seventy-five per cent of the then eligible members of the association, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have arranged for payment of their individual contributions to the association.

(4) Charges collected from the insured members specifically for the insurance, and the dues of the association if they include the cost of insurance, may be determined according to each attained age or in not less than four reasonably spaced attained age groups.

(5) The policy must cover at least twenty-five persons at date of issue.

(6) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the association. [L 1987, c 347, pt of §2]

**§431:10D-211 Credit union groups.** The lives of the members of a credit union may be insured under a policy issued to the credit union that shall be deemed the policyholder to insure members of the credit union for the benefit of persons other than the credit union or any of its officials, subject to the following requirements:

(1) Except for paragraph (2), the members eligible for insurance under the policy shall be all of the members of the credit union;

(2) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer;

(3) The premiums for the policy shall be paid by the policyholder, either from the credit union's own funds or from charges collected from the insured members specifically for the insurance, or from both; provided that when the premium is paid by the members, or by the credit union and its members jointly, at least seventy-five per cent of the then eligible members, excluding any as to whom evidence of insurability is not satisfactory to the insurer, shall elect to make the required contributions; and

(4) The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the members or by the credit union.

As used in this section, "credit union" means a credit union chartered under the provisions of the Federal Credit Union Act or article 10 of chapter 412. [L 1987, c 347, pt of §2; am L 1993, c 350, §17; am L 2004, c 122, §52]

**[§431:10D-211.5] Other groups; limits.** Group life insurance offered to a Hawaii resident under a group life insurance policy issued to a group, other than a group described in sections 431:10D-202 through 431:10D-211, shall be subject to the following requirements:

(1) No group life insurance policy shall be delivered in this State unless the commissioner finds that:

(A) The issuance of the group life insurance policy is not contrary to the best interest of the public;
(B) The issuance of the group life insurance policy would result in economies of acquisition or administration; and
(C) The benefits of the group life insurance policy are reasonable in relation to the premium charged;

(2) No group life insurance coverage may be offered in this State, pursuant to this section, by an insurer under a group life insurance policy issued in another state, unless:

(A) The commissioner finds that the requirements of paragraph (1) have been met; or
(B) The issuing state has requirements substantially similar to those contained in paragraph (1) and has determined that those requirements have been met;

(3) The premium for a group life insurance policy issued pursuant to this section shall be paid by the policyholder, by covered persons, or both; and

(4) An insurer may exclude from coverage or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer under a group life insurance policy issued pursuant to this section. [L 2010, c 32, §1]

**§431:10D-212 Spouses and dependents of insured individuals.** (a) Except for a policy issued under sections 431:10D-203 and 431:10D-211, insurance under any group life insurance policy issued pursuant to this article may be extended to insure the employees or members of such groups

against loss due to the death of their spouses and dependent children subject to the following:

(1) The spouse and dependent of the individual insured may be covered in amounts of insurance equivalent to the amount of coverage of the insured individual;

(2) The premiums for the insurance of the spouse or dependent shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued, or from funds contributed by the individual insured, or from both; and

(3) An insurer may exclude or limit the coverage on any spouse or dependent child as to whom evidence of individual insurability is not satisfactory to the insurer.

(b) For purposes of this section:
"Dependent" means a child of the insured individual:

(1) Under eighteen years of age;

(2) Under twenty-three years of age who is attending an educational institution and relying upon the insured individual for financial support; or

(3) Regardless of age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and is chiefly dependent upon the insured individual for support and maintenance.

"Individual" includes a person or a member of any group provided in section 431:10D-202 and sections 431:10D-204 through 431:10D-210. [L 1987, c 347, pt of §2; am L 2004, c 122, §53; am L 2008, c 155, §3; am L 2011, c 220, §12]

**§431:10D-213 Standard provisions required.** (a) No policy of group life insurance shall be delivered or issued for delivery in this State unless it contains in substance the standard provisions set forth below, or provisions that in the opinion of the commissioner are more favorable to the individuals insured. The policy shall provide that:

(1) Grace period. The policyholder is entitled to a grace period of not fewer than thirty days, for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder has given 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 shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

(2) Incontestability. The validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by an individual insured under the policy relating to the individual's 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 years during the individual's lifetime, nor unless it is contained in a written instrument signed by the individual.

(3) The contract, representations. A copy of the application, if any, of the policyholder shall be attached to the policy when issued and become a part of the contract; all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and 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 such persons, or, in the event of death or incapacity of the insured person, to the person's beneficiary or personal representative.

(4) Insurability. The conditions, if any, under which the insurer reserves the right to require a person

eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

(5) Misstatement of age. An equitable adjustment of premiums or of benefits or of both shall be made in the event the age of a person insured has been misstated, containing a clear statement of the method of adjustment to be used.

(6) Beneficiary. Any sum becoming due by reason of the death of the individual insured shall be payable to the beneficiary designated by the individual subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of the sum, living at the death of the individual insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding $2,000 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the individual insured.

(7) Certificates. The insurer will issue to the policyholder for delivery to each individual insured an individual certificate setting forth a statement as to the insurance protection to which the individual is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in paragraphs (8), (9), and (10).

(8) Conversion on termination of eligibility. If the insurance, or any portion of it, on an individual covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the individual shall be entitled to have issued to the individual by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits; provided that:

(A) Application for the individual policy shall be made, and the first premium paid to the insurer, within not fewer than thirty days, after such termination;

(B) The individual policy shall, at the option of the individual, be on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

(C) The individual policy shall be in an amount not in excess of the amount of life insurance that ceases because of such termination nor less than $1,000 unless a smaller amount of coverage was provided for the individual under the group policy less the amount of any life insurance for which such person becomes eligible under the same or any other group policy within not fewer than thirty days after such termination; provided that any amount of insurance that shall have matured on or before the date of such termination as an endowment payable to the individual insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount that is considered to cease because of such termination; and

(D) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which the individual then belongs, and to the individual's age attained on the effective date of the individual policy.

(9) Conversion on termination of policy. If the group policy terminates or is amended so as to terminate the insurance of any class of insured individuals, every individual insured thereunder at the date of such termination whose insurance terminates, including the insured dependent of a covered person, and who has

been so insured for at least five years prior to the termination date shall be entitled to have issued to the individual by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by paragraph (8), except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

(A) The amount of the individual's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the individual is or becomes eligible under any group policy issued or reinstated by the same or another insurer within not fewer than thirty days of such termination; or

(B) $10,000.

(10) Death pending conversion. If an individual insured under the group policy, or the insured dependent of a covered person, dies during the period within which the individual would have been entitled to have an individual policy issued to the individual in accordance with paragraphs (8) and (9), and before such an individual policy shall have become effective, the amount of life insurance that the individual would have been entitled to have issued to the individual under such individual policy shall be payable as a claim under the group policy, regardless of whether the individual policy or the payment of the first premium therefor has been made.

(b) Subsection (a)(6) through (a)(10) shall not apply to policies issued to a credit union to insure its members.

(c) Subsection (a)(6), and (a)(8) through (a)(10) shall not apply to policies issued to a creditor to insure its debtors.

(d) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions that in the opinion of the commissioner is or are equitable to the insured persons and to the policyholder, but such nonforfeiture benefits are not required to be the same as those required for individual life insurance policies. [L 1987, c 347, pt of §2; gen ch 1993; am L 2004, c 122, §54]

**§431:10D-214 Notice to insured regarding conversion right.** If any individual insured under a group life insurance policy delivered in this State becomes entitled under the terms of the policy to have an individual policy of life insurance issued to the individual without evidence of insurability, subject to making of application and payment of the first premium within the period specified in the policy, and if the individual is not given notice of the existence of such right at least fifteen days prior to the expiration date of such period, then, in such event the individual shall have an additional period within which to exercise the right, but nothing herein shall be construed to continue any insurance beyond the period provided in the policy. This additional period shall expire fifteen days next after the individual is given such notice but in no event shall the additional period extend beyond sixty days next after the expiration date of the period provided in the policy. Written notice presented to the individual or mailed by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purposes of this section. [L 1987, c 347, pt of §2]

**§431:10D-215 Assignment of policies.** Subject to the terms of the policy, or pursuant to an agreement between the insured, the group

policyholder, and the insurer, any person insured under a group life insurance policy may make to any person, other than the policyholder, an assignment of all or any part of the incidents of ownership conferred on the insured by the policy or by law, including specifically, but not by way of limitation, the right to exercise the conversion privilege and the right to name a beneficiary. [L 1987, c 347, pt of §2]

## PART III. INDUSTRIAL LIFE INSURANCE

**§431:10D-301 Scope.** This part shall apply only to industrial life insurance contracts. [L 1987, c 347, pt of §2]

**§431:10D-302 General life insurance provisions applicable.** The following [sections] of part I of this article shall apply to industrial life insurance policies:

(1) 431:10D-104;

(2) 431:10D-108;

(3) 431:10D-109;

(4) 431:10D-110; and

(5) 431:10D-116. [L 1987, c 347, pt of §2]

**§431:10D-303 Industrial life insurance defined.** Industrial life insurance is any life insurance provided by an individual insurance contract issued in face amount of less than $1,000 under which premiums are payable monthly or more often, and bearing the words "Industrial Policy" printed upon the policy as a part of the descriptive matter. [L 1987, c 347, pt of §2]

**§431:10D-304 Compliance required.** No policy of industrial life insurance shall be delivered or be issued for delivery in this State, except in compliance with the provisions of this part, and with other applicable provisions of this code. [L 1987, c 347, pt of §2]

**§431:10D-305 Standard provisions required.** No policy of industrial life insurance shall be issued or delivered unless it contains in substance the provisions as required by this part, or provisions which in the opinion of the commissioner are at least as favorable to the policyholder. There shall be a provision that:

(1) Grace period. The insured is entitled to a grace period of four weeks within which the payment of any premium after the first may be made, except that in policies the premiums for which are payable monthly, the grace period shall be not less than thirty days; and that during such period the policy shall continue in full force, but if during the grace period the policy becomes a claim, then any overdue and unpaid premiums may be deducted from any settlement under the policy;

(2) Entire contract. The policy shall constitute the entire contract between the parties, or, if a copy of the application is endorsed upon or attached to the policy when issued, the policy and the application therefor shall constitute the entire contract. If the application is so made a part of the contract, the policy shall also

provide that all statements made by the applicant in the application shall, in the absence of fraud, be deemed to be representations and not warranties;

(3) Incontestability. The policy shall be incontestable after it has been in force during the lifetime of the insured for a specific period not more than two years from its date of issue, except for nonpayment of premiums and except for provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident or accidental means;

(4) Misstatement of age. If it is found that the age of the individual insured, or the age of any other individual considered in determining the premium, has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages;

(5) Participation. If a participating policy, the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy. This provision shall not prohibit the payment of additional dividends on default of payment of premiums or termination of the policy;

(6) Nonforfeiture benefits. There shall be a provision for nonforfeiture benefits as required by section 431:10D-104;

(7) Cash surrender value. There shall be a provision for a cash surrender value as required by section 431:10D-104;

(8) Reinstatement. The policy be reinstated at any time within two years after the date of default in the payment of any premium, unless the policy has been surrendered for its cash value or the period of any extended insurance provided by the policy has expired, upon evidence of insurability, including good health, satisfactory to the insurer and the payment of all overdue premiums, and payment (or, within the limits permitted by the then cash values of the policy, reinstatement) of any other indebtedness to the insurer upon the policy with interest as to both premiums and indebtedness at a rate not exceeding six per cent a year compounded annually;

(9) Payment of claims. When the policy becomes a claim by the death of the insured, settlement shall be made upon surrender of the policy and receipt of due proof of death, or after a specified period not exceeding two months after the surrender and receipt of proof; provided, however, an insurer is also permitted to require that the premium receipt book be delivered to it prior to settlement;

(10) Authority to alter contract. There shall be a provision that no producer shall have the power or authority to waive, change, or alter any of the terms or conditions of any policy; except that, at the option of the insurer, the terms or conditions may be changed by an endorsement signed by a duly authorized officer of the insurer;

(11) Conversion; weekly premium policies. In the case of weekly premium policies granting, upon proper written request and upon presentation of evidence of the insurability of the insured satisfactory to the insurer, the privilege of converting the insured's weekly premium industrial insurance to any form of life insurance with less frequent premium payments regularly issued by the insurer, in accordance with terms and conditions agreed upon with the insurer. The privilege of making the conversion need be granted only if the insurer's weekly premium industrial policies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and exclusive of any dividend additions, in an amount not less than the minimum amount of the insurance with less frequent premium payments issued by the insurer at the age of the insured on the plan of industrial or ordinary insurance desired; and

(12) Conversion; monthly premium policies. In the case of monthly premium industrial policies, granting, upon written request and upon presentation of evidence of the insurability of the insured satisfactory to the insurer, the privilege of converting the insured's monthly premium industrial insurance to any form of ordinary life insurance regularly issued by the insurer, in accordance with terms and conditions agreed upon with the insurer. The privilege of making the conversions need be granted only if the insurer's monthly premium industrial policies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and

exclusive of any dividend additions, in an amount not less than the minimum amount of ordinary insurance issued by the insured at the age of the insured on the plan of ordinary insurance desired. [L 1987, c 347, pt of §2; am L 2003, c 212, §88]

**§431:10D-306 Title on policy.** There shall be a title on the face of each policy briefly describing its form. [L 1987, c 347, pt of §2]

**§431:10D-307 Beneficiary.** (a) Each policy shall have a space on the front or back page of the policy for the name of the beneficiary designated with a reservation of the right to designate or change the beneficiary after the issuance of the policy.

(b) The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. [L 1987, c 347, pt of §2]

**§431:10D-308 Facility of payment.** Such a policy may also provide that if the beneficiary designated in the policy does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than thirty days after the death of the insured, or if the beneficiary is the estate of the insured or is a minor, or dies before the insured or is not legally competent to give a valid release, then the insurer may make payment under the policy to the personal representative of the insured, or to any of the insured's relatives by blood, legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled to such payment by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention, or burial of the insured. The policy may also include a similar provision applicable to any other payment due under the policy. [L 1987, c 347, pt of §2]

**§431:10D-309 Premiums paid direct.** In the case of weekly premium policies, there may be a provision that upon proper notice to the insurer while premiums on the policy are not in default beyond the grace period, of the intention to pay future premiums directly to the insurer at its home office or any office designated by the insurer for the purpose, the insurer will, at the end of each period of a year from the due date of the first premium so paid, for which period the premiums are so paid continuously without default beyond the grace period, refund a stated percentage of the premiums in an amount which fairly represents the savings in collection expense. [L 1987, c 347, pt of §2]

**§431:10D-310 Application to term and specified insurance.** Any of the provisions required by this part or any portion thereof which are not applicable to single premium or term policies or to policies issued or granted pursuant to nonforfeiture provisions, shall to that extent not be incorporated therein. [L 1987, c 347, pt of §2]

**§431:10D-311 Crediting of dividends.** An insurer shall credit annually beginning not later than the fifth policy year, any dividend

arising under a participating industrial life insurance contract. [L 1987, c 347, pt of §2]

**§431:10D-312 Prohibited provisions.** No industrial life insurance policy shall contain:

(1) A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer.

(2) A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical, or surgical treatment or attention; except a provision which gives the insurer the right to declare the policy void if the insured has, within two years prior to the issuance of the policy, received institutional, hospital, medical, or surgical treatment or attention, and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk.

(3) A provision giving the insurer the right to declare the policy void because the insured had been rejected for insurance, unless such right is conditioned upon a showing by the insurer, that knowledge of such rejection would have led to a refusal by the insurer to make the contract. [L 1987, c 347, pt of §2]

**§431:10D-313 Limitation of liability.** The insurer may in any such policy limit its liability for the same causes and to the same extent as is provided in section 431:10D-312 for other life insurance contracts. [L 1987, c 347, pt of §2]

## [PART IV.] LIFE INSURANCE POLICY ILLUSTRATIONS

**[§431:10D-401] Scope.** This part shall apply to all group and individual life insurance policies and certificates except:

(1) Variable life insurance;

(2) Individual and group annuity contracts;

(3) Credit life insurance; and

(4) Life insurance policies with no illustrated death benefits for any individual exceeding $10,000. [L 2000, c 252, pt of §2]

**[§431:10D-402] Definitions.** For the purposes of this part:

"Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and adopt standards of actuarial practice.

"Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and nonguaranteed elements.

"Contract premium" means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

"Currently payable scale" means a scale of nonguaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next ninety-five days.

"Disciplined current scale" means a scale of nonguaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

(1) Are consistent with all provisions of this part;

(2) Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(3) Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(4) Do not permit assumed expenses to be less than minimum assumed expenses.

"Generic name" means a short title descriptive of the policy being illustrated such as "whole life", "term life", or "flexible premium adjustable life".

"Guaranteed elements" means the premiums, benefits, values, credits, or charges under a policy of life insurance that are guaranteed and determined at issue.

"Illustrated scale" means a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(1) The disciplined current scale; or

(2) The currently payable scale.

"Illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years and that is a basic illustration, a supplemental illustration, or an in force illustration.

"Illustration actuary" means an actuary meeting the requirements of section 431:10D-409, who certifies to illustrations based on the standard of practice adopted by the Actuarial Standards Board.

"In force illustration" means an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

"Lapse-supported illustration" means an illustration of a policy form failing the test of self-supporting illustration as defined in this part, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five years and one hundred per cent policy persistency thereafter.

"Minimum assumed expenses" means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(1) Fully allocated expenses;

(2) Marginal expenses; and

(3) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the commissioner.

Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

"Nonguaranteed elements" means the premiums, benefits, values, credits, or charges under a policy of life insurance that are not guaranteed or not determined at issue.

"Non-term group life" means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(1) Every plan of coverage was selected by the employer or other group representative;

(2) Some portion of the premium is paid by the group or through payroll deduction; and

(3) Group underwriting or simplified underwriting is used.

"Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

"Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

"Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value shall include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

"Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this part, and that may be presented in a format differing from the basic illustration, but may only depict a scale of nonguaranteed elements that is permitted in a basic illustration. [L 2000, c 252, pt of §2]

**[§431:10D-403] Policies to be illustrated.** (a) Each insurer marketing policies to which this part is applicable shall notify the commissioner whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on July 1, 2001, the insurer shall identify in writing the forms and whether or not an illustration will be used with them. For policy forms filed after July 1, 2001, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the commissioner.

(b) If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

(c) If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this part is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

(d) Potential enrollees of non-term group life subject to this part shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and nonguaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this part, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for non-term group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any non-term group life enrollee who requests it. [L 2000, c 252, pt of §2]

**Revision Note**

"July 1, 2001" substituted for "the effective date of this part".

**[§431:10D-404] General requirements and prohibitions.** (a) An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this part, be clearly labeled "life insurance illustration", and contain the following basic information:

(1) Name of insurer;

(2) Name and business address of producer and insurer's authorized representative, if any;

(3) Name, age, and sex of proposed insured, except where a composite illustration is permitted under this part;

(4) Underwriting or rating classification upon which the illustration is based;

(5) Generic name of policy, the company product name, if different, and form number;

(6) Initial death benefit; and

(7) Dividend option election or application of non-guaranteed elements, if applicable.

(b) When using an illustration in the sale of a life insurance policy, an insurer, its producers, or other authorized representatives shall not:

(1) Represent the policy as anything other than a life insurance policy;

(2) Use or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(3) State or imply that the payment or amount of nonguaranteed elements is guaranteed;

(4) Use an illustration that does not comply with the requirements of this part;

(5) Use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

(6) Provide an applicant with an incomplete illustration;

(7) Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is a fact;

(8) Use the term "vanish" or "vanishing premium", or a similar term that implies the policy becomes paid up, to describe a plan for using nonguaranteed elements to pay a portion of future premiums;

(9) Except for policies that can never develop nonforfeiture values, use an illustration that is lapse-supported; or

(10) Use an illustration that is not self-supporting.

(c) If an interest rate used to determine the illustrated nonguaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale. [L 2000, c 252, pt of §2]

**[§431:10D-405] Standards for basic illustrations.** (a) The format of a basic illustration shall conform with the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared;

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (e.g., the fourth page of a seven page illustration shall be labeled "page 4 of 7 pages");

(3) The assumed dates of payment receipt and benefit pay out within a policy year shall be clearly identified;

(4) If the age of the proposed insured is shown as a component of the tabular detail, the age shown shall be the age of the insured at the time the policy is issued plus the numbers of years the policy is assumed to have been in force;

(5) The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay;

(6) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed;

(7) If the illustration shows any nonguaranteed elements, they shall not be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled nonguaranteed;

(8) The guaranteed elements, if any, shall be shown before corresponding nonguaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the nonguaranteed elements (e.g., "see page one for guaranteed elements");

(9) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender;

(10) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans, and policy loan interest, as applicable;

(11) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form;

(12) Any illustration of nonguaranteed elements shall be accompanied by a statement indicating that:

(A) The benefits and values are not guaranteed;

(B) The assumptions on which they are based are subject to change by the insurer; and
(C) Actual results may be more or less favorable;

(13) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using nonguaranteed values, the illustration shall clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up; and

(14) If the applicant plans to use dividends or policy values, guaranteed or nonguaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.

(b) A basic illustration shall include a narrative summary which shall include the following:

(1) A brief description of the policy being illustrated, including a statement that it is a life insurance policy;

(2) A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code of 1986, as amended;

(3) A brief description of any policy features, riders, or options, guaranteed or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

(4) Identification and a brief definition of column headings and key terms used in the illustration; and

(5) A statement containing in substance the following:

"This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

(c) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable, provided that:

(1) For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five, ten, and twenty and at age seventy, if applicable, on the three bases shown below. For multiple life policies the summary shall show policy years five, ten, twenty, and thirty. The illustration shall include:

(A) Policy guarantees;
(B) The insurer's illustrated scale;
(C) The insurer's illustrated scale used but with the nonguaranteed elements reduced as follows:
(i) Dividends at fifty per cent of the dividends contained in the illustrated scale used;
(ii) Nonguaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and
(iii) All nonguaranteed charges, including but not limited

to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates, and the rates contained in the illustrated scale used; and

(2) If coverage would cease prior to policy maturity or age one hundred, the year in which coverage ceases shall be identified for each of the three bases.

(d) The following statements shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in this part:

(1) A statement to be signed and dated by the applicant or policy owner reading as follows:

"I have received a copy of this illustration and understand that any nonguaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."; and

(2) A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading as follows:

"I certify that this illustration has been presented to the applicant and that I have explained that any nonguaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

(e) A basic illustration shall include the following details:

(1) For at least each policy year from one to ten and for every fifth policy year thereafter ending at age one hundred, policy maturity or final expiration; and except for term insurance beyond the twentieth year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(A) The premium outlay and mode the applicant plans to pay and the contract premium, as applicable;
(B) The corresponding guaranteed death benefit, as provided in the policy; and
(C) The corresponding guaranteed value available upon surrender, as provided in the policy;

(2) For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium; and

(3) Nonguaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends, provided that:

(A) If any nonguaranteed elements are shown they must be shown at the same durations as the corresponding guaranteed elements, if any; and
(B) If no guaranteed benefit or value is available at any duration for which a nonguaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column. [L 2000, c 252, pt of §2]

**[§431:10D-406] Standards for supplemental illustrations.** (a) A supplemental illustration may be provided so long as:

(1) It is appended to, accompanied by, or preceded by a basic illustration that complies with this part;

(2) The nonguaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration;

(3) It contains the same statement required of a basic illustration that nonguaranteed elements are not guaranteed; and

(4) For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

(b) The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information. [L 2000, c 252, pt of §2]

**§431:10D-407 Delivery of illustration and record retention.** (a) If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this part, shall be submitted to the insurer at the time of policy application. A copy also shall be provided to the applicant.

(b) If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall:

(1) Conform to the requirements of this part;

(2) Be labeled "Revised Illustration"; and

(3) Be signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer no later than the time the policy is delivered.

A copy of the revised illustration shall be provided to the insurer and the policy owner.

(c) If the policy is identified as one to be marketed with an illustration, and no illustration is used by an insurance producer or other authorized representative in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect in writing on a form provided by the insurer; provided that:

(1) On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application;

(2) If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered; and

(3) A copy shall be provided to the insurer and the policy owner.

(d) If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection shall be satisfied if it can demonstrate that it has made

a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

(e) A copy of the basic illustration and a revised illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three years after the policy is no longer in force. A copy need not be retained if no policy is issued. [L 2000, c 252, pt of §2; am L 2004, c 122, §55]

**§431:10D-408 Annual reports and notice to policy owners.** (a) In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

(1) For universal life policies, the report shall include the following:

(A) The beginning and end date of the current report period;
(B) The policy value at the end of the previous report period and at the end of the current report period;
(C) The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense, and riders);
(D) The current death benefit at the end of the current report period on each life covered by the policy;
(E) The net cash surrender value of the policy as of the end of the current report period; and
(F) The amount of outstanding loans, if any, as of the end of the current report period; and

(2) For fixed premium policies: if assuming guaranteed interest, mortality, and expense loads, and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

(3) For flexible premium policies: if, assuming guaranteed interest, mortality, and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report; or

(4) For all other policies, where applicable:

(A) Current death benefit;
(B) Annual contract premium;
(C) Current cash surrender value;
(D) Current dividend;
(E) Application of current dividend; and
(F) Amount of outstanding loan; and

(5) Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

(b) If the annual report does not include an in force illustration,

it shall contain the following notice displayed prominently:

"IMPORTANT POLICY OWNER NOTICE: You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's phone number), writing to (insurer's name) at (insurer's address), or contacting your agent or producer. If you do not receive a current illustration of your policy within thirty days from your request, you should contact your state insurance department."

(c) Upon the request of the policy owner, the insurer shall furnish an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of sections 431:10D-404(a), 431:10D-404(b), 431:10D-405(a), and 431:10D-405(e). No signature or other acknowledgment of receipt of this illustration shall be required.

(d) If an adverse change in nonguaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change shall be prominently displayed. [L 2000, c 252, pt of §2; am L 2003, c 212, §89]

**§431:10D-409 Annual certifications.** (a) The board of directors of each insurer shall appoint one or more illustration actuaries.

(b) The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the National Association of Insurance Commissioners' Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this part.

(c) The illustration actuary shall:

(1) Be a member in good standing of the American Academy of Actuaries;

(2) Be familiar with the standard of practice regarding life insurance policy illustrations;

(3) Not have been found by the commissioner, following appropriate notice and hearing, to have:

(A) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of acting as an illustration actuary;
(B) Been found guilty of fraudulent or dishonest practices;
(C) Demonstrated incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or
(D) Resigned or been removed as an illustration actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards;

(4) Not fail to notify the commissioner of any action taken by a commissioner of another state similar to that under paragraph (3);

(5) Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If

nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in force policies are not consistent with the nonguaranteed elements actually being paid, charged, or credited to the same or similar forms, this must be disclosed in the annual certification; and

(6) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(A) Fully allocated expenses;
(B) Marginal expenses; or
(C) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the commissioner.

(d) The illustration actuary shall file a certification with the board and with the commissioner:

(1) Annually for all policy forms for which illustrations are used; and

(2) Before a new policy form is illustrated.

(e) If an error in a previous certification is discovered, the illustration actuary shall immediately notify the board of directors of the insurer and the commissioner.

(f) If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall immediately notify the board of directors of the insurer and the commissioner of the inability to certify.

(g) A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

(1) That the illustration formats meet the requirements of this part and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(2) That the company has provided its producers or other representatives with information about the expense allocation method used by the company in its illustrations and disclosed as required in subsection (c)(6).

(h) The annual certifications shall be provided to the commissioner each year by a date determined by the insurer.

(i) If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the commissioner of that fact promptly and disclose the reason for the change. [L 2000, c 252, pt of §2; am L 2003, c 212, §90]

**§431:10D-410 Penalties.** In addition to any other penalties provided by the laws of this State, an insurer or producer that violates a requirement of this part shall be guilty of an unfair or deceptive act or practice in violation of article 13. [L 2000, c 252, pt of §2; am L 2004, c 122, §56]

**[§431:10D-411] Authority to adopt rules.** The commissioner may adopt rules under chapter 91 implementing this part. [L 2000, c 252, pt of §2]

**§431:10D-412 REPEALED.** L 2000, c 282, §2.

**Cross References**

Uniform electronic transactions act, see chapter 489E.

## [PART V.] REPLACEMENT OF LIFE INSURANCE POLICIES AND ANNUITIES

**§431:10D-501 Purpose and scope.** (a) The purpose of this part is to:

(1) Regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities; and

(2) Protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions that will:

(A) Assure that purchasers receive information with which a decision can be made in the purchasers' best interests;
(B) Reduce the opportunity for misrepresentation and incomplete disclosure; and
(C) Establish penalties for failure to comply with requirements of this part.

(b) Unless otherwise specifically included, this part shall not apply to transactions involving:

(1) Credit life insurance;

(2) Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals when initiated by an individual member of the group assisting with the selection of investment options offered by a single annuity provider in connection with enrolling the individuals. Group life insurance or group annuity certificates marketed through direct-response solicitation shall be subject to section 431:10D-507;

(3) Group life insurance used to fund prearranged funeral contracts;

(4) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

(5) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(6) Policies or contracts used to fund:

(A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);
(B) A plan described by sections 401(a), 401(k) or 403(b) of the Internal Revenue Code of 1986, as amended, where the plan, for purposes of ERISA, is established or maintained by an employer;
(C) A governmental or church plan defined in section 414 of the Internal Revenue Code of 1986, as amended, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the Internal Revenue Code of 1986, as amended; or

(D) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

provided that, notwithstanding the exemptions listed in subparagraphs (A) to (D), this part shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more annuity providers or policy providers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee assisting with the selection of investment options offered by a single annuity provider in connection with enrolling that individual employee;

(7) Where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(8) Existing life insurance that is a non-convertible term life insurance policy that will expire in five years or less and cannot be renewed;

(9) Immediate annuities that are purchased with proceeds from an existing contract; provided that immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this part; and

(10) Structured settlements.

(c) Registered contracts shall be exempt from the requirements of sections 431:10D-505(a)(2) and 431:10D-506(2) with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead. [L 2000, c 252, pt of §3; am L 2008, c 155, §4]

**§431:10D-502 Definitions.** For the purposes of this part:

"Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individual solely through mails, telephone, the Internet, or other mass communication media.

"Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of replacement.

"Existing policy or contract" means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

"Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender, or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four months before or thirteen months after the effective date of the new policy, it shall be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in section 431:10D-504(1)(E).

"Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in part IV of this article.

"Policy summary" for the purposes of this part:

(1) For policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information: current death benefit, annual contract premium, current cash surrender value, current dividend, application of current dividend, and amount of outstanding loan.

(2) For universal life policies, means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense, and riders); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

"Producer" includes any person, firm, association, or corporation licensed pursuant to article 9A.

"Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

"Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

"Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

"Sales material" means a sales illustration and any other written, printed, or electronically presented information created, completed, or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased. [L 2000, c 252, pt of §3; am L 2001, c 216, §20; am L 2002, c 155, §73; am L 2004, c 122, §57]

**§431:10D-503 Duties of producers.** (a) A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the answer is "no", the producer's duties with respect to replacement are

complete.

(b) If the applicant answered "yes" to the question regarding existing coverage referred to in subsection (a), the producer shall present and read to the applicant, not later than at the time of taking the application, a notice in a form approved by the commissioner. However, no approval shall be required when amendments to the notice are limited to the omission of references not applicable to the product being sold or replaced. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and the notice was left with the applicant.

(c) The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available. The notice shall include a statement as to whether a policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(d) In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.

(e) Except as provided in section 431:10D-505(c), in connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this section, a statement identifying any preprinted or electronically presented company-approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific contract or policy purchased. [L 2000, c 252, pt of §3; am L 2001, c 121, §2]

**§431:10D-504 Duties of insurers that use producers.** Each insurer shall:

(1) Maintain a system of supervision and control to insure compliance with the requirements of this part that shall include at least the following:

(A) Inform its producers of the requirements of this part and incorporate the requirements of this part into all relevant producer training manuals prepared by the insurer;

(B) Provide to each producer a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(C) A system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with subparagraph (B);

(D) Procedures to confirm that the requirements of this part have been met; and

(E) Procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant

or producer.

Compliance with this section may include but shall not be limited to systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring;

(2) Have the capacity to monitor each producer's life insurance policy and annuity contract for replacements for the insurer, and shall produce, upon request, and make such records available to the commissioner. The capacity to monitor shall include the ability to produce records for each producer's:

(A) Life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;
(B) Number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;
(C) Annuity contract replacements as a percentage of the producer's total annual contract sales;
(D) Number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by paragraph (1)(E); and
(E) Replacements, indexed by replacing producer and existing insurer;

(3) Require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

(4) Require with each application for life insurance or an annuity that indicates an existing policy or contract a completed notice as required by section 431:10D-503(b) regarding replacements;

(5) When the applicant has existing policies or contracts, each insurer shall be able to produce copies of any sales material as required by section 431:10D-503(e), the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the producer's and applicant's signed statements with respect to financing and replacement for at least five years after the termination or expiration of the proposed policy or contract;

(6) Ascertain that the sales material and illustrations required by section 431:10D-503(e) meet the requirements of this part and are complete and accurate for the proposed policy or contract;

(7) If an application does not meet the requirements of this part, notify the producer and applicant and fulfill the outstanding requirements; and

(8) Maintain records in paper, photograph, microprocess, mechanical, or electronic media, or by any process that accurately reproduces the actual paper document. [L 2000, c 252, pt of §3; am L 2001, c 121, §3]

**§431:10D-505 Duties of replacing insurers that use producers.** (a) Where a replacement is involved in the transaction, the replacing insurer shall:

(1) Verify that the required forms are received and are in compliance with this part;

(2) Notify any other existing insurer that may be affected by the proposed replacement within five business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five business days of a request from an existing insurer;

(3) Be able to produce copies of the notification regarding replacement required in section 431:10D-503(b), indexed by producer, for at least five years or until the next regular examination by the insurance department of a company's state of domicile, whichever is later; and

(4) Provide to the policy or contract owner notice of the right to return the policy or contract within thirty days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy or contract; provided that such notice may be included in forms approved by the commissioner pursuant to this part.

(b) In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, the replacing insurer shall allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to financed purchases, the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

(c) If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements made of an insurer pursuant to section 431:10D-503(e), the insurer may:

(1) Require with each application a statement signed by the producer that:

(A) Represents that the producer used only company-approved sales material; and
(B) States that copies of all sales material were left with the applicant in accordance with section 431:10D-503(d); and

(2) Within ten days of the issuance of the policy or contract:

(A) Notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with section 431:10D-503(d);
(B) Provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and
(C) Stress the importance of retaining copies of the sales material for future reference; and

(3) Be able to produce a copy of the letter or other verification in the policy file for at least five years after the termination or expiration of the policy or contract. [L 2000, c 252, pt of §3; am L 2001, c 121, §4; am L 2004, c 122, §58]

**[§431:10D-506] Duties of the existing insurer.** Where a replacement is involved in the transaction, the existing insurer shall:

(1) Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the insurance commissioner of its state of domicile, whichever is later;

(2) Send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within five business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five business days of receipt of the request from the policy or contract owner; and

(3) Upon receipt of a request to borrow, surrender, or withdraw any policy values, send a notice, advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount, or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan. [L 2000, c 252, pt of §3]

**§431:10D-507 Duties of insurers with respect to direct-response solicitations.** (a) In the case of an application that is initiated as a result of a direct-response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue, or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice in a form approved by the commissioner, which shall state the following:

**"NOTICE REGARDING REPLACEMENT**
**REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or producer that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest."

(b) If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(1) Provide to applicants or prospective applicants with the policy or contract a notice, in a form similar to that required by section 431:10D-503(b). In these instances the insurer may delete the references to the producer, including the producer's signature, without having to obtain approval of the form from the commissioner. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this paragraph. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this section; and

(2) Comply with the requirements of section 431:10D-505(a)(2), if the applicant furnishes the names of the existing insurers, and the requirements of sections 431:10D-505(a)(3), 431:10D-505(a)(4), and 431:10D-505(b). [L 2000, c 252, pt of §3; am L 2003, c 212, §91]

**§431:10D-508 Violations and penalties.** (a) Any failure to comply

with this part shall be considered a violation of article 13 of this chapter. Violations shall include but are not limited to:

(1) Any deceptive or misleading information set forth in sales material;

(2) Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(3) The intentional incorrect recording of an answer;

(4) Advising an applicant to respond negatively to any question regarding replacement to prevent notice to the existing insurer; or

(5) Advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

(b) Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed prima facie evidence of the producer's intent to violate this part.

(c) Where it is determined that the requirements of this part have not been met the replacing insurer shall provide to the policy owner an in force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the appropriate notice regarding replacements required under this part.

(d) Violations of this part shall subject the violators to penalties that may include the revocation or suspension of a producer's or company's license, monetary fines and the forfeiture of any commissions or compensation paid to a producer as a result of the transaction in connection with which the violations occurred. In addition, where the commissioner has determined that the violations were material to the sale, the insurer may be required to make restitution, restore policy or contract values, and pay appropriate interest on the amount refunded in cash. [L 2000, c 252, pt of §3; am L 2003, c 212, §92]

**[§431:10D-509] Authority to adopt rules.** The commissioner may adopt rules under chapter 91 implementing this part. [L 2000, c 252, pt of §3]

**§431:10D-510 REPEALED.** L 2000, c 282, §2.

**Cross References**

Uniform electronic transactions act, see chapter 489E.

## [PART VI.] ANNUITY DISCLOSURE

**[§431:10D-601] Definitions.** Whenever used in this part, unless a different meaning clearly appears from the context:

"Buyer's guide" means:

(1) A buyer's guide to fixed deferred annuities approved by the commissioner; or

(2) The National Association of Insurance Commissioners Buyer's Guide to Fixed Deferred Annuities.

"Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

"Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion but where the values or amounts cannot be determined until some point after issue. These elements include:

(1) Premiums;

(2) Credited interest rates, including any bonus;

(3) Benefits;

(4) Values;

(5) Non-interest-based credits;

(6) Charges; or

(7) Elements of formulas used to determine any of the above.

These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

"Disclosure document" means a document provided by an insurer to applicants or prospective applicants for an annuity contract that explains the terms of the contract and contains the information required in section 431:10D-603(d).

"Funding agreement" means an agreement for an insurer to:

(1) Accept and accumulate funds; and

(2) Make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

"Generic name" means a short title descriptive of the annuity contract being applied for or illustrated, such as "single premium deferred annuity".

"Guaranteed elements" means:

(1) Premiums;

(2) Credited interest rates, including any bonus;

(3) Benefits;

(4) Values;

(5) Non-interest-based credits;

(6) Charges; or

(7) Elements of formulas used to determine any of the above,

which are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements used in its calculation are guaranteed.

"Non-guaranteed elements" means:

(1) Premiums;

(2) Credited interest rates, including any bonus;

(3) Benefits;

(4) Values;

(5) Non-interest-based credits;

(6) Charges; or

(7) Elements of formulas used to determine any of the above,

which are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

"Structured settlement annuity" means:

(1) A "qualified funding asset" as defined in section 130(d) of the Internal Revenue Code; or

(2) An annuity that would be a "qualified funding asset" but for the fact that it is not owned by an assignee under a qualified assignment. [L 2006, c 71, pt of §1]

**[§431:10D-602] Applicability of standards for disclosure.** This part shall apply to all group and individual annuity contracts and certificates, except:

(1) Registered or non-registered variable annuities or other registered products;

(2) Immediate and deferred annuities that contain no non-guaranteed elements;

(3) Annuities used to fund:

(A) An employee pension plan that is covered by the Employee Retirement Income Security Act;
(B) A plan under section 401(a), 401(k), or 403(b) of the Internal Revenue Code, where the plan, for purposes of the Employee Retirement Income Security Act, is established or maintained by an employer;
(C) A governmental or church plan defined in section 414 of the Internal Revenue Code;
(D) A deferred compensation plan of a state or any of its political subdivisions under section 457 of the Internal Revenue Code;
(E) A tax-exempt organization under section 457 of the Internal Revenue Code; or
(F) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

provided that this part shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions that an employee elects to make on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract.

For the purposes of this paragraph, "direct solicitation" does not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

(4) Structured settlement annuities;

(5) Funding agreements; and

(6) Charitable gift annuities issued pursuant to paragraphs (1) to (4) of section 431:1-204(c). [L 2006, c 71, pt of §1]

**Revision Note**

Subsection designation deleted pursuant to §23G-15.

**§431:10D-603 Standards for the disclosure document and buyer's guide.** (a) Where the application for an annuity contract is taken:

(1) In a personal meeting, both the buyer's guide and disclosure document shall be given to the applicant at or before the time of application;

(2) By means other than in a personal meeting, both the buyer's guide and disclosure document shall be sent to the applicant no later than five business days after the completed application is received by the insurer;

(3) By means of a direct solicitation through the mail, providing both the buyer's guide and disclosure document in the mailing inviting the prospective applicant to apply for the annuity contract shall be deemed to satisfy the requirement that the buyer's guide and disclosure statement be provided no later than five business days after receipt of the application; and

(4) By means of the insurer's internet website, the insurer's reasonable steps to make the buyer's guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the buyer's guide and disclosure statement be provided no later than five business days after receipt of the application.

(b) A solicitation for an annuity contract provided in other than a personal meeting shall include a statement that the prospective applicant may contact the insurance division for a free buyer's guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free buyer's guide.

(c) If the buyer's guide and disclosure document are not provided at or before the time of application, a free-look period of no less than fifteen days shall be provided for the applicant to return the annuity contract without penalty, which period shall run consecutively with any other free-look period provided by law.

(d) The disclosure document shall include at least the following information:

(1) The generic name of the contract;

(2) The company product name, if different from the generic name;

(3) The form number;

(4) The fact that the product is an annuity;

(5) The insurer's name and address;

(6) A description of the contract and its benefits, which shall emphasize its long-term nature and include examples, where appropriate, such as:

(A) The guaranteed, non-guaranteed, and determinable elements of the contract, their limitations, if any, and an explanation of how they operate; and

(B) An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate, and the fact that rates may change from time to time and are not guaranteed;

(7) Periodic income options on both a guaranteed and non-guaranteed basis;

(8) Any value reductions caused by withdrawals from or surrender of the contract;

(9) How values in the contract can be accessed;

(10) The death benefit, if available, and how it will be calculated;

(11) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract;

(12) The effect of any rider, such as a long-term-care rider;

(13) A listing of specific dollar-amount or percentage charges and fees and an explanation of how they apply; and

(14) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

(e) Insurers shall define terms used in the disclosure statement in language that facilitates comprehension by the average person within the segment of the public to which the disclosure statement is directed. [L 2006, c 71, pt of §1; am L 2010, c 116, §1(21)]

**[§431:10D-604] Report to contract owners.** For annuities in the payout period with changes in non-guaranteed elements, and for the accumulation period of a deferred annuity, the insurer shall at least annually provide each contract owner with a report of the status of the contract that contains at least the following information:

(1) The beginning and ending dates of the current report period;

(2) The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

(3) The total amounts, if any, that have been credited, charged to the contract value, or paid during the current report period; and

(4) The amount of outstanding loans, if any, as of the end of the current report period. [L 2006, c 71, pt of §1]

**Revision Note**

Subsection designation deleted pursuant to §23G-15.

**[§431:10D-605] Penalties.** In addition to any other penalties provided by law, violation of any requirement of this part is an unfair method of competition or unfair or deceptive act or practice under section 431:13-102. [L 2006, c 71, pt of §1]

## [PART VII.] SUITABILITY IN ANNUITY TRANSACTIONS

### Cross References

Variable contracts, see §431:10D-118.

**§431:10D-621 Scope.** (a) This part applies to any recommendation to purchase, exchange, or replace an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase, exchange, or replacement recommended.

(b) This part does not apply to transactions involving:

(1) Direct-response solicitations where there is no recommendation based on information collected from the consumer pursuant to this part; or

(2) Contracts used to fund:

(A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act;

(B) A plan described by sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the Internal Revenue Code of 1986, as amended, if established or maintained by an employer;

(C) A governmental plan or church plan defined in section 414 of the Internal Revenue Code of 1986, as amended, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization subject to section 457 of the Internal Revenue Code of 1986, as amended;

(D) A non-qualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(E) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(F) Formal prepaid funeral contracts.

(c) Nothing in this part shall be construed to affect in any manner any provision of chapter 485A. [L 2007, c 257, pt of §2, §§4, 5, 9; am L 2011, c 108, §3]

**§431:10D-622 Definitions.** For the purposes of this part:

"Annuity" means an annuity that is an insurance product under state law that is individually solicited, whether the product is classified as an individual or group annuity.

"Approved continuing education course provider" means an individual or entity that is approved to offer continuing education courses pursuant to article 9A.

"Continuing education credit" means one continuing education credit hour. For the purposes of this paragraph, "credit hour" has the same meaning as set forth in section 431:9A-102.

"Insurance producer" means a person required to be licensed under the laws of this State to sell, solicit, or negotiate insurance, including annuities.

"Insurer" means a company required to be licensed under the laws of this State to provide insurance products, including annuities.

"Recommendation" means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase, exchange, or replacement of an annuity in accordance with that advice.

"Replacement" means a transaction for the purchase of a new policy or contract that the proposing producer, or the proposing insurer if there is no producer, knows or has reason to know will cause an existing policy or contract to be:

(1) Terminated, lapsed, forfeited, or surrendered, partially surrendered, or assigned to the replacing insurer;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended to effect a reduction in either benefits or the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a finance purchase.

"Suitability information" means information about the consumer that is reasonably related to the determination of the appropriateness of a recommendation, including the following:

(1) Age;

(2) Annual income;

(3) Financial situation and needs, including the financial resources used for funding the annuity at issue;

(4) Financial experience;

(5) Financial objectives;

(6) Intended use of the annuity;

(7) Financial time horizon;

(8) Existing assets, including investment and life insurance holdings;

(9) Liquidity needs;

(10) Liquid net worth;

(11) Risk tolerance; and

(12) Tax status. [L 2007, c 257, pt of §2; am L 2011, c 108, §4; am L 2012, c 66, §13]

**Note**

Definitions of "approved continuing education course provider" and "continuing education credit" take effect retroactive to January 1, 2012. L 2012, c 66, §17.

**§431:10D-623 Duties of insurers and insurance producers.** (a) In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer based on the facts, including the consumer's suitability information, disclosed by the consumer about the consumer's investments, other insurance products, financial situation, and needs and that:

(1) The consumer has been reasonably informed of the various features of the annuity, including the potential surrender period and surrender charge; potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity; mortality and expense fees; investment advisory fees; potential charges for and features of riders; limitations on interest returns; insurance and investment components; and market risk;

(2) The consumer would benefit from certain features of the annuity, including tax-deferred growth, annuitization, or death or living benefit;

(3) The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of the purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable and, in the case of an exchange or replacement, the transaction as a whole is suitable for the particular consumer; and

(4) In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable for the particular consumer taking into consideration whether:

(A) The consumer will incur a surrender charge; be subject to the commencement of a new surrender period; lose existing benefits such as death, living, or other contractual benefits; or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;

(B) The consumer would benefit from product enhancements and improvements; and

(C) The consumer has had another annuity exchange or replacement, particularly an exchange or replacement within the preceding thirty-six months.

(b) Prior to the execution of a purchase, exchange, or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer's suitability information.

(c) Except as permitted under subsection (d), an insurer shall not issue an annuity that has been recommended to a consumer unless the insurer has a reasonable basis to believe the annuity is suitable for the particular consumer based on the consumer's suitability information.

(d)(1) Except as provided under paragraph (2), neither an insurance producer nor an insurer shall have any obligation to a consumer related to any annuity transaction if:

(A) No recommendation is made;
(B) A recommendation was made based on materially inaccurate information provided by the consumer;
(C) A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended; or
(D) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer; and

(2) An insurer's issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

(e) An insurance producer or a representative of the insurer, where no insurance producer is involved, shall at the time of sale:

(1) Make a record of any recommendation subject to this section;

(2) Obtain a signed statement from the consumer documenting the customer's refusal to provide suitability information, if applicable; and

(3) Obtain a signed statement from the consumer acknowledging that an annuity transaction is not recommended if a consumer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

(f) An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with this part, including:

(1) Reasonable procedures to inform the insurer's insurance producers of the requirements of this part, including incorporating the requirements of this part into relevant insurance producer training manuals;

(2) Standards for insurance producer product training, including reasonable procedures to require its insurance producers to comply with section 431:10D-626;

(3) Product-specific training and training materials that explain all material features of its annuity products to its insurance producers;

(4) Procedures for review of each recommendation prior to the issuance of an annuity to ensure that there is a reasonable basis to determine the suitability of a recommendation that may include additional review of selected transactions through electronic, physical, or other means; provided that the insurer may specify criteria for selection of transactions for additional review;

(5) Reasonable procedures to detect recommendations that are not suitable, including confirmation of consumer suitability information, systematic consumer surveys, interviews, confirmation letters, and programs of internal monitoring; provided that nothing in this paragraph shall prevent an insurer applying sampling procedures or confirming suitability information after issuance or delivery of the annuity;

(6) Annual review and testing of the supervision system which shall be documented in a report to the insurer's senior management, including the senior manager responsible for audit functions, to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any;

(7) Procedures for monitoring contracts and, as appropriate, conducting audits to assure that any contracted functions are properly performed; and

(8) Annual certification based on reasonable facts from a senior manager who has responsibility for contracted functions that the contracted functions are properly performed.

(g) An insurer may contract for performance of any functions, including maintenance of procedures, required by subsection (f)(1) to (6); provided that an insurer shall be responsible for taking any appropriate corrective action and may be subject to sanctions and penalties pursuant to section 431:10D-624 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subsection (f).

(h) An insurer is not required to include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer.

(i) An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer's request for confirmation of suitability information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

(j) Sales made in compliance with requirements of the Financial Industry Regulatory Authority or its successor agency pertaining to suitability and supervision of annuity transactions shall satisfy the requirements of this section; provided that an insurer that issues an annuity subject to this part shall:

(1) Monitor the sales by entities registered as broker-dealers with the Financial Industry Regulatory Authority of annuities issued by the insurer using information collected in the normal course of an insurer's business; and

(2) Provide the entity subject to paragraph (1) with any information and reports that are reasonably necessary to assist the entity in maintaining the supervision system required by the Financial Industry Regulatory Authority.

This subsection shall apply to sales of variable annuities and fixed annuities where suitability and supervision requirements are similar to those applied to variable annuity sales. Nothing in this subsection shall limit the insurance commissioner's ability to enforce this part. [L 2007, c 257, pt of §2; am L 2011, c 108, §5]

**§431:10D-624 Compliance mitigation; penalties.** (a) An insurer shall be responsible for compliance with this part. If a violation occurs because of the action or inaction of the insurer or its insurance producer, the commissioner may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's or its insurance producer's violation of this part;

(2) A business entity, general agency, independent agency, or the insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of this part; and

(3) Appropriate penalties and sanctions.

(b) Any penalty applicable to an insurer, a managing general agent, independent agencies, or a producer under article 13 of chapter 431 may

be applicable to a violation of this part; provided that penalties may be reduced or eliminated if corrective action for the consumer was taken promptly after a violation was discovered or if the violation was not part of a pattern or practice. [L 2007, c 257, pt of §2; am L 2011, c 108, §6]

**[§431:10D-625] Recordkeeping.** Insurers, managing general agents, independent agencies, and insurance producers shall maintain or make available to the commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for five years after the insurance transaction has been completed by the insurer. An insurer may maintain documentation on behalf of an insurance producer. [L 2007, c 257, pt of §2]

**§431:10D-626 Insurance producer training.** (a) An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

(b) Any insurance producer who is authorized to sell annuity products on or before January 31, 2012, shall complete by January 31, 2012, a one-time training course on annuity products meeting the requirements of subsection (d).

(c) An insurance producer who obtains a life or variable life and variable annuity products line of authority after January 31, 2012, shall not engage in the sale of annuities until the insurance producer has completed training meeting the requirements of subsection (d).

(d) The training required by this section shall be approved by the commissioner, be conducted by an approved continuing education course provider, and meet the following requirements:

(1) The minimum length of the training shall be sufficient to qualify for at least four continuing education credits;

(2) The training shall include information on the following topics:

(A) The types and various classifications of annuities available on the market;
(B) Identification of the parties to an annuity;
(C) How fixed, variable, and indexed annuity contract provisions affect consumers;
(D) The application of income taxation to qualified and non-qualified annuities;
(E) The primary uses of annuities; and
(F) Appropriate sales practices, replacement, and disclosure requirements; and

(3) The training shall not include any marketing information for products of any particular insurer or training on sales techniques.

(e) A provider of an annuity training course intending to comply with this section shall register as an approved continuing education

course provider in this State and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in article 9A.

(f) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with article 9A.

(g) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with article 9A.

(h) The satisfaction of the training requirements of another state that are substantially similar to the provisions of this section shall be deemed to satisfy the training requirements of this section in this State.

(i) An insurer shall verify that an insurance producer has completed the annuity training course required by this section before allowing the producer to sell an annuity product for the insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved continuing education course providers. [L 2011, c 108, §2; am L 2012, c 66, §14]

**Note**

The 2012 amendment is retroactive to January 1, 2012. L 2012, c 66, §17.

## PART VIII. USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS

**Note**

Part heading amended by L 2012, c 34, §10.

**[§431:10D-641] Purpose.** The purpose of this part is to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation of, sale of, or purchase of, or advice given in connection with a life insurance or annuity product. [L 2011, c 108, pt of §7]

**[§431:10D-642] Prohibited uses of senior-specific certifications and professional designations.** (a) It is an unfair and deceptive act or practice in the business of insurance within the meaning of article 13 for an insurance producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that the insurance producer has a special certification or training in advising or servicing seniors in connection with the solicitation, sale, or purchase of a life insurance or annuity product or in providing advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product either directly or indirectly through publications or writings or by issuing or promulgating analyses or reports related to a life insurance or annuity product.

(b) The prohibited use of senior-specific certifications or professional designations includes the following:

(1) Use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use the certification or designation;

(2) Use of a non-existent, false, or self-conferred certification or professional designation;

(3) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the insurance producer using the certification or designation does not have; and

(4) Use of a certification or professional designation that was obtained from a certifying or designating organization that:

(A) Is primarily engaged in the business of instruction in sales or marketing;
(B) Does not have reasonable standards or procedures for assuring the competency of its certificants or designees;
(C) Does not have reasonable standards or procedures for monitoring and penalizing its certificants or designees for improper or unethical conduct; or
(D) Does not have reasonable continuing education requirements for its certificants or designees to maintain the certificate or designation.

(c) There is a rebuttable presumption that a certifying or designating organization is not disqualified for purposes of subsection (b) when the certification or designation issued from the organization does not primarily apply to sales or marketing and when the organization or the certification or designation in question has been accredited by:

(1) The American National Standards Institute;

(2) The National Commission for Certifying Agencies; or

(3) Any organization that is on the United States Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes".

(d) In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered shall include:

(1) Use of one or more words such as "senior", "retirement", "elder", or like words combined with one or more words such as "certified", "registered", "chartered", "adviser", "specialist", "consultant", "planner", or like words, in the name of the certification or professional designation; and

(2) The manner in which those words are combined.

(e) For purposes of this section, a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency is not a certification or professional designation unless it is used in a manner that would confuse or mislead a reasonable consumer when the job title:

(1) Indicates seniority or standing within the organization; or

(2) Specifies an individual's area of specialization within the organization. [L 2011, c 108, pt of §7]

# ARTICLE 10E
# PROPERTY INSURANCE

## PART I. INSURABLE INTEREST IN PROPERTY; OVER-INSURANCE

### Note

Sections 431:10E-101 to 431:10E-103 designated as Part I by L 2012, c 80, §2.

**§431:10E-101 Insurable interest in property required.** No contract of insurance on property or of any interest therein or arising therefrom shall be enforceable except for the benefit of persons having an insurable interest in the property insured. Insurable interest means any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage. [L 1987, c 347, pt of §2]

**§431:10E-102 Over-insurance prohibited; exceptions.** (a) Over-insurance shall be deemed to exist if property or an insurable interest in the property is insured by one or more insurance contracts against the same hazard in any amount in excess of the actual cash value of the property or of such interest, as determined as of the effective date of the insurance or of any renewal thereof.

(b) For the purposes of this section only, the term actual cash value means the cost of replacement less such depreciation as is properly applicable to the subject insured.

(c) No person shall knowingly sell, solicit, negotiate, or make any contract for insurance which would result in over-insurance of the property or interest therein proposed to be insured, except as is provided in section 431:10E-103.

(d) Each violation of this section shall subject the violator to the penalties provided by this code. [L 1987, c 347, pt of §2; am L 2002, c 155, §74]

**§431:10E-103 Exceptions.** Section 431:10E-102 does not apply to:

(1) Insurance on buildings and building service equipment pertaining thereto and part thereof, and machinery, tools, and other equipment appurtenant to or used in connection with any trade, business, manufacturing process, governmental operations, or public and private institutions, and household furniture and furnishings in dwelling houses, with respect to the difference between the actual value of the insured property at the time any loss or damage occurs and the cost of repairing, rebuilding, or replacing with new materials of like size, kind and quality, such property as has been damaged or destroyed by fire or other peril insured against.

(2) Insurance against the cost of demolition or reconstruction, or both, of any portion of the insured premises which has not suffered damage, and the additional cost of repair or reconstruction, or both, of portions of the insured premises which have suffered damage, necessary to comply with applicable laws or ordinances. [L 1987, c 347, pt of §2]

## PART II. HOMEOWNERS INSURANCE CLAIMS HISTORY

**[§431:10E-121] Purpose.** The purpose of this part is to regulate the use of claims history information for homeowners insurance and provide certain consumer protections with respect to the use of this information. [L 2012, c 80 pt of §1]

**[§431:10E-122] Scope; effective dates.** This part shall apply to all homeowners insurance policies delivered or issued for delivery in this State after July 31, 2012. [L 2012, c 80, pt of §1]

**[§431:10E-123] Definitions.** As used in this part, "inquiry" means a telephone call or other communication made to an insurer regarding the terms, conditions, or coverage afforded under an insurance policy that does not result in a claim, including questions concerning whether a policy will cover a loss or the process for filing a claim. The term shall not constitute a claim for purposes of section 431:13-103(a)(11). [L 2012, c 80, pt of §1]

**[§431:10E-124] Use of inquiries and other information.** An insurer shall not refuse to issue, refuse to renew, or cancel a homeowners insurance policy, or establish rates for coverage based in whole or in part on inquiries made by any consumer to an insurer, unless the inquiry provides information not previously disclosed by the insured. [L 2012, c 80, pt of §1]

## [PART III. LAVA ZONES]

### Revision Note

Part heading added pursuant to §23G-15.

**[§431:10E-141] Lava zone defined.** As used in this article, "lava zone" means a volcanic hazard zone identified by the United States Geological Survey on the island of Hawaii. [L 2015, c 32, pt of §2]

**[§431:10E-142] Provisions for properties in lava zones in the county of Hawaii.** (a) Where the mayor of the county of Hawaii has issued a proclamation declaring the existence of a state of emergency due to the threat of imminent disaster from a lava flow in a lava zone, the total number (rounded to the nearest whole number) of property insurance policies that an insurer may non-renew in a lava zone shall be limited for each calendar year to five per cent of the total number of covered policies of the insurer in force in that lava zone.

(b) Notwithstanding subsection (a), an insurer may cancel or non-renew a property insurance policy where:

(1) Premium payments for the policy are not made after reasonable demand therefor; or

(2) The commissioner determines the financial soundness of the insurer would be impaired. [L 2015, c 32, pt of §2]

**Cross References**

Hawaii property insurance association, issuance of new policies on properties in lava zones, see §431:21-119.

## [PART IV.] COVERAGES

**[§431:10E-151] Notice requirement.** Thirteen months prior to discontinuation of writing property insurance coverage, an insurer shall file an affidavit with the commissioner stating the reasons for the discontinuation. [L 2016, c 141, pt of §1]

**[§431:10E-152] Extended coverage.** Insurers seeking to provide multi-peril coverage for residential property after July 1, 2016, shall submit to the commissioner a written request for permission to write the coverage. The commissioner may disapprove the request. If the request is disapproved, the insurer shall not write the coverage. [L 2016, c 141, pt of §1]

# ARTICLE 10F
# SURETY INSURANCE

**Cross References**

Bail agents; sureties, see article 9N.

**§431:10F-101 Requirements deemed met by surety insurer.** Whenever by law or by rule of any court, public official, or public body, a surety bond is required or is permitted to be given, provided the bond is otherwise proper and its conditions are guaranteed by an authorized surety insurer or by an unauthorized surety insurer pursuant to article 8, part II, the bond shall be approved and accepted and shall be deemed to fulfill all requirements as to number of sureties, residence or status of sureties, and other similar requirements, and no justification by the surety shall be necessary. For the purpose of this section, surety bond shall also include a recognizance, obligation, stipulation or undertaking. [L 1987, c 347, pt of §2]

**§431:10F-102 Fiduciary bonds, expense.** Any fiduciary required by law to give bonds, may include, as part of the fiduciary's lawful expense to be allowed by the court or official by whom the fiduciary was appointed, the reasonable amount paid as premium for the bonds to the surety insurer who issued or guaranteed the bonds. [L 1987, c 347, pt of §2]

**§431:10F-103 Court bonds, costs.** In any proceeding, the party

entitled to recover costs may include in the costs such reasonable sum as was paid to the surety insurer as premium for any bond or undertaking required therein, and as may be allowed by the court having jurisdiction of the proceeding. [L 1987, c 347, pt of §2]

**§431:10F-104 Release from liability.** A surety insurer may be released from its liability on the same terms and conditions as are provided by law for the release of individuals as sureties. [L 1987, c 347, pt of §2]

**[§431:10F-105] Directed suretyship; coercion of contractors.** (a) No person may require as a condition precedent to the granting, awarding, or issuing a contract for the construction or renovation of improvements to real property, that the person whose obligation under such contract is to provide, construct, or renovate improvements to real property is to acquire or negotiate a surety bond or other contract guaranteeing completion of such improvements through a particular surety insurer or group of surety insurers, or a particular producer or group of producers.

(b) The commissioner may examine and investigate the insurance related activities of any person whom the commissioner believes may be in violation of this section. Any person may submit to the commissioner a complaint or any material pertinent to the enforcement of this section.

(c) Nothing in this section shall prevent a person who grants, awards, or issues contracts for the construction or renovation of improvements to real property from requiring a person to acquire or negotiate a surety bond or other contract guaranteeing completion of the improvements through authorized surety insurers or producers licensed to do business in the State or both. [L 2007, c 251, §1]

## ARTICLE 10G
## MOTORCYCLE AND MOTOR SCOOTER INSURANCE

### Case Notes

The plain language of this chapter as well as its legislative history disqualified plaintiff, who was injured by someone operating a motorcycle, from no-fault benefits. 91 H. 299 (App.), 983 P.2d 200.

### PART I. GENERAL PROVISIONS

**§431:10G-101 Definitions.** As used in this article:

"Accidental harm" means bodily injury, death, sickness, or disease caused by a motorcycle or motor scooter accident to a person.

"Injury" means accidental harm not resulting in death.

"Motorcycle" has the meaning prescribed by section 286-2.

"Motorcycle accident" means an accident arising out of the operation, maintenance, or use of a motorcycle, but not involving a motor vehicle.

"Motor scooter" has the meaning prescribed by section 286-2.

"Motor scooter accident" means an accident arising out of the operation, maintenance, or use of a motor scooter, but not involving a motor vehicle.

"Owner" means a person who holds the legal title to a motorcycle or motor scooter; except that when a motorcycle or motor scooter is the subject of a security agreement or lease with a term of not less than one

year, with the debtor or lessee having the right of possession, the term owner shall mean the debtor or lessee. Whenever transfer of title to a motorcycle or motor scooter occurs, the seller shall be considered the owner until delivery of the executed title to the buyer. Upon delivery of the executed title, the buyer holding the equitable title shall be considered the owner.

"Person" means, when appropriate to the context, not only individuals, but corporations, firms, associations, and societies. [L 1989, c 208, pt of §1]

**§431:10G-102 Conditions of operation and registration of motorcycles and motor scooters.** No person shall drive a motorcycle or motor scooter upon any public street, road, or highway of this State at any time unless such motorcycle or motor scooter is insured at all times under a liability policy as provided in section 431:10G-301; provided that this article shall not apply to any antique motorcycle or motor scooter as defined in section 249-1. [L 1989, c 208, pt of §1; am L 1996, c 56, §3]

**§431:10G-103 Motorcycle or motor scooter self-insurance.** The motorcycle or motor scooter insurance required by section 431:10G-102 may be satisfied by any owner of a motorcycle or motor scooter if:

(1) Such owner provides proof of qualifications as a self-insurer, and a surety bond or other securities affording security substantially equivalent to that afforded under a policy meeting the requirements of section 431:10G-301 and providing coverage at all times for the entire motorcycle or motor scooter registration period, as determined and approved by the commissioner under rules; and

(2) The commissioner is satisfied that in case of injury, death, or property damage, any claimant would have the same rights against such owner as the claimant would have had if a policy meeting the requirements of section 431:10G-301 had been applicable to such motorcycle or motor scooter. [L 1989, c 208, pt of §1]

**§431:10G-104 Prerequisites for obtaining coverage.** (a) Any person seeking to obtain the liability coverage required by this part after June 7, 1989, shall first:

(1) Have obtained a valid motorcycle or motor scooter license; or

(2) Have obtained a valid motorcycle or motor scooter learner's permit and have taken and passed a motorcycle education course approved by the department of transportation.

(b) A temporary insurance binder covering a period of not more than ninety days may be issued to a person who has a valid motorcycle or motor scooter learner's permit. To obtain a temporary binder, a person shall submit proof to the insurer of the person's enrollment in an approved motorcycle education course. The temporary insurance binder shall be subject to cancellation should the person fail to take, complete, and pass the course for which proof was submitted to the insurer. [L 1989, c 208, pt of §1; am L 1990, c 241, §1; am L 1991, c 174, §1]

**§431:10G-105 Tort liability.** (a) With respect to accidental harm incurred in or arising out of a motorcycle accident or motor scooter accident, tort liability is not abolished.

(b) Any owner or operator of a motorcycle or motor scooter involved in a motor vehicle accident as defined in section 431:10C-103 and who incurs accidental harm as defined in section 431:10C-103, including such person's representative or legal guardian, shall have a cause of action in tort as provided in section 431:10C-306. [L 1989, c 208, pt of §1; am L 1997, c 251, §54]

**§431:10G-106 Verification of insurance.** Every insurer shall issue to each of its insureds a paper or electronic proof of insurance card for each motorcycle or motor scooter for which a liability policy under this article is written. The electronic proof of insurance card may be accessed directly through the licensed insurer's website, application, or database. The proof of insurance card shall show the following:

(1) Name, make, year, and factory or serial number of the motorcycle or motor scooter; provided that insurers of five or more motorcycles or motor scooters that are under common registered ownership and used in the regular course of business shall not be required to indicate the name, make, year, and the factory or serial number of each motorcycle or motor scooter;

(2) Policy number;

(3) Names of the insured and the insurer; and

(4) Effective dates of coverage including the expiration date.

The proof of insurance card shall be carried on, or accessible on a mobile electronic device, as defined in section 291C-137, by the person operating the insured motorcycle or motor scooter at all times and shall be exhibited to a law enforcement officer upon demand. [L 1989, c 208, pt of §1; am L 2004, c 122, §59; am L 2016, c 82, §4]

**§431:10G-107 Drivers education fund underwriters fee; motorcycle and motor scooter operators education fund.** (a) The commissioner shall assess and levy upon each insurer, and self-insurer, a drivers education fund underwriters fee of $2 a year on each motorcycle or motor scooter insured by each insurer or self-insurer. This fee shall be due and payable on an annual basis by means and at a time to be determined by the commissioner.

(b) There is created in the treasury of the State a special fund to be known as the motorcycle and motor scooter operators education fund. The commissioner shall deposit the fees collected under this section into the motorcycle and motor scooter operators education fund.

(c) The fees deposited for each fiscal year into the motorcycle and motor scooter operators education fund, when appropriated, shall be available to the department of transportation for the administration of a drivers education program for operators of motorcycles or motor scooters. The department of transportation may spend the amount collected from these fees for the purposes of this section. [L 1989, c 208, pt of §1; am L 1997, c 184, §1; am L 2002, c 121, §2]

**§431:10G-108 Penalties.** Any person who violates this article shall be subject to a citation by the police and shall be subject to a nonsuspendable fine of not less than $100 nor more than $1,000, thirty days imprisonment, a one year driver's license suspension, or any

combination thereof, for each violation.

Any person cited under this section shall have an opportunity to present a good faith defense, including but not limited to lack of knowledge or proof of insurance. The general penalty provision of this section shall not apply to:

(1) Any operator of a motorcycle or motor scooter owned by another person if the operator's own insurance covers such driving;

(2) Any operator of a motorcycle or motor scooter owned by that person's employer during the normal scope of that person's employment; or

(3) Any operator of a borrowed motorcycle or motor scooter if the operator holds a reasonable belief that the subject vehicle is insured. [L 1989, c 208, pt of §1; am L 2000, c 64, §1]

**§431:10G-109 Rules.** The commissioner may adopt rules pursuant to chapter 91 necessary for the purposes of this article. [L 1989, c 208, pt of §1]

## PART II. RATES AND ADMINISTRATION

**§431:10G-201 Making of motorcycle and motor scooter insurance rates.** (a) All premium rates for motorcycle and motor scooter insurance shall be made in accordance with the following provisions:

(1) Rates shall not be excessive, inadequate, or unfairly discriminatory;

(2) Due consideration shall be given to:

(A) Past and prospective loss experience within and outside this State, catastrophe hazards, if any, reasonable margin for profit, and contingencies, dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

(B) Past and prospective expenses both country-wide and those specially applicable to this State in the sale and administration of motorcycles and motor scooters insurance; and

(C) Investment income from reserves, unearned insurance premiums, and other unearned proceeds received on account of motorcycle and motor scooter insurance sold, and all other factors that may be deemed relevant, if they are established to have a probable effect upon losses, expense, or rates, such as but not limited to types of vehicles, occupations, and involvement in past accidents;

(3) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any insurer or group with respect to any class of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable; and

(4) Risks may be grouped by classifications for the establishing of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. The standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or

expenses.

(b) Except to the extent necessary to meet the provisions of subsection (a)(4), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

(c) After June 7, 1989, each insurer of a motorcycle or motor scooter shall provide a fifteen per cent reduction off premium charges each insurer assesses for each new and renewal policy for liability coverage issued pursuant to this article if the applicant has successfully completed a motorcycle education course approved by the department of transportation. [L 1989, c 208, pt of §1]

**Revision Note**

"June 7, 1989" substituted for "the effective date of this section".

**Case Notes**

Discussed: 78 H. 325, 893 P.2d 176.

**§431:10G-202 Rate filings.** (a) Every insurer shall file with the commissioner every manual of classification, rule, rate, rating plan, designation of rating territories, or standard for motorcycle or motor scooter insurance which it proposes to use. Every filing shall state the proposed effective date of the filing and the character and extent of the coverage contemplated.

(b) The commissioner also may accept from an advisory organization basic standards, manuals of classification, territories, endorsements, forms, and other materials, not dealing with rates, for reference filings by insurers.

(c) Each filing shall be accompanied by a $20 fee payable to the commissioner, which fee shall be deposited in the commissioner's education and training fund.

(d) A filing and any supporting information shall be open to the public upon filing with the commissioner. [L 1989, c 208, pt of §1]

**Cross References**

Commissioner's education and training fund, see §431:2-214.

**§431:10G-203 Rate review: request by aggrieved party.** (a) Any person aggrieved by the application as to such person of any classification, rule, standard, rate, or rating plan made, followed, or adopted by an insurer may make written request to the commissioner to review such application and grant the relief requested. If the commissioner finds that probable cause for the complaint exists or that the complaint charges a violation of this article, the commissioner shall conduct a hearing on the complaint according to the procedure set forth in section 431:14-118.

(b) If, after a hearing conducted pursuant to subsection (a), the commissioner finds that the complainant is entitled to relief or that any classification, rule, standard, rate, rating territory, or rating plan violates this article, the commissioner shall issue an order granting the complainant's claim for relief or prohibiting the insurer from using such classification, rule, standard, rate, rating territory, or rating plan. The order shall contain the commissioner's findings of fact and

conclusions of law, including a specification of the respects in which a violation of this article exists and specifying a reasonable time period within which the insurer shall comply with the terms of the order. Any such order shall be subject to judicial review in the manner provided in chapter 91. [L 1989, c 208, pt of §1]

**§431:10G-204 Rate review: rate methods in noncompliance with article.** (a) If the commissioner has good cause to believe that a classification, rule, standard, rate, rating territory, or rating plan made, followed, or adopted by an insurer does not comply with the requirements of this article, the commissioner shall, unless the commissioner has good cause to believe that such noncompliance is wilful, give notice in writing to each insurer, stating in what manner and to what extent such noncompliance is alleged to exist and specifying a reasonable time, not less than ten days thereafter, within which such noncompliance may be corrected. Notices under this subsection shall be confidential as between the commissioner and the parties unless a hearing is held as provided in subsection (b).

(b) If the commissioner has good cause to believe such noncompliance to be wilful, or if, within the period prescribed by the commissioner in the notice given under subsection (a), the insurer does not:

(1) Correct the noncompliance specified by the commissioner; or

(2) Establish to the satisfaction of the commissioner that such noncompliance does not exist,

then the commissioner may proceed with a hearing which shall be subject to the hearing procedure provided in section 431:14-118. [L 1989, c 208, pt of §1]

**§431:10G-206 Rate administration.** Except as otherwise provided in this article, the commissioner shall implement and evaluate motorcycle and motor scooter insurance rates in compliance with article 14. [L 1989, c 208, pt of §1]

## PART III. COVERAGES AND RIGHTS

**§431:10G-301 Required motorcycle and motor scooter policy coverage.** (a) An insurance policy covering a motorcycle or motor scooter shall provide insurance in the following amounts to pay, on behalf of the owner or any operator of the insured motorcycle or motor scooter, sums that the owner or any operator may legally be obligated to pay for injury, death, or damage to the property of others, except property owned by, being transported by, or in charge of the insured that arise out of the ownership, operation, maintenance, or use of the motorcycle or motor scooter:

(1) Liability coverage of not less than $20,000 per person, with an aggregate limit of $40,000 per accident, for all damages arising out of accidental harm sustained as a result of any one accident; and

(2) Liability coverage of not less than $10,000 for all damages arising out of injury to or destruction of property, including motorcycles or motor scooters and including the loss of use thereof, but not including property owned by, being transported by, or in the charge of the insured, as a result of any one accident.

(b) At the option of the owner, each insurer shall:

(1) Offer medical payment coverage up to $10,000 to pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical, dental, ambulance, hospital, professional, and nursing services;

(2) Offer an income disability plan; and

(3) Offer liability coverage in excess of the minimum coverages required by this section.

(c) Any operator or passenger of a motorcycle or motor scooter as defined in section 286-2 who receives injuries or dies in a motor vehicle accident may not claim personal injury protection benefits under a motor vehicle insurance policy, unless expressly provided for in the motor vehicle policy. [L 1989, c 208, pt of §1; am L 1994, c 128, §5; am L 1998, c 275, §34]

## ARTICLE 10H
## LONG-TERM CARE INSURANCE

### Note

See table at end of this Article for derivation of HRS sections from the National Association of Insurance Commissioners 1998 Model Act or Regulations.

### Cross References

Long-term care financing, see chapter 346C.

### PART I. LONG-TERM CARE INSURANCE MODEL ACT

**[§431:10H-101] Purpose.** The purpose of this article is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage. [L 1999, c 93, pt of §2]

**[§431:10H-102] Scope.** The requirements of this article shall apply to policies delivered or issued for delivery in this State on or after July 1, 2000. This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. [L 1999, c 93, pt of §2]

**[§431:10H-103] Short title.** This article may be known and cited as the "Long-Term Care Insurance Act". [L 1999, c 93, pt of §2]

**§431:10H-104 Definitions.** As used in this article, unless the context requires otherwise, the definitions in this section apply throughout this article.

"Applicant" means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

"Certificate" means, for the purposes of this article, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.

"Exceptional increase" means only those increases filed by an insurer that are extraordinary and for which the commissioner determines the need for the premium rate increase is justified:

(1) Due to:

(A) Changes in laws or rules applicable to long-term care coverage in this State; or

(B) Increased and unexpected utilization that affects the majority of insurers of similar products;

(2) Except as provided in section 431:10H-232, exceptional increases are subject to the same requirements as other premium rate schedule increases;

(3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase; and

(4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

"Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this State and issued to:

(1) One or more employers or labor organizations, or a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association:

(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within this State, the association or the insurer of the association shall file evidence with the commissioner that the association has at the outset a minimum of one hundred persons; has been organized and maintained in good faith for purposes other than that of obtaining insurance; has been in active existence for at least one year; and has a constitution and bylaws which provide that:

(A) The association holds regular meetings not less than

annually to further purposes of the members;

(B) Except for credit unions, the association collects dues or solicits contributions from members; and

(C) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing the association will be deemed to satisfy the organizational requirements unless the commissioner makes a finding that the association does not satisfy those organizational requirements; or

(4) A group other than as described in paragraphs (1), (2), and (3), subject to a finding by the commissioner 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; and

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

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

"Incidental", as used in section 431:10H-207.5(j), means that the value of the long-term care benefits provided is less than ten per cent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issue life or health insurance.

Long-term care insurance shall not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Notwithstanding any other provision contained herein, any product

advertised, marketed, or offered as long-term care insurance shall be subject to this article.

"NAIC" means the National Association of Insurance Commissioners.

"Policy" means, for the purposes of this article, any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization; or any similar organization.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(3) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in paragraph (5);

(5) All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(6) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code of 1986, as amended.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended. [L 1999, c 93, pt of §2; am L 2007, c 233, §§5, 6]

**[§431:10H-105] Extraterritorial jurisdiction; group policies.** No group long-term insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in paragraph (4) under the definition of "group long-term care insurance" in section 431:10H-104, unless this State or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this State has made a determination that these requirements have been met. [L 1999, c 93, pt of

§2]

**[§431:10H-106] Rules.** The commissioner may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definition of terms. [L 1999, c 93, pt of §2]

**[§431:10H-106.5] Producer training requirements.** (a) Effective on the date that is one year following the enactment by the State of legislation establishing the long-term care partnership program as provided in title VI, section 6021 of the Federal Deficit Reduction Act of 2005, an individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident, health, or life insurance and has completed a one-time training course and ongoing training every twenty-four months thereafter. This training shall meet the requirements set forth in subsections (c) and (d). The producer training requirements provided in this section shall be required of every producer selling, soliciting, or negotiating long-term care insurance.

(b) The training requirements of subsections (c) and (d) may be approved as continuing education courses under section 431:9A-153.

(c) The one-time training required under this section shall be no less than eight hours and the ongoing training required by this section shall be no less than four hours for every twenty-four month period thereafter.

(d) The training required under this section shall consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs, including but not limited to:

(1) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(2) Available long-term care services and providers;

(3) Changes or improvements in long-term care services or providers;

(4) Alternatives to the purchase of long-term care insurance;

(5) The effect of inflation on benefits and the importance of inflation protection; and

(6) Consumer suitability standards and guidelines.

(e) The training required by this section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training other than those required by state or federal law.

(f) Insurers subject to article 10H, chapter 431, shall obtain

verification that a producer received training required by this section before a producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products, maintain records subject to the State's record retention requirements, and make that verification available to the commissioner upon request.

(g) Insurers subject to article 10H, chapter 431, shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the commissioner to provide assurance to the State's medicaid agency that producers have received the training required by this section and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including medicaid, in the State. These records shall be maintained in accordance with the State's record retention requirements and shall be made available to the commissioner upon request.

(h) The satisfaction of training requirements in any state shall be deemed to satisfy the training requirements provided in this section. [L 2007, c 233, pt of §3]

**[§431:10H-107] Basic standards.** No long-term care insurance policy may:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care. [L 1999, c 93, pt of §2]

**Revision Note**

Subsection designation deleted pursuant to §23G-15.

**[§431:10H-108] Preexisting conditions--group and individual policies.** (a) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104 shall use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104 may exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The commissioner may extend the limitation periods in subsections (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of

the public.

(d) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (b) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (b). [L 1999, c 93, pt of §2]

**[§431:10H-109] Prior hospitalization; prior institutionalization.** (a) No long-term care insurance policy may be delivered or issued for delivery in this State if the policy:

(1) Conditions eligibility for any benefits on a prior hospitalization requirement;

(2) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(b) A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label, in a separate paragraph of the policy or certificate, entitled "Limitations or Conditions on Eligibility for Benefits", such limitations or conditions including any required number of days of confinement.

(c) A long-term care insurance policy that conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days. [L 1999, c 93, pt of §2]

**[§431:10H-110] Loss ratio standards; factors; commissioner approval.** The commissioner may adopt rules establishing loss ratio standards for long-term care insurance policies; provided that a specific reference to long-term care insurance policies is contained in the rule. [L 1999, c 93, pt of §2]

**§431:10H-111 Right to return; free look provision.** Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, the applicant is not satisfied for any reason. This section shall also

apply to a denial of an application for a long-term care contract. Any refund shall be made within thirty days of the return or denial. [L 1999, c 93, pt of §2; am L 2007, c 233, §7]

**§431:10H-112 Outline of coverage required.** (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose. The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage. In the case of producer solicitations, a producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitation, the outline of coverage shall be presented in conjunction with any application or enrollment form. In the case of a policy issued to a group defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, an outline of coverage shall not be required to be delivered; provided that the information described in subsection (b) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

(b) The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(5) A description of the terms under which the policy or certificate may be returned and premium refunded;

(6) A brief description of the relationship of costs of care and benefits; and

(7) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended. [L 1999, c 93, pt of §2; am L 2003, c 212, §93; am L 2007, c 233, §8]

**[§431:10H-113] Group policy certificate requirements.** A certificate issued pursuant to a group long-term care insurance policy which is delivered or issued for delivery in this State shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions. [L 1999, c 93, pt of §2]

**§431:10H-114 Life insurance policies offering long-term care benefits.** (a) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of the request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the policy summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions, and limitations on benefits of long-term care;

(4) A statement that any long-term care inflation protection option required by section 431:10H-220 is not available under this policy;

(5) If applicable to the policy type, the summary shall also include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantees related to long-term care costs of insurance charges, and current and projected maximum lifetime benefits; and

(6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered or into the life insurance policy summary that is required to be delivered.

(b) Any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, for example death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

(c) Any policy advertised, marketed, or offered as long-term care or nursing home insurance shall comply with this article. [L 1999, c 93, pt of §2; am L 2007, c 233, §9]

**§431:10H-115 Incontestability period--group and individual policies.** (a) For a policy or certificate that has been in force for less than six months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance of coverage.

(b) For a policy or certificate that has been in force at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance of coverage and which pertains to the condition for which benefits are sought.

(c) After a policy or certificate has been in force for two years it is not contestable solely upon the grounds of misrepresentation

alone. The policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d) No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this subsection, "field issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer.

(e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer if the policy or certificate is rescinded.

(f) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by article 10D of this chapter. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care. [L 1999, c 93, pt of §2; am L 2003, c 212, §94]

**[§431:10H-116] Nonforfeiture benefits.** (a) Except as provided in subsection (b), a long-term care insurance policy shall not be delivered or issued for delivery in this State unless the policyholder or certificate holder has been offered an option to purchase a policy or certificate that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(b) For a group long-term care insurance policy, the offer of a nonforfeiture benefit under subsection (a) shall be made to the group policyholder. However, if the policy is issued as a group long-term care insurance, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(c) The commissioner shall adopt rules to specify the type of nonforfeiture benefits to be offered as part of long-term care insurance policies or certificates, the standards for nonforfeiture benefits, and the rules for contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse shall be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as provided in subsection (a). [L 1999, c 93, pt of §2]

**[§431:10H-116.5] Delivery of the contract or certificate of insurance.** If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval. [L 2007, c 233, pt of §3]

**[§431:10H-116.6] Denial of claims; compliance requirements.** (a) If a claim under a long-term care insurance contract is denied, the issuer, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative thereof shall:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

(b) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with this article. [L 2007, c 233, pt of §3]

**§431:10H-117 Authority to adopt rules.** The commissioner may adopt reasonable rules to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, producer compensation, producer testing, penalties, and reporting practices for long-term care insurance. [L 1999, c 93, pt of §2; am L 2003, c 212, §95]

## PART II. LONG-TERM CARE INSURANCE MODEL REGULATION

**§431:10H-201 Policy definitions.** (a) No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth in this section, unless the terms are defined in the policy and the definitions satisfy the following requirements:

"Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

"Acute condition" means that the individual is medically unstable. This individual requires frequent monitoring by medical professionals such as physicians and registered nurses, in order to maintain the individual's health status.

"Adult day care" means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

"Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

"Cognitive impairment" means a deficiency in a person's short- or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

"Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

"Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

"Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

"Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

"Home health care services" means medical and nonmedical services, provided to ill, disabled, or infirm persons in their residences. These services may include homemaker services, assistance with activities of daily living, and respite care services.

"Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then

Constituted or Later Amended", or title I, part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import.

"Mental or nervous disorder" means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder, and shall not be defined beyond these terms.

"Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

"Skilled nursing care", "personal care", "home care", "specialized care", "assisted living care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

"Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

"Transferring" means moving into or out of a bed, chair, or wheelchair.

(b) All providers of services, including but not limited to a "skilled nursing facility", "extended care facility", "convalescent nursing home", "personal care facility", "assisted living facility", "home care agency", and "specialized care providers" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed, certified, or registered; provided that when the definition so requires, it shall also state what requirements a provider shall meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies, or registers the provider of services under another name. [L 1999, c 93, pt of §2; am L 2007, c 233, §10]

**§431:10H-202 Renewability.** (a) The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section 431:10H-211. A policy issued to an individual shall not contain renewal provisions other than guaranteed renewable or noncancellable.

(b) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(c) The term "noncancellable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(d) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this section, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended. [L 1999, c 93, pt of §2; am L 2007, c

233, §11]

**[§431:10H-202.5] Licensing.** A producer is not authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by article 9A. [L 2007, c 233, pt of §4]

**§431:10H-203 Limitations and exclusions.** (a) A policy may not be delivered or issued for delivery in this State as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment, or medical condition arising out of:

(A) War or act of war, whether declared or undeclared;
(B) Participation in a felony, riot, or insurrection;
(C) Service in the armed forces or units auxiliary thereto;
(D) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
(E) Aviation (this exclusion applies only to non-fare-paying passengers);

(5) Treatment provided in a government facility (unless required by law), services for which benefits are available under medicare or other governmental program (except medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, or any motor vehicle insurance law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(b) This section is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

(1) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, registration; or

(2) When the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

For purposes of this subsection, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(c) This section is not intended to prohibit territorial

limitations. [L 1999, c 93, pt of §2; am L 2007, c 233, §12]

**[§431:10H-204] Extension of benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. [L 1999, c 93, pt of §2]

**[§431:10H-204.5] Electronic enrollment for group policies.** (a) In the case of a group defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(1) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(2) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

(3) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and privileged information is maintained.

(b) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. [L 2007, c 233, pt of §4]

**[§431:10H-205] Continuation or conversion.** (a) Group long-term care insurance issued in this State beginning July 1, 2000, shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(c) For purposes of this section, "a basis for conversion of coverage" means a policy provision that entitles an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or any group policy that it replaced for at least six months immediately prior to termination shall

be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

(d) For purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium, if any, shall be paid as directed by the insurer no later than thirty-one days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group policy coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced a previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) The terminating coverage is replaced not later than thirty-one days after termination by another group coverage effective on the day following the termination of coverage:

(A) Providing benefits or benefits determined by the commissioner to be identical substantially equivalent to or in excess of those provided by the terminating coverage; and

(B) The premium for which is calculated in a manner consistent with the requirements of subsection (f).

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred per cent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that

would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage or reciprocal beneficiary relationship.

(k) For purposes of this section "managed care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks. [L 1999, c 93, pt of §2]

**[§431:10H-206] Discontinuance and replacement.** If a group long-term care insurance policy is replaced by another group long-term care insurance policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to person under the new group policy shall not:

(1) Result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services. [L 1999, c 93, pt of §2]

**[§431:10H-207] Premiums charged--group and individual policies.** (a) The premium charged to an insured shall not increase due to either:

(1) Increasing age of the insured at ages beyond sixty-five; or

(2) The duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under section 431:10H-233, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c) A reduction of benefits shall not be considered a premium change, but for purpose of calculation required under section 431:10H-233, the initial annual premium shall be based on reduced benefits. [L 1999, c 93, pt of §2]

**[§431:10H-207.5] Premium rate schedule increases.** (a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to any long-term care policy or certificate issued in this State after December 31, 2007; and

(2) For certificates issued after June 30, 2007, under a group long-term care insurance policy, as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, which policy was in force on July 1, 2007, this section shall apply on the policy anniversary following July 1, 2007.

(b) An insurer shall provide notice of a pending premium rate

schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to the notice to the policyholders and shall include:

(1) Information required by section 431:10H-221;

(2) A certification by a qualified actuary that:

(A) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(B) The premium rate filing is in compliance with this section;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(A) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale; provided that:

(i) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with subsection (c); and

(iv) For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase. If the commissioner determines, as provided in paragraph (4) of the definition of "exceptional increase" in section 431:10H-104, that offsets may exist, the insurer shall use appropriate net projected experience;

(B) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger a contingent benefit upon lapse;

(C) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(D) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(E) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for the review of the premium rate schedule increase by the commissioner.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy per cent of the present value of projected additional premiums from the exceptional increase shall be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(A) The accumulated value of the initial earned premium times fifty-eight per cent;
(B) Eighty-five per cent of the accumulated value of prior premium rate schedule increases on an earned basis;
(C) The present value of future projected initial earned premiums times fifty-eight per cent; and
(D) Eighty-five per cent of the present value of future projected premiums not in subparagraph (C) on an earned basis;

(3) If a policy form has both exceptional and other increases, the values in paragraph (2)(B) and (D) shall also include seventy per cent for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves, as applicable, as specified in sections 431:5-303 and 431:5-307. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as provided in subsection (b)(3)(A), annually for the next three years, and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than two hundred per cent of the comparable rate in the initial premium schedule, lifetime projections, as provided in subsection (b)(3)(A), shall be filed for review by the commissioner every five years following the end of the required period in subsection (d). For group insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(f) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (c), the commissioner may require the insurer to implement any of the following:

(1) Premium rate schedule adjustments; or

(2) Other measures to reduce the difference between the projected and actual experience.

In determining whether the actual experience adequately matches the

projected experience, consideration should be given to subsection (b)(3)(E), if applicable.

(g) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to the commissioner's approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection (h); and

(2) The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to subsection (c), had the greater of the original anticipated lifetime loss ratio or fifty-eight per cent been used in the calculations described in subsection (c)(2)(A) and (C).

(h) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsing has occurred or is anticipated:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms;

(2) The rate increase is not an exceptional increase; and

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

If significant adverse lapsing has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds, subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates; provided that the offer shall be subject to the approval of the commissioner, be based on actuarially sound principles but not on attained age, and provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of the maximum rate increase determined based on the combined experience or the maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten per cent.

(i) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner, in addition to subsection (h), may prohibit the insurer from either of the following:

(1) Filing and marketing comparable coverage for a period of up to five years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(j) Subsections (a) to (i) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in section 431:10H-104, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits, other than long-term care coverage, meets the nonforfeiture requirements as applicable in any of the following:

(A) Section 431:10D-104; and
(B) Section 431:10D-107;

(3) The policy meets the disclosure requirements of sections 431:10H-113 and 431:10H-114;

(4) The portion of the policy that provides insurance benefits, other than long-term care coverage, meets the requirements as applicable in the following:

(A) Policy illustrations as required by part IV of article 10D; and
(B) Disclosure requirements, as applicable, in article [10D]; and

(5) An actuarial memorandum is filed with the commissioner that includes:

(A) A description of the basis on which the long-term care rates were determined;
(B) A description of the basis for the reserves;
(C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
(D) A description and a table of each actuarial assumption used. For expenses, an insurer shall include per cent of premium dollars per policy and dollars per unit of benefits, if any;
(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
(F) The estimated average annual premium per policy and the average issue age;
(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when that underwriting occurs; and
(H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(k) Subsections (f) and (h) shall not apply to group insurance policies as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104 where:

(1) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(2) The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than twenty per cent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(l) "Exceptional increase" for purposes of this section shall be as defined in section 431:10H-104. [L 2007, c 233, pt of §4]

**[§431:10H-208] Unintentional lapse.** (a) Each insurer offering long-term care insurance, as a protection against unintentional lapse, shall comply with this section.

(b) No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation shall provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address.

(c) In the case of an applicant who elects not to designate an additional person, the waiver shall state:

> "Protection Against Unintended Lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

(d) The insurer shall notify the insured of the right to change this written designation, no less often than every two years.

(e) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the notice requirement contained in subsection (c) need not be met until sixty days after the policyholder or certificate holder is no longer on a payment plan. The application or enrollment form for these policies or certificates shall clearly indicate the payment plan selected by the applicant. [L 1999, c 93, pt of §2]

**[§431:10H-209] Lapse or termination for nonpayment of premium.** No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated in section 431:10H-208 at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid and notice may not be given until

thirty days after a premium is unpaid. Notice shall be deemed to have been given as of five days after the date of mailing. [L 1999, c 93, pt of §2]

**[§431:10H-210] Reinstatement.** In addition to the requirements of sections 431:10H-208 and 431:10H-209, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. [L 1999, c 93, pt of §2]

**§431:10H-211 Disclosure; renewability.** (a) Individual long-term care insurance policies shall contain a renewability provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies that do not contain a nonrenewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change. [L 1999, c 93, pt of §2; am L 2007, c 233, §13]

**[§431:10H-212] Disclosure; riders and endorsements.** (a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured.

(b) After the date of policy issuance, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing by the insured, except if the increased benefits or coverages are required by law.

(c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement. [L 1999, c 93, pt of §2]

**[§431:10H-213] Disclosure; payment of benefits.** A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or similar words or phrases shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage. [L

1999, c 93, pt of §2]

**[§431:10H-214] Disclosure; limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations". [L 1999, c 93, pt of §2]

**[§431:10H-215] Disclosure; other limitations and conditions on eligibility for benefits.** A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in section 431:10H-109 shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall be labeled as "Limitations or Conditions on Eligibility of Benefits". [L 1999, c 93, pt of §2]

**§431:10H-216 Disclosure of tax consequences.** With regard to life insurance policies that provide for an accelerated benefit for long-term care, a disclosure is required at the time of application for the policy and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy and any other related documents. This section shall not apply to qualified long-term care insurance contracts. [L 1999, c 93, pt of §2; am L 2007, c 233, §14]

**§431:10H-217 Disclosure; benefit triggers.** Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits". Any additional benefit triggers shall also be explained in this section. If these benefit triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician, advanced practice registered nurse, or other specified person is required to certify a certain level of functional dependency in order to be eligible for benefits, this requirement shall be specified. [L 1999, c 93, pt of §2; am L 2014, c 45, §10]

**§431:10H-217.5 Required disclosure of rating practices to consumers.** (a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to any long-term care policy or certificate issued in this State on or after January 1, 2008; and

(2) For certificates issued on or after July 1, 2007, under a group long-term care insurance policy as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, which policy was in force on July 1, 2007, this section shall apply on the policy anniversary following July 1, 2007.

(b) Other than for policies for which no applicable premium rate or

rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment; unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this subsection to the applicant no later than at the time of delivery of the policy or certificate as follows:

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(A) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date or next billing date); and
(B) The right to a revised premium rate or rate schedule as provided in paragraph (3) if the premium rate or rate schedule is changed;

(5) With respect to disclosure of premium rate increases:

(A) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this State or any other state that, at a minimum, identifies:
(i) The policy forms for which premium rates have been increased;
(ii) The calendar years when the policy form was available for purchase; and
(iii) The amount or per cent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;
(B) The insurer, in a fair manner, may provide additional explanatory information related to the rate increases;
(C) An insurer may exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;
(D) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of July 1, 2007, or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph (A); and
(E) If the acquiring insurer in subparagraph (D) files for a

subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph (D), the acquiring insurer shall make all disclosures required by this paragraph, including disclosure of the earlier rate increase referenced in subparagraph (D).

(c) An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsection (b)(1) to (5). If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(d) An insurer shall use the forms in Appendix B of the April 2002, NAIC Model Long-Term Care Insurance Model Regulation and Appendix F of the December 2006, NAIC Model Long-Term Care Insurance Model Regulation to comply with the requirements of subsections (b) and (c).

(e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (b) when the rate increase is implemented. [L 2007, c 233, pt of §4; am L 2009, c 49, §1]

**§431:10H-218 Prohibition against post-claims underwriting.** (a) All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(c) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(d) Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

"CAUTION: If your answers on this application are incorrect or untrue, the (company) has the right to deny benefits or rescind your policy.";

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

"CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the (company) has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the (company) at this address: (insert address).";
and

(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the insurer shall obtain one of the following:

(A) A report of a physical examination;
(B) An assessment of functional capacity;
(C) An attending physician's statement; or
(D) Copies of medical records.

(e) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(f) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. Every insurer shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A to the April, 2002, NAIC Long-Term Care Insurance Model Regulation. [L 1999, c 93, pt of §2; am L 2007, c 233, §15]

**Revision Note**

Subsections (e) and (f) redesignated pursuant to §23G-15(1).

**[§431:10H-219] Minimum standards for home health and community care benefits.** (a) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

(1) Requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

(3) Limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the person's licensure or certification;

(5) Excluding coverage for personal care services provided by a home health aide;

(6) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) Requiring that the insured or claimant have an acute condition before home health care services are covered;

(8) Limiting benefits to services provided by medicare-certified agencies or providers; or

(9) Excluding coverage for adult day care service.

(b) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health

or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(c) Home health care coverage may be applied to nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. [L 1999, c 93, pt of §2]

**§431:10H-220 Requirement to offer inflation protection; group and individual policies.** (a) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five per cent;

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five per cent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) Where the policy is issued to a group, the required offer in subsection (a) shall be made to the group policyholder; except if the policy is issued to a group defined in paragraph (4) under the definition of "group long-term care insurance" in section 431:10H-104 other than to a continuing care retirement community, the offering shall be made to each certificate holder.

(c) The offer in subsection (a) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(d) Insurers shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(e) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(f) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous

manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(g) Inflation protection in subsection (a)(2) shall be included in a long-term care insurance policy unless the insurer obtains a rejection of inflation protection signed by the policyholder as required in subsection (h).

(h) The rejection shall be considered a part of the application and shall state:

> "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I REJECT INFLATION PROTECTION."

[L 1999, c 93, pt of §2; am L 2003, c 212, §96]

**§431:10H-221 Requirements for application forms and replacement coverage.** (a) Application forms shall include questions designed to elicit information as to whether, as of the date of application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and health or sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by paragraph (1) under the definition of "group long-term care insurance" in section 431:10H-104, the following questions may be modified only to the extent necessary to elicit information about accident and health or sickness and long-term care insurance policies other than the group policy being replaced; provided that the certificate holder has been notified of the replacement:

(1) Do you have another long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve months?

> (A) If so, with which company?
> (B) If that policy lapsed, when did it lapse?

(3) Are you covered by medicaid?

(4) Do you intend to replace any of your medical or accident and health or sickness insurance coverage with this policy (certificate)?

(b) Producers shall list any other accident and health or sickness insurance policies they have sold to the applicant, and the producer shall list policies sold that are still in force and list policies sold in the past five years that are no longer in force.

(c) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and health or sickness or long-term care coverage. One copy of the notice shall be retained by the applicant

and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the same manner as shown in section 14C of the April, 2002, NAIC Long-Term Care Insurance Model Regulation.

(d) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and health or sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the same manner as shown in section 14D of the April, 2002, NAIC Long-Term Care Insurance Model Regulation.

(e) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address including zip code. Notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(f) Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements for life insurance policies. If a life insurance policy that accelerates benefits for long-term care is replaced by another policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements. [L 1999, c 93, pt of §2; am L 2001, c 216, §21; am L 2003, c 212, §97; am L 2007, c 233, §16]

**§431:10H-222 Reporting requirements.** (a) Every insurer shall maintain records for each producer of the producer's amount of replacement sales as a per cent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a per cent of the producer's total annual sales.

(b) Every insurer shall report annually by June 30 the ten per cent of its producers with the greatest percentages of lapses and replacements as measured in subsection (a). The form shall be in the format contained in Appendix G to the April, 2002, NAIC Long-Term Care Insurance Model Regulation.

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the end of the preceding calendar year. The form shall be in the format contained in Appendix G to the April, 2002, NAIC Long-Term Care Insurance Model Regulation.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the end of the preceding calendar year. The form shall be in the format contained in Appendix G to the April, 2002, NAIC Long-Term Care Insurance Model Regulation.

(f) For qualified long-term care insurance contracts, every insurer shall report annually by June 30, the number of claims denied for each class of business, expressed as a percentage of claims denied. The form shall be in the format contained in Appendix E to the April, 2002, NAIC

Long-Term Care Insurance Model Regulation.

(g) Reports required under this section shall be filed with the commissioner.

(h) For purposes of this section:

"Claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met. Claims shall be subject to the definition of "denied".

"Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

"Policy" means only long-term care insurance.

"Report" means on a statewide basis. [L 1999, c 93, pt of §2; am L 2001, c 216, §22; am L 2007, c 233, §17]

**[§431:10H-223] Discretionary powers of the commissioner.** The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this part with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3) One of the following conditions have been met:

(A) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(B) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of the community; or

(C) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product. [L 1999, c 93, pt of §2]

**[§431:10H-224] Reserve standards; life insurance policies or riders.** (a) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, the policy reserves for the benefits shall be determined in accordance with section 431:5-307. Claim reserves shall also be established in the case where the policy or rider is in claim status.

(b) Reserves for policies subject to this section shall be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit

and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(c) In the development and calculation of reserves for policies and riders subject to this section, due regard shall be given to applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including but not limited to the following:

(1) Definition of insured events;

(2) Covered long-term care facilities;

(3) Existence of home convalescence care coverage;

(4) Definition of facilities;

(5) Existence or absence of barriers to eligibility;

(6) Premium waiver provision;

(7) Renewability;

(8) Ability to raise premiums;

(9) Marketing method;

(10) Underwriting procedures;

(11) Claims adjustment procedures;

(12) Waiting period;

(13) Maximum benefit;

(14) Availability of eligible facilities;

(15) Margins in claim costs;

(16) Optional nature of benefit;

(17) Delay in eligibility for benefit;

(18) Inflation protection provisions; and

(19) Guaranteed insurability option.

(d) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. [L 1999, c 93, pt of §2]

**[§431:10H-225] Reserve standards; insurance other than life.** When long-term care benefits are provided through insurance other than as in section 431:10H-224, reserves shall be determined by a table certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries and filed with the commissioner. [L 1999, c 93, pt of §2]

**§431:10H-226 Loss ratio.** (a) Benefits under long-term care

insurance policies shall be deemed reasonable in relation to premiums; provided that the expected loss ratio is at least sixty per cent, calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio due consideration shall be given to all relevant factors, including:

(1) Statistical credibility of incurred claims experience and earned premiums;

(2) The period for which rates are computed to provide coverage;

(3) Experienced and projected trends;

(4) Concentration of experience within early policy duration;

(5) Expected claim fluctuation;

(6) Experience refunds, adjustments, or dividends;

(7) Renewability features;

(8) All appropriate expense factors;

(9) Interest;

(10) Experimental nature of the coverage;

(11) Policy reserves;

(12) Mix of business by risk classification, if applicable; and

(13) Product features such as long elimination periods, high deductibles, and high maximum limits.

(b) For purposes of this section, the commissioner shall consult with a qualified long-term care actuary.

(c) Subsection (a) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements for life insurance;

(3) The policy meets the disclosure requirements of section 431:10H-114 as applicable;

(4) Any policy illustration that meets the applicable requirements for policy illustration;

(5) An actuarial memorandum is filed with the insurance division that includes:

(A) A description of the basis on which the long-term care rates were determined;
(B) A description of the basis for the reserves;
(C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
(D) A description and a table of each actuarial assumption

used. For expenses, an insurer shall include per cent of premium dollars per policy and dollars per unit of benefits, if any;

(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(F) The estimated average annual premium per policy and the average issue age;

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used, and if used, the statement shall include a description of the type or types of underwriting used such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

(d) This section shall apply to all long-term care insurance policies or certificates except those covered under sections 431:10H-207.5 and 431:10H-226.5. [L 1999, c 93, pt of §2; am L 2007, c 233, §18]

**§431:10H-226.5 Initial filing requirements.** (a) This section applies to any long-term care policy issued in this State after December 31, 2007.

(b) An insurer shall provide the information listed in this subsection to the commissioner thirty days prior to making a long-term care insurance form available for sale as follows:

(1) A copy of the disclosure documents required in section 431:10H-217.5; and

(2) An actuarial certification consisting of at least the following:

(A) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(B) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal

years is sufficient to cover expected renewal expenses; or if that statement cannot be made, a complete description of the situations where this does not occur; provided that an aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; provided further that if the gross premiums for certain age groups are inconsistent with this requirement, the commissioner may request a demonstration under subsection (c) based on a standard age distribution; and

(E) With respect to premium rate schedules:

(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(c) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, or relevant and credible data from other studies, or both. If the commissioner asks for additional information under this subsection, the period in subsection (b) does not include the period during which the insurer is preparing the requested information. [L 2007, c 233, pt of §4; am L 2009, c 49, §2]

**[§431:10H-227 Filing requirements; extraterritorial.]** Prior to an insurer or similar organization offering group long-term care insurance to a resident of this State pursuant to section 431:10H-105, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this State. [L 1999, c 93, pt of §2]

**§431:10H-228 [Filing requirements; advertisements.]** (a) Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this State shall provide a copy of any long-term care insurance advertisement intended for use in this State through written, radio, or television media to the commissioner for review or approval by the commissioner to determine compliance with this article. All advertisements subject to this section shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

(b) The commissioner may exempt from the requirements of this section any advertising form or material when, in the commissioner's opinion, this requirement may not reasonably be applied. [L 1999, c 93, pt of §2; am L 2011, c 81, §7]

**Revision Note**

Subsection (b) redesignated pursuant to §23G-15(1).

**§431:10H-229 Standards for marketing.** (a) Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this State, directly or through producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate;

(2) Establish marketing procedures to assure excessive insurance is not sold or issued;

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance currently has long-term care insurance and the types and amounts of any long-term care insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required;

(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection;

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer, at solicitation, shall provide written notice to the prospective policyholder or certificate holder of a state senior insurance counseling program including the name, address, and telephone number of the program;

(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to section 431:10H-202;

(8) Provide copies of the disclosure forms required in section 431:10H-217.5(c) to the applicant; and

(9) Provide an explanation of contingent benefit upon lapse provided for in section 431:10H-233(f) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in section 431:10H-233(g).

(b) In addition to the acts or practices prohibited in article 13, all of the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

(4) Misrepresentation. Falsifying a material fact in selling or offering to sell a long-term care insurance

policy. [L 1999, c 93, pt of §2; am L 2002, c 155, §75; am L 2007, c 233, §19; am L 2009, c 49, §3]

**§431:10H-230 Standards of marketing--certain group policies.** (a) With respect to the obligations set forth in this section, the primary responsibility of an association as defined in paragraph (2) of the definition of "group long-term care insurance" under section 431:10H-104, when endorsing or selling long-term care insurance, shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold through the association to ensure that members of the association receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The insurer shall file the following information with the commissioner:

(1) The policy and certificate;

(2) A corresponding outline of coverage; and

(3) All advertisements requested by the commissioner.

(c) The association shall disclose in any long-term care insurance solicitation:

(1) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees, and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(d) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(e) The board of directors of an association endorsing or selling long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(f) The association shall also:

(1) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including benefits, features, and rates, and update the examination thereafter in the event of material change;

(2) Actively monitor the marketing efforts of the insurer and its producers; and

(3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

This subsection shall not apply to qualified long-term care insurance contracts.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the commissioner the information required in this section.

(h) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this section.

(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of article 13 of this chapter. [L 1999, c 93, pt of §2; am L 2002, c 155, §76; am L 2007, c 233, §20]

**§431:10H-231 Suitability.** (a) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

(b) Every insurer, health care service plan, or other entity marketing long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) Train its producers in the use of its suitability standards; and

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet". The personal worksheet used by the issuer shall contain, at a minimum, information in the format contained in Appendix B of the April, 2002, NAIC Long-Term Care Insurance Model Regulation, in not less than twelve-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

(d) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(e) The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B of the April, 2002, NAIC Long-Term Care Insurance Model Regulation is prohibited.

(f) The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to a particular applicant is appropriate. The producers shall use the suitability standards developed by the issuer in

marketing long-term care insurance.

(g) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C to the December, 2006, NAIC Long-Term Care Insurance Model Regulation, in not less than twelve-point type.

(h) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the April, 2002, NAIC Long-Term Care Insurance Model Regulation, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternate method of verification shall be made part of the applicant's file.

(i) The issuer shall report annually to the commissioner the total number of applications received from residents of this State, the number of those who declined to provide information on a personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. [L 1999, c 93, pt of §2; am L 2001, c 216, §23; am L 2007, c 233, §§21 to 23]

**[§431:10H-232] Prohibition against preexisting conditions and probationary periods in replacement policies and certificates.** If a long-term care insurance policy or certificate replaces another long-term care insurance policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy. [L 1999, c 93, pt of §2]

**§431:10H-233 Nonforfeiture benefit requirement.** (a) This section does not apply to life insurance policies containing accelerated long-term care benefits.

(b) To comply with the requirement to offer a nonforfeiture benefit pursuant to section 431:10H-116, the following shall be met:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (j); and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(c) If the offer required to be made under section 431:10H-116 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subsection (g) shall still apply.

(d) After rejection of the offer required under section 431:10H-116, for individual and group policies without nonforfeiture benefits issued after June 30, 2000, the insurer shall provide a contingent benefit upon lapse.

(e) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide

either the nonforfeiture benefit or the contingent benefit upon lapse.

(f) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the table below based on the insured's issue age, and the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased. Unless otherwise required, policyholders and certificate holders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

| Issue Age | Per Cent Increase Over Initial Premium |
|---|---|
| 29 and under | 200% |
| 30-34 | 190% |
| 35-39 | 170% |
| 40-44 | 150% |
| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |
| 75 | 30% |
| 76 | 28% |
| 77 | 26% |
| 78 | 24% |
| 79 | 22% |
| 80 | 20% |
| 81 | 19% |
| 82 | 18% |
| 83 | 17% |
| 84 | 16% |
| 85 | 15% |
| 86 | 14% |
| 87 | 13% |
| 88 | 12% |
| 89 | 11% |
| 90 and over | 10% |

(g) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an

insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within one hundred and twenty days of the due date of the premium so increased, and the ratio in subsection (i)(2) is forty per cent or more. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

| Issue Age | Per Cent Increase Over Initial Premium |
|---|---|
| Under 65 | 50% |
| 65-80 | 30% |
| Over 80 | 10% |

This provision shall be in addition to the contingent benefit provided by subsection (f) and where both are triggered, the benefit provided shall be at the option of the insured.

(h) On or before the effective date of a substantial premium increase as defined in subsection (f), the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (j). This option may be elected at any time during the one-hundred-twenty-day period referenced in subsection (f); and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the one-hundred-twenty-day period under subsection (f) shall be deemed to be the election offer to convert in paragraph (2), unless the automatic option in subsection (i)(3) applies.

(i) On or before the effective date of a substantial premium increase as defined in subsection (g) above, the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety per cent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one-hundred-twenty-day period referenced in subsection (g); and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the one-hundred-twenty-day period referenced in subsection (g) shall be deemed to be the election of the offer to convert in paragraph (2) if the ratio is forty per cent or more.

(j) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (f) but not (g), are described in this subsection, as follows:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one per cent per year prior to age fifty, and at least three per cent per year beyond age fifty;

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as provided in paragraph (3);

(3) The standard nonforfeiture credit shall be equal to one hundred per cent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard forfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (k);

(4) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date; provided that the contingent benefit upon lapse shall be effective during the first three years and thereafter;

(5) Notwithstanding the provisions in paragraph (4), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or
(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating; and

(6) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(k) All benefits paid by the insurer while the policy or certificate is in premium paying status and in paid up status shall not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(l) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(m) The requirements set forth in this section shall become effective July 1, 2000, and shall apply as follows:

(1) This section shall apply to any long-term care policy issued in this State after June 30, 2000; and

(2) For certificates issued after June 30, 2000, under a group long-term care insurance policy as defined in paragraph (1) under the definition of "group long-term care insurance" in section 431:10H-104, which policy was in force on July 1, 2000, this section shall not apply;

provided that the provisions in subsections (c), (g), and (i) that pertain to contingent benefits for a policy with a fixed or limited premium paying period shall apply to any long-term care insurance policy or certificate issued in the State after December 31, 2007; provided further that for new certificates on a group policy as defined in section 431:10H-104, the provisions in subsections (c), (g), and (i) that pertain to contingent benefits for a policy with a fixed or limited premium paying period shall apply after July 1, 2008.

(n) Premiums charged for a policy or certificate containing nonforfeiture benefits or contingent benefit on lapse shall be subject to the loss ratio requirements of section 431:10H-207.5 or 431:10H-226, whichever is applicable, treating the policy as a whole.

(o) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (f) or (g), a replacing insurer

that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(p) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned;

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) The nonforfeiture provision shall provide at least one of the following:

(A) Reduced paid-up insurance;
(B) Extended term insurance;
(C) Shortened benefit period; or
(D) Other similar offerings approved by the commissioner. [L 1999, c 93, pt of §2; am L 2007, c 233, §24; am L 2009, c 49, §4]

**[§431:10H-234] Standards for benefit triggers.** (a) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(b) Activities of daily living shall include at least the following as defined in section 431:10H-201 and the policy: bathing, continence, dressing, eating, toileting, and transferring. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in the preceding sentence as long as they are defined in the policy.

(c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate, however the provisions shall not restrict and are not in lieu of the requirements under subsections (a) and (b).

(d) For purposes of this section the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(e) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

(f) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

(g) The requirements set forth in this section shall be effective July 1, 2000, and shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy issued in this State after June 30, 2000;

(2) For certificates issued after June 30, 2000, under a group long-term care insurance policy as defined in paragraph (1) under the definition of "group long-term care insurance" in section 431:10H-104, which policy was in force on July 1, 2000, this section shall not apply. [L 1999, c 93, pt of §2]

**[§431:10H-234.5] Additional standards for benefit triggers for qualified long-term care insurance contracts.** (a) For purposes of this section, the following definitions apply:

"Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2)(A) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(1) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or

(2) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

"Chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

"Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, and any registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury.

"Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

"Qualified long-term care services" means services that meet the requirements of section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(c) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment.

(d) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (c) shall be

performed by a licensed health care practitioner.

(e) Certifications required pursuant to subsection (d) may be performed by a licensed health care practitioner at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is claiming payment of benefits, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(f) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations. [L 2007, c 233, pt of §4]

**§431:10H-235 Standard format outline of coverage; group and individual policies.** This section implements, interprets, and makes specific, the provisions of section 431:10H-112 in prescribing a standard format and the content of an outline of coverage, as follows:

(1) The outline of coverage shall be a freestanding document, using no smaller than ten-point type;

(2) The outline of coverage shall contain no material of an advertising nature;

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring;

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated; and

(5) The format for outline of coverage shall be substantially similar to the Outline of Coverage in section 29 of the April, 2002, NAIC Long-Term Care Insurance Model Regulation. [L 1999, c 93, pt of §2; am L 2007, c 233, §25]

**Revision Note**

Subsection designation deleted pursuant to §23G-15.

**§431:10H-236 Delivery of shopper's guide; group and individual policies.** (a) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(b) In the case of producer solicitations, a producer shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with application or enrollment form.

(d) Life insurance policies containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under sections 431:10H-106 to 431:10H-114. [L 1999, c 93, pt of §2; am L 2001, c 216, §24]

**[§431:10H-237] Penalties.** In addition to any other penalties provided by the laws of this State, any insurer or producer found to have violated any requirement of this State relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater. [L 2007, c 233, pt of §4]

## PART III. FEDERAL CONFORMITY

**[§431:10H-301] Group long-term care insurance policies conformance to Health Insurance Portability and Accountability Act and Internal Revenue Code.** (a) Every group long-term care insurance policy sold after June 30, 2000, may conform to Subtitle C of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, and to Section 7702B of the Internal Revenue Code of 1986, as amended; provided that if it does not conform, then it shall not qualify for federal or state income tax benefits.

(b) A group long-term care insurance policy may provide coverage, at a minimum, for "qualified long-term care services", as defined in Subtitle C of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, and in Section 7702B of the Internal Revenue Code of 1986, as amended.

(c) For the purpose of subsection (b) and for the purpose of describing examples of services typically found in this State, coverage shall be one or more of the following services or any combination of services:

(1) Home health care services, as defined in section 431:10H-201;

(2) Adult day care, as defined in section 431:10H-201;

(3) Adult residential care home, as defined in section 321-15.1;

(4) Extended care adult residential care home, as defined in section 323D-2;

(5) Nursing home, as defined in section 457B-2;

(6) Skilled nursing facilities and intermediate care facilities, as referenced in section 321-11(10);

(7) Hospices, as referenced in section 321-11;

(8) Assisted living facility, as defined in section 323D-2;

(9) Personal care, as defined in section 431:10H-201;

(10) Respite care, as defined in section 333F-1; and

(11) Any other care as provided by rule of the commissioner. [L 1999, c 93, pt of §2]

**[§431:10H-302] Individual long-term care insurance policy coverages.** (a) Every individual long-term care insurance policy sold after June 30, 2000, shall provide coverage for one or more of the types of care enumerated under section 431:10H-301(c).

(b) An individual long-term care insurance policy sold after June 30, 2000, shall not be required to conform to Subtitle C of the Health

Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, and to Section 7702B of the Internal Revenue Code of 1986, as amended; provided that if it does not conform, then it shall not qualify for federal or state income tax benefits. [L 1999, c 93, pt of §2]

**[§431:10H-303] Conflict with Health Insurance Portability and Accountability Act.** If a conflict occurs between a provision of this article and the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, the provision shall be deemed amended to comply with that federal Act and any related regulations, to the extent that a particular policy is intended to qualify for federal income tax benefits. [L 1999, c 93, pt of §2]

**[§431:10H-304] Disclosure of qualification for tax benefits.** (a) Every policy that is intended to be a qualified long-term care insurance contract as provided in the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits."

(b) Every policy that is not intended to be a qualified long-term care insurance contract as provided in the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract and is not intended to qualify you for federal and state tax benefits." [L 1999, c 93, pt of §2]

## PART IV. UNIVERSAL AVAILABILITY OF LONG-TERM CARE INSURANCE

**[§431:10H-401] Publicizing of policies.** For purposes of section 371-16, upon request by an employer, labor organization, retiree organization, or other entity specified under the definition of "group long-term care insurance" in section 431:10H-104, an insurer that is subject to this part shall be allowed, if it chooses, to publicize a long-term care policy and may sell and underwrite that policy. [L 1999, c 93, pt of §2]

**[§431:10H-402] Purchase of policy and payment of premiums on an individual's behalf.** An insurer shall allow a person to purchase an individual or group long-term care insurance policy and pay the premiums for an individual or group long-term care insurance policy that covers the person, the person's spouse, or reciprocal beneficiary, as well as their parents and grandparents, and in-law parents and grandparents. Nothing in this section shall preclude an insurer from underwriting such a policy. [L 1999, c 93, pt of §2]

## DERIVATION TABLE OF ARTICLE 10H FROM THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 1998 MODEL ACT OR REGULATIONS

| 1998 NAIC ACT § | 1998 NAIC REGULATION § | HRS § |
|---|---|---|
| 1 | 0 431:10H-101 | |
| 2 | 0 431:10H-102 | |
| 3 | 0 431:10H-103 | |
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| 5 | 0 431:10H-105 | |
| 6A | 0 431:10H-106 | |
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| 0 | 7A 431:10H-209 | |
| 0 | 7B 431:10H-210 | |
| 0 | 8A 431:10H-211 | |
| 0 | 8B 431:10H-212 | |
| 0 | 8C 431:10H-213 | |
| 0 | 8D 431:10H-214 | |
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| 0 | 15 431:10H-223 | |
| 0 | 16A 431:10H-224 | |
| 0 | 16B 431:10H-225 | |
| 0 | 17 431:10H-226 | |
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| 0 | 20A, 20B 431:10H-229 | |
| 0 | 20C 431:10H-230 | |
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| 0 | 0 | 431:10H-302 |
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| 0 | 0 | 431:10H-401 |
| 0 | 0 | 431:10H-402 |

## ARTICLE 11
## INSURANCE HOLDING COMPANY SYSTEM

**§431:11-101 Scope and purpose.** (a) This article applies to all persons doing an insurance business in this State unless specifically exempted under subsection (b).

(b) The commissioner may exempt:

(1) Any insurer or class of insurers from any provision of this article, when the commissioner deems the exemption consistent with the purposes of this article and in the public interest; or

(2) Upon request of the person required to supply information or perform an act, that person from any provision of this article, when the commissioner deems the exception consistent with the purposes of this article and in the public interest.

(c) The purposes of this article include:

(1) Exercising surveillance over the acquisition of a domestic insurer, to ensure that in the process of making it part of an insurance holding company system, the interests of policyholders, shareholders, and the public are not harmed;

(2) Providing the regulatory monitoring of those intercorporate relationships and transactions among affiliates within an insurance holding company system that may affect the solidity of insurers;

(3) Controlling the payment of dividends that might affect the solidity of insurers; and

(4) Providing, in appropriate cases, recoupment of dividends paid. [L 1987, c 349, pt of §8; am L 2010, c 116, §1(22)]

**§431:11-102 Definitions.** As used in this article, unless the context shall otherwise require:

"Affiliate" (including affiliate of, or person affiliated with, a specific person) means a person that, directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

"Control" (including controlling, controlled by, and under common control with) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(1) Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten per cent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by section 431:11-105(k) that control does not in fact exist.

(2) The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the commissioner's determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

"Domestic insurance holding company system" means an insurance holding company system that consists of an ultimate controlling person formed in this State prior to January 1, 2000, and its insurer affiliates, all of which are domestic insurers authorized to transact insurance business only in this State.

"Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including but not limited to anything that would cause the insurer's risk-based capital to fall into company action level as set forth in section 431:3-403 or would cause the insurer to be in hazardous financial condition as pursuant to section 431:15-103.5.

"Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, or any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

"Insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer.

"Insurer" shall have the same meaning as set forth in article 1, except that it shall not include:

(1) Agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(2) Fraternal benefit societies;

(3) Nonprofit medical and hospital service associations; or

(4) Unauthorized insurers.

"Person" means an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, and any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property, or a securities broker performing only the usual and customary broker's function.

"Security holder" of a specified person means one who owns any security of the person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

"Statement" means information required to be filed with the commissioner pursuant to sections 431:11-104, 431:11-105, and 431:11-106, and guidelines set forth on a form or in a format approved by the commissioner.

"Subsidiary of a specified person" means an affiliate controlled by the person directly or indirectly through one or more intermediaries.

"Ultimate controlling person" means a person who is not controlled by any other person.

"Voting security" shall include any security convertible into or evidencing a right to acquire a voting security. [L 1987, c 349, pt of §8; am L 1989, c 195, §37; am L 2000, c 24, §8; am L 2014, c 234, §7]

**§431:11-103 Subsidiaries of insurers.** (a) Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

(1) Any kind of insurance business authorized by the jurisdiction in which it is incorporated;

(2) Acting as an insurance producer for its parent or for any of its parent's insurer subsidiaries;

(3) Investing, reinvesting, or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;

(4) Management of any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

(5) Acting as a broker/dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

(6) Rendering investment advice to governments, government agencies, corporations, or other organizations or groups;

(7) Rendering other services related to the operations of an insurance business including but not limited to actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal, and collection services;

(8) Ownership and management of assets which the parent corporation could itself own or manage; provided that the aggregate investment by the insurer and its subsidiaries acquired or organized pursuant to this paragraph shall not exceed the limitations applicable to the investments by the insurer;

(9) Acting as administrative agent for a governmental instrumentality which is performing an insurance function;

(10) Financing of insurance premiums, producers, and other forms of consumer financing;

(11) Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business; and

(12) Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted in this chapter, a domestic insurer may also:

(1) Invest in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten per cent of the insurer's assets or fifty per cent of the insurer's surplus as regards policyholders; provided that after the investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, investments in domestic or foreign insurance subsidiaries shall be excluded, and there shall be included:

(A) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and

(B) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

(2) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer; provided that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in paragraph (1) or in this chapter. For the purpose of this subsection, the total investment of the insurer shall include:

(A) Any direct investment by the insurer in an asset; and
(B) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary; and

(3) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after the investment, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(c) Investments in common stock, preferred stock, debt obligations, or other securities of subsidiaries made pursuant to subsection (b) shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this code applicable to investments of insurers.

(d) Whether any investment pursuant to subsection (b) meets the applicable requirements thereof is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

(e) If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under any other section of this code, and the insurer has notified the commissioner thereof. [L 1987, c 349, pt of §8; am L 2000, c 24, §9; am L 2002, c 155, §77; am L 2003, c 212, §98]

**§431:11-104 Acquisition of control or merger with domestic insurer.** (a) The following are filing requirements for the acquisition of control of or merger with a domestic insurer:

(1) No person other than the issuer shall make a tender offer or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, the person, directly or indirectly (by conversion or by exercise of any right to acquire), would be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any offer, request, or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the

person has filed with the commissioner and has sent to the insurer, and the insurer has sent to its shareholders, a statement containing the information required by this section and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner prescribed in this article.

(2) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, a confidential notice of its proposed divestiture at least thirty days prior to the cessation of control. The commissioner shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in the commissioner's discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in paragraph (1) is otherwise filed, this paragraph shall not apply.

(3) With respect to a transaction subject to this section, the acquiring person shall also file a preacquisition notification with the commissioner containing the information set forth in section 431:11-104.3(b). Failure to file the notification may subject the acquiring person to penalties specified in section 431:11-104.5(f).

(4) For purposes of this section:

"Domestic insurer" includes any person controlling a domestic insurer unless the commissioner determines that the person, directly or through its affiliates, is primarily engaged in business other than the business of insurance.

"Person" shall not include any securities broker holding, in the usual and customary broker's function, less than twenty per cent of the voting securities of an insurance company or of any person who controls an insurance company.

(b) The statement to be filed with the commissioner hereunder shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (a) is to be effected (hereinafter called "acquiring party"), and:

(A) If the person is an individual, the principal occupation and all offices and positions held by the individual during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years; or

(B) If the person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as the person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to the positions. The list shall include for each individual the information required by subparagraph (A);

(2) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any purpose (including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates), and the identity of persons furnishing the consideration; provided that where a source of the consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement requests confidentiality;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years (or for the lesser period as the acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than ninety days prior to the filing of the statement;

(4) Any plans or proposals that each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to in subsection (a) that each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (a), and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to in subsection (a) that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (a) in which any acquiring party is involved including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements, or understandings have been entered into;

(8) A description of the purchase of any security referred to in subsection (a) during the twelve calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers, and considerations paid or agreed to be paid therefore;

(9) A description of any recommendations to purchase any security referred to in subsection (a) made during the twelve calendar months preceding the filing of the statement by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;

(10) Copies of all tender offers for, requests or invitation for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (a), and (if distributed) of additional soliciting material relating thereto;

(11) The term of any agreement, contract, or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto;

(12) An agreement by the person required to file the statement referred to in subsection (a) that the person will provide the annual report, specified in section 431:11-105(l), for so long as control exists;

(13) An acknowledgment by the person required to file the statement referred to in subsection (a) that the person and all subsidiaries within the person's control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(14) Any additional information as the commissioner may by rule prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection (a) is a partnership, limited partnership, or other group, the commissioner may require that the information called for by paragraphs (1) through (14) shall be given with respect to each partner of the partnership or limited partnership, each member of the group, and each person who controls such partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in subsection (a) is a corporation, the commissioner may require that the information called for by paragraphs (1) through (14)

shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten per cent of the outstanding voting securities of the corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two business days after the person learns of the change. The insurer shall send the amendment to its shareholders.

(c) If any offer, request, invitation, agreement or acquisition referred to in subsection (a) is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) may utilize the documents in furnishing the information called for by that statement.

(d)(1) The commissioner shall approve any merger or other acquisition of control referred to in subsection (a) unless, after a public hearing thereon, the commissioner finds that:

(A) After the change of control, the domestic insurer referred to in subsection (a) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(B) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this State or tend to create a monopoly therein. In applying the competitive standard in this subparagraph:

(i) The informational requirements of section 431:11-104.3(b) and the standards of section 431:11-104.4(b) shall apply;

(ii) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by section 431:11-104.4(c) exist; and

(iii) The commissioner may condition the approval of the merger or other acquisition on the removal of the grounds for disapproval within a specified period of time;

(C) The financial condition of any acquiring party might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders;

(D) The plans or proposals that the acquiring party has to liquidate the insurer, sell its assets, or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer or not in the public interest;

(E) The competence, experience, and integrity of those persons who would control the operation of the insurer would not be in the interest of policyholders of the insurer or not in the public interest; or

(F) The acquisition is likely to be hazardous or prejudicial

to the insurance-buying public.

(2) The public hearing referred to in paragraph (1) shall commence within thirty days after the statement required by subsection (a) is filed, except that the hearing may commence within such additional time as agreed to by the commissioner, the acquiring party, and the person to be acquired, and at least twenty days notice of the scheduled public hearing shall be given by the commissioner to the person filing the statement. Not less than seven days notice of the public hearing shall be given by the person filing the statement to the insurer and to any other persons as may be designated by the commissioner. The insurer shall give notice to its security holders. The commissioner shall make a determination within the sixty-day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in chapter 91. All discovery proceedings shall be concluded not later than three days prior to the commencement of the public hearing.

(3) If the proposed acquisition of control requires the approval of more than one commissioner, the public hearing referred to in paragraph (2) may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (a). The person shall file the statement referred to in subsection (a) with the National Association of Insurance Commissioners within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten days of the receipt of the statement referred to in subsection (a). A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. The commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and rules of this State shall be made not later than sixty days after the date of notification of the change in control submitted pursuant to subsection (a)(1).

(5) The commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

(e) All statements, amendments, or other material filed pursuant to subsections (a) or (b), and all notices of public hearings held pursuant to subsection (d), shall be mailed by the insurer to its shareholders within five business days after the insurer has received the statements, amendments, other material, or notices. The expenses of mailing shall be borne by the person making the filing. As security for the payment of the expenses, the person shall file with the commissioner an acceptable bond or other deposit in an amount to be determined by the commissioner.

(f) The provisions of this section shall not apply to:

(1) Any transaction which is subject to the provisions of article 4, dealing with the merger or consolidation of two or more insurers; or

(2) Any offer, request, invitation, agreement, or acquisition which the commissioner by order shall exempt therefrom as:

(A) Not having been made or entered into for the purpose of, and not having the effect of, changing or influencing the control of a domestic insurer; or

(B) Not otherwise comprehended within the purposes of this section.

(g) The following shall be violations of this article:

(1) The failure to file any statement, amendment, or other material required to be filed pursuant to subsections (a) or (b); or

(2) The effectuation or any attempt to effectuate an acquisition of, control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval.

(h) The courts of this State are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this State who files a statement with the commissioner under this section, and overall actions involving the person arising out of violations of this article. Each person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the commissioner to be the person's true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of this article. Copies of all lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to the person at the person's last known address. [L 1987, c 349, pt of §8; am L 1989, c 195, §38 and c 207, §14; am L 1993, c 321, §14; am L 1997, c 233, §5; am L 2014, c 234, §8]

**[§431:11-104.1] Definitions.** The following definitions shall apply for the purposes of sections 431:11-104.2 through 431:11-104.6 only:

"Acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance, and mergers.

"Involved insurer" means an insurer which either acquires or is acquired, is affiliated with an acquirer or person acquired, or is the result of a merger. [L 1992, c 176, pt of §3]

**§431:11-104.2 Scope.** (a) Except as otherwise provided in subsection (b), this section and sections 431:11-104.3 through 431:11-104.6 apply to any acquisition in which there is a change in control of an insurer authorized to do business in this State.

(b) This section and sections 431:11-104.3 through 431:11-104.6 shall not apply to the following:

(1) A purchase of securities solely for investment purposes, so long as those securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this State. If a purchase of securities results in a presumption of control as defined in section 431:11-102, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner;

(2) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the commissioner in accordance with section 431:11-104.3 thirty days prior to the proposed effective date of the acquisition. However, the preacquisition notification is not required for exclusion from this section and sections 431:11-104.3 through 431:11-104.6 if the acquisition would otherwise be excluded by any other paragraph of this subsection;

(3) The acquisition of affiliated persons;

(4) An acquisition if, as an immediate result of the acquisition:

(A) In no market would the combined market share of the involved insurers exceed five per cent of the total market;
(B) There would be no increase in any market share; or
(C) In no market would:
(i) The combined market share of the involved insurers exceed twelve per cent of the total market; and
(ii) The market share increase by more than two per cent of the total market.

For the purpose of this paragraph, "market" means direct written insurance premiums in this State for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this State;

(5) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business; and

(6) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and those findings are communicated by the domiciliary commissioner to the commissioner of this State. [L 1992, c 176, pt of §3; am L 2014, c 234, §9]

**§431:11-104.3 Preacquisition notification; waiting period.** (a) An acquisition covered by section 431:11-104.2 may be subject to an order pursuant to section 431:11-104.5 unless the acquiring person or the acquired person files a preacquisition notification and the waiting period has expired. The commissioner shall treat information submitted under this subsection as confidential in the same manner as provided in section 431:11-108.

(b) The preacquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners, including information relating to those markets in which the acquisition would not be exempted pursuant to section 431:11-104.2(b)(5). The commissioner may require such additional material and information as the commissioner deems necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of section 431:11-104.4. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this State accompanied by a summary of the education and experience indicating that economist's ability to render an informed opinion.

(c) The waiting period required shall begin on the date of receipt by the commissioner of a preacquisition notification and shall end on the earlier of the thirtieth day after the date of that receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner, on a one-time basis, may require the submission of additional information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner. [L 1992, c 176, pt of §3; am L 2006, c 189, §8]

**[§431:11-104.4] Competitive standard.** (a) The commissioner may enter an order under section 431:11-104.5 with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be to substantially lessen competition in any line of insurance in this State, or tend to create a monopoly therein, or if the insurer fails to file adequate information in compliance with section 431:11-104.3.

(b) In determining whether a proposed acquisition would violate the competitive standard of subsection (a), the commissioner shall consider the following:

(1) Any acquisition covered under section 431:11-104.2 involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards:

(A) If the market is highly concentrated and the involved insurers possess the following shares of the market:

| Insurer A | Insurer B |
|---|---|
| 4% | 4% or more |
| 10% | 2% or more |
| 15% | 1% or more; or |

(B) If the market is not highly concentrated and the involved insurers possess the following shares of the market:

| Insurer A | Insurer B |
|---|---|
| 5% | 5% or more |
| 10% | 4% or more |
| 15% | 3% or more |
| 19% | 1% or more |

A highly concentrated market is one in which the share of the four largest insurers is seventy-five per cent or more of the market. Percentages not shown in the tables shall be interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard of subsection (a). For the purpose of this paragraph, the insurer with the largest share of the market shall be deemed to be insurer A;

(2) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven per cent or more of the market over a period of time extending from any base year five to ten years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under section 431:11-104.2 involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in subsection (a) if:

(A) There is a significant trend toward increased concentration in the market;
(B) One of the insurers involved is one of the insurers in a grouping of the large insurers showing the requisite increase in the market share; and
(C) Another involved insurer's market is two per cent or more;

(3) For the purposes of this subsection:

(A) The term "insurer" includes any insurer or group of insurers under common management, ownership, or control;
(B) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the National Association of Insurance Commissioners, and to information, if any, submitted by parties to the

acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premiums for a line of business, the line being that used in the annual statement required to be filed by insurers doing business in this State, and the relevant geographical market is assumed to be this State; and

(C) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner; and

(4) Even though an acquisition is not prima facie violative of the competitive standard under paragraph (1) or (2), the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under paragraph (1) or (2), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(c) An order may not be entered under section 431:11-104.5(a) if:

(1) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(2) The acquisition will substantially increase the availability of insurance, and the public benefits of that increase exceed the public benefits which would arise from not lessening competition. [L 1992, c 176, pt of §3]

**[§431:11-104.5] Orders and penalties.** (a) If an acquisition violates the competitive standards of section 431:11-104.4, the commissioner may enter an order:

(1) Requiring an involved insurer to cease and desist from doing business in this State with respect to the line or lines of insurance involved in the violation; or

(2) Denying the application of an acquired or acquiring insurer for a license to do business in this State.

(b) Such an order shall not be entered unless there is a hearing, notice of such hearing is issued before the end of the waiting period and not less than fifteen days before the hearing, and the hearing is concluded and the order is issued no later than sixty days after the end of the waiting period. Every order shall be accompanied by a written decision of the commissioner setting forth the commissioner's findings of fact and conclusions of law.

(c) An order entered under this section shall not become final earlier than thirty days after it is issued, during which time an involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon the plan or other information, the commissioner shall specify the conditions, if any, and the time period during which the aspects of the acquisition causing a violation of the competitive standards of section 431:11-104.4 must be remedied, and may vacate or modify the order to set forth those conditions.

(d) Any order issued pursuant to this section shall be void if the acquisition is never consummated.

(e) Any person who violates a cease and desist order of the

commissioner under subsection (a) while the order is in effect, upon order of the commissioner after notice and hearing, may be subject to one or both of the following:

(1) A fine of not more than $10,000 for every day of violation; and

(2) Suspension or revocation of the person's license.

(f) Any insurer or other person who fails to make any filing required by this section or sections 431:11-104.2 and 431:11-104.3, and who also fails to demonstrate a good faith effort to comply with any such filing requirement, shall be subject to a fine of not more than $50,000. [L 1992, c 176, pt of §3]

**[§431:11-104.6] Inapplicable provisions.** Sections 431:11-110(b), 431:11-110(c), and 431:11-112 do not apply to acquisitions to which sections 431:11-104.1 through 431:11-104.5 apply. [L 1992, c 176, pt of §3]

**§431:11-105 Registration of insurers.** (a) Every insurer that is authorized to do business in this State and is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section and section 431:11-106(a)(1), (b), and (d). The insurer shall file a copy of the summary of its registration statement as required by subsection (c) in each state in which that insurer is authorized to do business if requested by the commissioner of that state. Any insurer that is subject to registration under this section shall register within fifteen days after it becomes subject to registration, and annually thereafter by March 15 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state that is a member of an insurance holding company system, and that is not subject to registration under this section, to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

(b) Every insurer subject to registration shall file the registration statement with the commissioner on a form and in a format prescribed by the National Association of Insurance Commissioners, which shall contain the following current information:

(1) The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(2) The identity and relationship of every member of the insurance holding company system;

(3) The following agreements in force, and transactions currently outstanding or that have occurred during the last calendar year between the insurer and its affiliates:

(A) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;
(B) Purchases, sales, or exchange of assets;

(C) Transactions not in the ordinary course of business;
(D) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;
(E) All management agreements, all service contracts, and all cost-sharing arrangements;
(F) Reinsurance agreements;
(G) Dividends and other distributions to shareholders; and
(H) Consolidated tax allocation agreements;

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(5) If requested by the commissioner, financial statements of an insurance holding company system. Financial statements may include but are not limited to annual audited financial statements filed with the Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed financial statements of the parent corporation that have been filed with the Securities and Exchange Commission;

(6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner; and

(7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(c) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) No information need be disclosed on the registration statement filed pursuant to subsection (b) if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one per cent or less of an insurer's admitted assets as of the December 31 next preceding shall not be deemed material for purposes of this section.

(e) Subject to section 431:11-106(b), each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen business days following the declaration thereof.

(f) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this article.

(g) The commissioner shall terminate the registration of any insurer that demonstrates that it no longer is a member of an insurance holding company system.

(h) The commissioner may require or allow two or more affiliated insurers subject to registration to file a consolidated registration statement.

(i) The commissioner may allow an insurer that is authorized to do business in this State and is part of an insurance holding company system to register on behalf of any affiliated insurer that is required to register under subsection (a) and to file all information and material required to be filed under this section.

(j) The provisions of this section shall not apply to any insurer, information, or transaction if and to the extent that the commissioner by rule or order shall exempt the same from the provisions of this section.

(k) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty days following receipt of a complete disclaimer, notifies the filing party that the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

(l) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The ultimate controlling person of a domestic insurance holding company system shall be exempt from this requirement. The report shall identify, to the best of the ultimate controlling person's knowledge and belief, the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(m) The failure to file a registration statement, any summary of the registration statement, or enterprise risk filing required by this section within the time specified for the filing shall be a violation of this section. [L 1987, c 349, pt of §8; am L 1993, c 321, §15; am L 2000, c 182, §12; am L 2014, c 234, §10]

**§431:11-106 Standards and management of an insurer within a holding company system.**

(a)(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(A) The terms shall be fair and reasonable;

(B) Agreements for cost sharing services and management shall include provisions as required by rule adopted by the commissioner;

(C) Charges or fees for services performed shall be reasonable;

(D) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(E) The books, accounts, and records of each party to all transactions shall be maintained so as to clearly and accurately disclose the nature and details of the transactions including the accounting information necessary to support the reasonableness of the charges or fees to the respective parties; and

(F) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's

outstanding liabilities and adequate to its financial needs;

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards found in subparagraphs (A) through (G), shall not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty days prior to the transaction, or a shorter period as the commissioner may permit, and the commissioner has not disapproved the transaction within that period; provided that the notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer; provided further that informal notice shall be reported within thirty days after a termination of a previously filed agreement to the commissioner for determination of the type of filing required, if any:

(A) Sales, purchases, exchanges, loans, extensions of credit, or investments; provided that the transactions are equal to or exceed:
  (i) With respect to nonlife insurers, the lesser of three per cent of the insurer's admitted assets or twenty-five per cent of surplus as regards policyholders as of the December 31 next preceding; or
  (ii) With respect to life insurers, three per cent of the insurer's admitted assets as of the December 31 next preceding;

(B) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit; provided that the transactions are equal to or exceed:
  (i) With respect to nonlife insurers, the lesser of three per cent of the insurer's admitted assets or twenty-five per cent of surplus as regards policyholders as of the December 31 next preceding; or
  (ii) With respect to life insurers, three per cent of the insurer's admitted assets as of the December 31 next preceding;

(C) Reinsurance agreements or modifications to reinsurance agreements, including:
  (i) All reinsurance pooling agreements;
  (ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five per cent of the insurer's surplus as regards policyholders, as of the December 31 next preceding, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(D) All management agreements, service contracts, tax allocation agreements, guarantees, and all cost-sharing arrangements;

(E) Guarantees when made by a domestic insurer; provided that a guarantee that is quantifiable as to amount shall not be subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one per cent of the insurer's admitted assets or ten per cent of surplus as regards policyholders as of the December 31 next preceding. All guarantees that are not quantifiable as to amount are subject to the notice requirements of this paragraph;

(F) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in such investments, exceeds two and one-half per cent of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to section 431:11-103, or in nonsubsidiary insurance affiliates that are subject to this article, are exempt from this requirement; and

(G) Any material transactions, specified by rule, that the commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions that, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law;

(3) A domestic insurer may not enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would otherwise occur; provided that the commissioner determines that the separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise the commissioner's authority under section 431:11-111;

(4) The commissioner, in reviewing transactions pursuant to paragraph (2), shall consider whether the transactions comply with the standards set forth in paragraph (1) and whether the transactions may adversely affect the interests of policyholders; and

(5) The commissioner shall be notified within thirty days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten per cent of the corporation's voting securities.

(b)(1) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(A) Thirty days after the commissioner has received notice of the declaration thereof and has not within the period disapproved the payment; or

(B) The commissioner has approved the payment within the thirty-day period.

(2) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds the lesser of:

(A) Ten per cent of the insurer's surplus as regards policyholders as of the thirty-first day of December next preceding; or

(B) The net gain from operations of a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month

period ending the thirty-first day of December next preceding.

Extraordinary dividend or distribution shall not include pro rata distributions of any class of the insurer's own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provisions of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the commissioner's approval thereof, and the declaration shall confer no rights upon shareholders until the commissioner has either approved the payment of the dividend or distribution or has not disapproved the payment within the thirty-day period referred to above.

(c)(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject to by law. The insurer shall be managed so as to assure its separate operating identity consistent with this article.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of subsection (a)(1).

(3) At least one-third of the directors of a domestic insurer, and at least one-third of the members of each committee of the board of directors of any domestic insurer, shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person shall be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one or more committees composed solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer, and recommending to the board of directors the selection and compensation of the principal officers.

(5) Paragraphs (3) and (4) shall not apply to:

(A) A domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of paragraphs (3) and (4) with respect to the controlling entity; or

(B) A domestic insurance holding company system.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this subsection if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including but not limited to the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

(d) For purposes of this article, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among the several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification, and liquidity of the insurer's investment portfolio;

(7) The recent past and projected future trend in the size of the insurer's investment portfolio;

(8) The surplus as regards policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer's reserves; and

(10) The quality and liquidity of investments in affiliates. The commissioner may treat any investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the commissioner's judgment the investment so warrants.

(e) In determining the adequacy and reasonableness of an insurer's surplus, no single factor is necessarily controlling, and the commissioner shall:

(1) Consider the net effect of all of the factors, along with other factors bearing on the financial condition of the insurer;

(2) In comparing the surplus maintained by other insurers, consider the extent to which each of these factors varies among insurers; and

(3) In determining the quality and liquidity of investments in subsidiaries, consider the individual subsidiary and discount or disallow its valuation to the extent warranted by individual investments. [L 1987, c 349, pt of §8; am L 1990, c 75, §1; am L 1993, c 321, §16; am L 2000, c 24, §10; am L 2010, c 116, §1(23); am L 2011, c 81, §8; am L 2014, c 234, §11]

**§431:11-107 Examination.** (a) Subject to the limitation contained in this section and in addition to the powers that the commissioner has under article 2 relating to the examination of insurers, the commissioner may examine any insurer registered under section 431:11-105 as reasonably necessary to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(b) To evaluate whether the operations of an ultimate controlling person, affiliate, or any combination of entities within the insurance holding company system may adversely and materially affect the operations, management, or financial condition of an insurer, the

commissioner may order any insurer registered under section 431:11-105 to:

(1) Produce the records, books, or other information in the possession of the insurer or its affiliates that are reasonably necessary to determine compliance with this article; and

(2) Determine compliance with this article, produce information not in the possession of the insurer if the insurer can obtain access to that information pursuant to contractual relationships, statutory obligations, or other methods. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer to pay a penalty of not less than $100 and not more than $500 for each day's delay, or may suspend or revoke the insurer's license.

(c) The commissioner may retain at the registered insurer's expense attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under subsections (a) and (e). Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(d) Each registered insurer producing for examination records, books, and papers pursuant to subsections (a) and (e) shall be liable for and shall pay the expense of the examination in accordance with article 2.

(e) In the event that:

(1) An insurer fails to comply with an order pursuant to subsection (b); or

(2) The commissioner, upon evaluating whether the operations of an ultimate controlling person, affiliate, or any combination of entities within the insurance holding company system pursuant to subsection (b), has reasonable cause to believe that:

(A) The operations of the ultimate controlling person, affiliate, or any combination of entities within the insurance holding company system may adversely and materially affect the operations, management, or financial condition of an insurer; or

(B) The commissioner is unable to obtain relevant information from the controlled insurer,

the commissioner may examine the ultimate controlling person, affiliate, or any combination of entities within the insurance holding company system.

The commissioner may also issue subpoenas, administer oaths, and examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the State. Every person shall be entitled to the same fees and mileage, if claimed, as a witness in a court of record, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

(f) An examination of affiliates by the commissioner under subsection (e) shall specify the grounds for the examination and shall be confined to those specified grounds. [L 1987, c 349, pt of §8; am L 2014, c 234, §12]

**[§431:11-107.5] Supervisory colleges.** (a) With respect to any insurer registered under section 431:11-105, and in accordance with subsection (c), the commissioner may participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations to determine compliance by the insurer with this article. The powers of the commissioner with respect to supervisory colleges shall include but not be limited to:

(1) Initiating the establishment of a supervisory college;

(2) Clarifying the membership and participation of other supervisors in the supervisory college;

(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(5) Establishing a crisis management plan.

(b) Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with subsection (c), including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(c) To assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes, and as part of the examination of individual insurers in accordance with section 431:11-107, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The commissioner may enter into agreements in accordance with section 431:11-108 providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within the commissioner's jurisdiction. [L 2014, c 234, §6]

**§431:11-108 Confidential treatment.** (a) Documents, materials, or other information in the possession or control of the insurance division that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 431:11-107 and all information reported pursuant to sections 431:11-104(b)(12) and (13), 431:11-105, and 431:11-106, shall be confidential by

law and privileged, shall not be disclosable under chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of the policyholders, shareholders, or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(b) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner or with whom the documents, materials, or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a).

(c) To assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (a), with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in section 431:11-107.5; provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information, and has verified in writing the legal authority to maintain confidentiality;

(2) Notwithstanding paragraph (1) to the contrary, may only share confidential and privileged documents, material, or information reported pursuant to section 431:11-105(l) with commissioners of states having statutes or regulations substantially similar to subsection (a) and who have agreed in writing not to disclose such information;

(3) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from the National Association of Insurance Commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(4) Shall enter into written agreements with the National Association of Insurance Commissioners governing sharing and use of information provided pursuant to this article and consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state, federal, or international regulators;

(B) Specify that ownership of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article remains with and for use by the commissioner and the National Association of Insurance Commissioners and is

subject to the direction of the commissioner;

(C) Require that prompt notice be given to an insurer whose confidential information is in the possession of the National Association of Insurance Commissioners pursuant to this article and require that the insurer is subject to a request or subpoena from the National Association of Insurance Commissioners for disclosure or production; and

(D) Require the National Association of Insurance Commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared pursuant to this article.

(d) The sharing of information by the commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner shall be solely responsible for the administration, execution, and enforcement of this article.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (c).

(f) Documents, materials, or information in the possession or control of the National Association of Insurance Commissioners pursuant to this article shall be confidential by law and privileged, shall not be disclosable under chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. [L 1987, c 349, pt of §8; am L 2014, c 234, §13]

**§431:11-109 Rules and regulations.** The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules and orders as shall be necessary to carry out the provisions of this article. [L 1987, c 349, pt of §8]

**§431:11-110 Injunctions; prohibitions against voting securities; sequestration of voting securities.** (a) Whenever it appears to the commissioner that any insurer or any director, officer, employee, or agent thereof has committed or is about to commit a violation of this article or of any rule or order issued by the commissioner hereunder, the commissioner may apply to the circuit court of the first judicial circuit for an order enjoining the insurer or the director, officer, employee, or agent thereof from violating or continuing to violate this article or any rule or order, and for other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(b) No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this article or of any rule or order issued by the commissioner hereunder may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding. No action taken at any such meeting shall be invalidated by

the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this State have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this article or of any rule or order issued by the commissioner hereunder the insurer or the commissioner may apply to the circuit court of the first judicial circuit to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of section 431:11-104 or any rule or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(c) In any case where a person has acquired or is proposing to acquire any voting securities in violation of this article or any rule or order issued by the commissioner hereunder, the circuit court of the first judicial circuit may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue an order with respect thereto as may be appropriate to effectuate the provisions of this article.

Notwithstanding any other provisions of law, for the purposes of this article, the sites of the ownership of the securities of domestic insurers shall be deemed to be in this State. [L 1987, c 349, pt of §8]

**§431:11-111 Sanctions.** (a) Any insurer failing, without just cause, to file any registration statement as required in this article shall be required, after notice and hearing, to pay a fine in an amount of not less than $100 and not more than $500 for each day's delay, to be recovered by the commissioner, and the penalty so recovered shall be paid into the compliance resolution fund. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(b) Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly permits any of the officers or agents of the insurer to engage in any transactions or make investments that have not been properly reported or submitted pursuant to section 431:11-105(a), 431:11-106(a)(2), or 431:11-106(b), or that violates this article, shall pay, in their individual capacity, a civil forfeiture of not less than $100 and not more than $10,000 per violation, after notice and hearing before the commissioner. In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the civil forfeiture with respect to the gravity of the violation, the history of previous violations, and other matters as justice may require.

(c) Whenever it appears to the commissioner that any insurer subject to this article or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract that is subject to section 431:11-106 and that would not have been approved had the approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the commissioner may also order the insurer to void any of the contracts and restore the status quo if that action is in the best interest of the policyholders, creditors, or

the public.

(d) Whenever it appears to the commissioner that any insurer or any director, officer, employee, or agent thereof has committed a wilful violation of this article, the commissioner may cause criminal proceedings to be instituted against the insurer or the responsible director, officer, employee, or agent thereof. Any insurer that wilfully violates this article may be fined not less than $100 and not more than $10,000 per violation. Any individual who wilfully violates this article may be fined in the person's individual capacity not less than $100 and not more than $10,000 per violation or be imprisoned for not more than one year, or both.

(e) Any officer, director, or employee of an insurance holding company system who wilfully and knowingly subscribes to or makes, or causes to be made, any false statements, false reports, or false filings with the intent to deceive the commissioner in the performance of the commissioner's duties under this article, upon conviction thereof, shall be imprisoned for not more than one year or fined $5,000, or both. Any fines imposed shall be paid by the officer, director, or employee in the person's individual capacity.

(f) Whenever it appears to the commissioner that any person has committed a violation of section 431:11-104 and that prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with part 2 of article 15. [L 1987, c 349, pt of §8; am L 1999, c 163, §15(1); am L 2000, c 182, §13; am L 2002, c 39, §14; am L 2014, c 234, §14]

**§431:11-112 Receivership.** Whenever it appears to the commissioner that any person has committed a violation of this article which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, then the commissioner may proceed as provided in article 15 to take possession of the property of the domestic insurer and to conduct the business thereof. [L 1987, c 349, pt of §8]

**§431:11-113 Recovery.** (a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer:

(1) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or

(2) Any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurer or its subsidiary(ies) to a director, officer, or employee.

Where the distribution or payment pursuant to items (1) or (2) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c), and (d).

(b) No distribution shall be recoverable if the parent or affiliate shows that when paid the distribution was lawful and reasonable, and that

the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under subsection (a) the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions the person would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) is insolvent or otherwise fails to pay claims due from it pursuant to subsection (c), its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it. [L 1987, c 349, pt of §8]

**§431:11-114 Revocation, suspension, or nonrenewal of insurer's license.** Whenever it appears to the commissioner that any person has committed a violation of this article which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke or refuse to renew the insurer's license or authority to do business in this State for the period the commissioner finds is required for the protection of policyholders or the public. Any determination shall be accompanied by specific findings of fact and conclusions of law. [L 1987, c 349, pt of §8]

**§431:11-115 Judicial review; mandamus.** (a) Any person aggrieved by any act, determination, rule or order or any other action of the commissioner pursuant to this article may appeal therefrom to the circuit court of the first judicial circuit. The court shall conduct its review without a jury and by trial de novo, except that if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

(b) The filing of an appeal pursuant to this section shall stay the application of any rule, order, or other action of the commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.

(c) Any person aggrieved by any failure of the commissioner to act or make a determination required by this article may petition the circuit court of the first judicial circuit for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make the determination forthwith. [L 1987, c 349, pt of §8]

**§431:11-116 Conflict with other laws.** All laws and parts of laws

of this State inconsistent with this article are hereby superseded with respect to matters covered by this article. [L 1987, c 349, pt of §8]

**§431:11-117 Severability of provisions.** If any provision of this article or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this article which can be given effect without the invalid provisions or applications, and for this purpose the provisions of this article are severable. [L 1987, c 349, pt of §8]

## [ARTICLE 11A]
## BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER

**§431:11A-101 Definitions.** For purposes of this article:

"Accredited state" means a state in which the insurance department or regulatory agency meets the minimum financial regulatory standards promulgated from time to time by the National Association of Insurance Commissioners.

"Control" has the meaning ascribed in section 431:11-102.

"Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

"Controlling producer" means a producer who, directly or indirectly, controls an insurer.

"Licensed insurer" or "insurer" means any person, firm, association, or corporation duly licensed to transact a property or casualty insurance business in this State. The following are not licensed insurers for the purposes of this article:

(1) All residual market pools and joint underwriting authorities or associations; and

(2) Captive insurance companies as defined in section 431:19-101, other than risk retention captive insurance companies.

"Producer" means any person, firm, association, or corporation licensed pursuant to article 9A, when, for any compensation, commission, or other thing of value, the person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association, or corporation. [L 1992, c 176, pt of §1; am L 2002, c 155, §78; am L 2003, c 212, §99; am L 2014, c 186, §8]

**[§431:11A-102] Applicability.** This article shall apply to insurers either domiciled in this State or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of article 11, to the extent they are not in conflict with this article, shall apply to all parties within a holding company system subject to this article. [L 1992, c 176, pt of §1]

**[§431:11A-103] Minimum standards.** (a) The minimum standards specified in this section shall apply if, in any calendar year, the aggregate amount of gross written premiums on business placed with a controlled insurer by a controlling producer is equal to or greater than

five per cent of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year. However, the provisions of this section shall not apply if:

(1) The controlling producer:

(A) Places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate, or subsidiary, and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(B) Accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds;

(2) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer; and

(3) The controlling producer is domiciled in the State and is authorized to do business only in the State and the controlled insurer is licensed and conducting business only in the State.

(b) A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the controlled insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the controlled insurer and contains the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

(2) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the controlling producer;

(3) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments of premiums collected by the controlling producer shall be remitted no later than ninety days after the effective date of the policy or policies placed with the controlled insurer under the contract;

(4) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal savings and loan insurance corporation or similar federal agency pursuant to section 431:6-315;

(5) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

(6) The contract shall not be assigned in whole or in part by the controlling producer;

(7) The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

(8) The rates and terms of the controlling producer's commissions, charges, or other fees and the purposes for those charges or fees. The rates of the commissions, charges, and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph and paragraph (7), examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business;

(9) If the contract provides that the controlling producer, on insurance business placed with the controlled insurer, is to be compensated contingent upon the controlled insurer's profits on that business, then that compensation shall not be determined and paid until at least five years after the premiums are earned on liability insurance and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subsection (c);

(10) A limit on the controlling producer's production in relation to the controlled insurer's surplus and total production. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if the producer has been notified by the controlled insurer that the limit has been reached; and

(11) The controlling producer may negotiate, but shall not bind, reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which those automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(c) Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the controlled insurer's loss reserves.

(d) In addition to any other required loss reserve certification, the controlled insurer annually, on April 1 of each year, shall file with the commissioner an opinion of an independent casualty actuary (or such other independent loss reserve specialist acceptable to the commissioner) reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end (including incurred but not reported) on business placed by the controlling producer. The controlled insurer shall annually report to the commissioner the amount of commissions paid to the controlling producer, the percentage that amount represents of the net premiums written, and comparable amounts and percentages paid to noncontrolling producers for placements of the same kinds of insurance with the controlled insurer. [L 1992, c 176, pt of §1]

**[§431:11A-104] Disclosure.** Prior to the effective date of the policy, the controlling producer shall deliver written notice to the prospective insured disclosing the relationship between the controlling producer and the controlled insurer; except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in the controlling producer's records a signed statement from the subproducer that the subproducer is aware of the relationship between the controlled insurer and the controlling producer and a written commitment that the subproducer has or will notify

the insured of that relationship. [L 1992, c 176, pt of §1]

**[§431:11A-105] Penalties.** (a) If the commissioner believes that a controlling producer or any other person has not complied with this article, or any applicable rule or order, after notice and opportunity to be heard, the commissioner may order the controlling producer to cease placing business with the controlled insurer. If the commissioner finds that because of noncompliance by a controlling producer or any other person with this article or any applicable rule or order, the controlled insurer or any policyholder thereof has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the controlled insurer or policyholder for recovery of compensatory damages for the benefit of the controlled insurer or policyholder, or other appropriate relief.

(b) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to article 15 and the receiver appointed under that order believes that the controlling producer or any other person has not complied with this article, or any applicable rule or order, and the controlled insurer suffered any loss or damage from the noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the controlled insurer.

(c) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance code.

(d) Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties. [L 1992, c 176, pt of §1]

## ARTICLE 12
## MASS MERCHANDISING OF INSURANCE

**§431:12-101 Definitions.** As used in this article:

"Employees" includes compensated officers, managers, and employees of a firm, corporation, partnership, sole proprietor, trust, estate, or members of an unincorporated association or nonprofit organization. A mass merchandising agreement may provide that the term "employees" shall include retired employees and the individual proprietor, partners, or trustees, if the employer is an individual proprietor, partnership, trust, or estate.

"Employer" includes any firm, corporation, partnership, sole proprietorship, trust, estate, and unincorporated association or nonprofit organization; it also includes the State, any county, any municipal corporation, and any governmental unit, agency, or department thereof.

"Insurer" means an insurer authorized to transact the business of motor vehicle, property, and casualty insurance in the State.

"Mass merchandise" means to sell and "mass merchandising" means a sale of insurance wherein:

(1) The insurance is offered to employees of particular employers, and

(2) The employer has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees.

"Mass merchandising agreement" means an agreement between an insurer

and an employer for the sale of insurance to the employees of the employer on a mass merchandising basis.

"Mass merchandising plan" or "plan" means a program, design, or scheme of the insurance to be mass merchandised, including terms, coverages, and premiums.

"Motor vehicle" means a vehicle of a type required to be registered under chapter 286, including a vehicle with less than four wheels or a trailer.

"Motor vehicle insurance" means an insurance policy and optional additional insurance as defined in article 10C. [L 1987, c 347, pt of §2; am L 1997, c 251, §55; am L 2003, c 212, §100]

**§431:12-102 Applicability.** This article shall apply to motor vehicle insurance and to property and casualty insurance as defined in sections 431:1-206 and 431:1-209. The provisions of this article are in addition to, and not in substitution for, other applicable requirements of law relating to motor vehicle and property and casualty insurance and the rules of the commissioner adopted pursuant thereto. The requirements of this article do not apply to methods of merchandising other than mass merchandising as defined in section 431:12-101. [L 1987, c 347, pt of §2; am L 2003, c 212, §101]

**§431:12-103 Mass merchandising authorized.** An insurer may mass merchandise motor vehicle, property and casualty insurance to the employees of any employer under a mass merchandising plan audited by the commissioner; provided that such mass merchandising is agreed to by the employer. An employer may contract with one or more insurers for mass merchandising of motor vehicle, property and casualty insurance to its employees. [L 1987, c 347, pt of §2]

**§431:12-104 Mass merchandising prohibited; when.** (a) No insurer shall mass merchandise insurance to members of any association or organization formed principally for the purpose of obtaining the benefits of mass merchandising.

(b) No insurer shall mass merchandise insurance to employees of any employer which requires the purchase of or participation in insurance sold on a mass merchandising basis as a condition of employment, or which subjects any employee to any penalty for failure to purchase or participate in insurance sold on a mass merchandising basis. [L 1987, c 347, pt of §2]

**§431:12-105 Mass merchandising requirements.** Mass merchandising of insurance and every mass merchandising plan shall be subject to the following conditions:

(1) The insurance offered shall be open to participation by or be available to every employee of the employer who meets the underwriting requirements of the insurer.

(2) The insurance shall be offered without discrimination against any employee as to rates, forms, or coverages. Nothing herein shall preclude the establishment of different classes of risks.

(3) Upon the termination of employment or upon the termination of the mass merchandising agreement, an insured employee shall have the option of continuing the employee's participation in a group policy or the employee's individual policy then in force for a period of one year upon payment of the applicable premium;

provided that the employee shall exercise the employee's option within thirty days following the date of the termination. The terms, conditions, and coverages for the one-year period are those that were effective on the date of termination and shall not be more restrictive than those contained in the mass merchandising agreement, the group policy, or the individual policy in force immediately prior to the date of termination.

(4) The insurer shall issue a certificate or other evidence of participation to every member covered under a group policy and a policy of insurance to every member insured under an individual policy.

(5) The insurance offered shall not be contingent upon the purchase of any other insurance, product, or service; nor shall the purchase of any other insurance, product, or service be contingent upon the purchase of the motor vehicle, property, and casualty insurance offered. [L 1987, c 347, pt of §2; am L 2000, c 24, §11]

**§431:12-106 Disclosure.** Every insurer selling insurance on a mass merchandising basis shall, prior to sale, make full and fair disclosures to prospective insureds of all features of the plan, including but not limited to premium rates, claims procedure, benefits, duration of coverage, and policyholder services. [L 1987, c 347, pt of §2]

**§431:12-107 Payroll deductions and premium collections.** A mass merchandising agreement may provide for the collection of premiums from employees by payroll deductions, assessments, or otherwise, and the remittance of the same to the insurer by the employer; provided that:

(1) No such collection and remittance of premiums by the employer shall constitute collection of premium within the meaning of this code;

(2) No act of furnishing information about such collection method by the employer to its employees shall constitute solicitation of applications for insurance; and

(3) The employer shall not be considered an insurance producer for purposes of this code by virtue of the employer's collection and remittance of premiums or the furnishing of information about such collection method. [L 1987, c 347, pt of §2; am L 2003, c 212, §102]

**§431:12-108 Employer's failure to remit premiums.** If any employer is required under a mass merchandising agreement to collect the premiums from its employees and remit the same to the insurer, its failure to so collect and remit as to any employee for any reason, including termination of the employee's employment, shall not be regarded by the insurer as nonpayment of premium by such employee, unless the insurer gives written notice of such failure to remit to the employee and the employee fails to pay the required premium by the later of:

(1) Thirty days after the mailing or delivery of the notice to the address of the employee last known to the insurer, or

(2) The due date of the premium. [L 1987, c 347, pt of §2]

**§431:12-109 Cancellation and nonrenewal.** Except as provided by section 431:12-108, no policy of an individual employee or participation of an employee in a group policy shall be cancelled or its renewal denied unless a thirty-day written notice of cancellation or renewal is given the employee. All such notices shall set forth the reasons for the

cancellation or nonrenewal. The insurer, prior to the expiration of the thirty-day period, shall afford the employer a reasonable opportunity to consult with the insured and to present facts in opposition to cancellation or nonrenewal. [L 1987, c 347, pt of §2; am L 2003, c 212, §103]

**§431:12-110 Premium rates.** Premium rates for insurance sold on a mass merchandising basis shall comply with the standards in article 10C for motor vehicle insurance and in article 14 for property and casualty insurance including the standards that rates not be excessive, inadequate or unfairly discriminatory.

Rates shall not be deemed to be unfairly discriminatory because different premiums result for policyholders with like loss exposure but different expense factors, or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates shall not be deemed to be unfairly discriminatory if they are averaged broadly among persons insured under a mass merchandising plan. [L 1987, c 347, pt of §2]

**§431:12-111 Readjustment of premiums; dividends.** (a) Any mass merchandising agreement may provide for the readjustment of the rate of premium based on experience at the end of the first year for any subsequent year of insurance, and such readjustment may be made retroactive only for the policy year.

(b) If a policy dividend is declared or a reduction in rate is made or continued under any mass merchandising plan, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over aggregate expenditure for insurance under such policies made from funds contributed by the policyholder, or by an employer of an insured person, or by a union or association to which an insured person belongs, including expenditures made in connection with administration of such policies, shall be applied by the policyholder for the sole benefit of insured employees. [L 1987, c 347, pt of §2]

**§431:12-112 Underwriting standards.** Every plan of mass merchandising and all rules and standards applicable to mass merchandising of insurance shall be subject to audit by the commissioner upon written request to the insurer. No underwriting standard for risk selection under a mass merchandising plan shall be more restrictive than the standards used for insurance sold by methods other than mass merchandising. [L 1987, c 347, pt of §2]

**§431:12-113 Statistics.** Every insurer mass merchandising insurance shall keep and maintain data on its experience under each plan, including data on premium income, losses, and expenses. The data shall be kept and maintained separately from any experience data on insurance sold by means other than mass merchandising. [L 1987, c 347, pt of §2]

**§431:12-114 Licenses.** No person shall act as an insurance producer in connection with mass merchandising of insurance, unless the person is licensed as such under article 9A. [L 1987, c 347, pt of §2; am L 2002, c 155, §79]

**§431:12-115 Establishment and maintenance of office.** (a) Every insurer selling insurance on a mass merchandising basis shall establish and maintain at all times an office in the State to conduct the administration of its business and handle claims.

(b) Establishment and maintenance of an office by any licensed producer of an insurer shall meet the requirements of this section. [L 1987, c 347, pt of §2; am L 2000, c 24, §12; am L 2002, c 155, §80]

**§431:12-116 Rules.** The commissioner shall adopt rules necessary to effectuate the purposes of this article. [L 1987, c 347, pt of §2]

## ARTICLE 13
## UNFAIR METHODS OF COMPETITION AND UNFAIR AND DECEPTIVE ACTS AND PRACTICES IN THE BUSINESS OF INSURANCE

## PART I. GENERAL PROVISIONS

### Case Notes

Supreme court of Hawai`i would not find that article 13 preempted suits against insurers for deceptive trade practices in violation of §480-2. 95 F.3d 791.

This article does not authorize a private cause of action. 795 F. Supp. 1036.

Article's administrative remedies not exclusive; bad faith cause of action may be brought by first-party insured for insurer misconduct. 82 H. 120, 920 P.2d 334.

As no private cause of action authorized under this article, summary judgment properly granted for workers' compensation insurer against employee's complaint of violation of this article by insurer. 83 H. 457, 927 P.2d 858.

No private cause of action exists under this article. 82 H. 363 (App.), 922 P.2d 976.

**§431:13-101 Purpose.** The purpose of this article is to regulate trade practice in the business of insurance in accordance with the intent of the Congress of the United States as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all acts, methods, and practices which constitute unfair methods of competition or unfair or deceptive acts or practices in this State, and by prohibiting the trade practices so defined or determined. [L 1987, c 347, pt of §2]

### Case Notes

Cited: 95 F.3d 791.

**§431:13-102 Unfair methods of competition; unfair or deceptive acts or practices prohibited.** No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to section 431:13-106 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. [L

1987, c 347, pt of §2]

**Case Notes**

An insurer that does not respond promptly to a party's settlement demand and does not negotiate settlement in good faith may violate section. 73 H. 412, 835 P.2d 627.

Discussed: 458 F. Supp. 2d 1167 (2006).

**§431:13-103 Unfair methods of competition and unfair or deceptive acts or practices defined.** (a) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

(A) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;
(B) Misrepresents the dividends or share of the surplus to be received on any insurance policy;
(C) Makes any false or misleading statement as to the dividends or share of surplus previously paid on any insurance policy;
(D) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;
(E) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;
(F) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;
(G) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy;
(H) Misrepresents any insurance policy as being shares of stock;
(I) Publishes or advertises the assets of any insurer without publishing or advertising with equal conspicuousness the liabilities of the insurer, both as shown by its last annual statement; or
(J) Publishes or advertises the capital of any insurer without stating specifically the amount of paid-in and subscribed capital;

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading;

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding,

abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance;

(4) Boycott, coercion, and intimidation.

(A) Entering into any agreement to commit, or by any action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; or

(B) Entering into any agreement on the condition, agreement, or understanding that a policy will not be issued or renewed unless the prospective insured contracts for another class or an additional policy of the same class of insurance with the same insurer;

(5) False financial statements.

(A) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of a material fact as to the financial condition of an insurer; or

(B) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, knowingly omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer;

(6) Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(7) Unfair discrimination.

(A) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any policy of life insurance or annuity contract or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract;

(B) Making or permitting any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charge therefor, or in the

benefits payable or in any other rights or privilege accruing thereunder;

(C) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(D) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(E) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex or marital status of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(F) Terminating or modifying coverage, or refusing to issue or renew any property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subparagraph shall not apply to accident and health or sickness insurance sold by a casualty insurer; provided further that this subparagraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(G) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual based solely upon the individual's having taken a human immunodeficiency virus (HIV) test prior to applying for insurance; or

(H) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because the individual refuses to consent to the release of information which is confidential as provided in section 325-101; provided that nothing in this subparagraph shall prohibit an insurer from obtaining and using the results of a test satisfying the requirements of the commissioner, which was taken with the consent of an applicant for insurance; provided further that any applicant for insurance who is tested for HIV infection

shall be afforded the opportunity to obtain the test results, within a reasonable time after being tested, and that the confidentiality of the test results shall be maintained as provided by section 325-101;

(8) Rebates. Except as otherwise expressly provided by law:

(A) Knowingly permitting or offering to make or making any contract of insurance, or agreement as to the contract other than as plainly expressed in the contract, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits, or any valuable consideration or inducement not specified in the contract; or

(B) Giving, selling, or purchasing, or offering to give, sell, or purchase as inducement to the insurance or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value not specified in the contract;

(9) Nothing in paragraph (7) or (8) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) In the case of any life insurance policy or annuity contract, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any bonus or abatement of premiums shall be fair and equitable to policyholders and in the best interests of the insurer and its policyholders;

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for the policy year; and

(D) In the case of any contract of insurance, the distribution of savings, earnings, or surplus equitably among a class of policyholders, all in accordance with this article;

(10) Refusing to provide or limiting coverage available to an individual because the individual may have a third-party claim for recovery of damages; provided that:

(A) Where damages are recovered by judgment or settlement of a third-party claim, reimbursement of past benefits paid shall be allowed pursuant to section 663-10;

(B) This paragraph shall not apply to entities licensed under chapter 386 or 431:10C; and

(C) For entities licensed under chapter 432 or 432D:

(i) It shall not be a violation of this section to refuse

to provide or limit coverage available to an individual because the entity determines that the individual reasonably appears to have coverage available under chapter 386 or 431:10C; and

(ii) Payment of claims to an individual who may have a third-party claim for recovery of damages may be conditioned upon the individual first signing and submitting to the entity documents to secure the lien and reimbursement rights of the entity and providing information reasonably related to the entity's investigation of its liability for coverage.

Any individual who knows or reasonably should know that the individual may have a third-party claim for recovery of damages and who fails to provide timely notice of the potential claim to the entity, shall be deemed to have waived the prohibition of this paragraph against refusal or limitation of coverage. "Third-party claim" for purposes of this paragraph means any tort claim for monetary recovery or damages that the individual has against any person, entity, or insurer, other than the entity licensed under chapter 432 or 432D;

(11) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) With respect to claims arising under its policies, failing to respond with reasonable promptness, in no case more than fifteen working days, to communications received from:

(i) The insurer's policyholder;

(ii) Any other persons, including the commissioner; or

(iii) The insurer of a person involved in an incident in which the insurer's policyholder is also involved.

The response shall be more than an acknowledgment that such person's communication has been received, and shall adequately address the concerns stated in the communication;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Failing to offer payment within thirty calendar days of affirmation of liability, if the amount of the claim has been determined and is not in dispute;

(G) Failing to provide the insured, or when applicable the insured's beneficiary, with a reasonable written explanation for any delay, on every claim remaining unresolved for thirty calendar days from the date it was reported;

(H) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has

become reasonably clear;

(I) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(J) Attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(K) Attempting to settle claims on the basis of an application which was altered without notice, knowledge, or consent of the insured;

(L) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(N) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician or advanced practice registered nurse of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(O) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage to influence settlements under other portions of the insurance policy coverage;

(P) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

(Q) Indicating to the insured on any payment draft, check, or in any accompanying letter that the payment is "final" or is "a release" of any claim if additional benefits relating to the claim are probable under coverages afforded by the policy; unless the policy limit has been paid or there is a bona fide dispute over either the coverage or the amount payable under the policy;

(12) Failure to maintain complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints which it has received since the date of its last examination under section 431:2-302. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this section, "complaint" means any written communication primarily expressing a grievance;

(13) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer, or individual; and

(14) Failure to obtain information. Failure of any insurance producer, or an insurer where no producer is involved, to comply with section 431:10D-623(a), (b), or (c) by making reasonable efforts to

obtain information about a consumer before making a recommendation to the consumer to purchase or exchange an annuity.

(b) The commissioner shall by certified mail notify the insurer's agent, as designated pursuant to section 431:2-205, of each complaint filed with the commissioner under this section.

(c) Three or more written complaints received by the commissioner within any twelve-month period charging separate violations of this section shall constitute a rebuttable presumption of a general business practice.

(d) Evidence as to numbers and types of complaints to the commissioner against an insurer, and the commissioner's complaint experience with other insurers writing similar lines of insurance, shall be admissible in an administrative or judicial proceeding brought under this section. No insurer shall be deemed in violation of this section solely by reason of the numbers and types of such complaints except if the presumption under subsection (c) is not rebutted.

(e) If it is found, after notice and an opportunity to be heard, that an insurer has violated this section, each instance of noncompliance may be treated as a separate violation of this section for the purposes of section 431:2-203.

(f) An insurer or licensee shall issue a written response with reasonable promptness, in no case more than fifteen working days, to any written inquiry made by the commissioner regarding a claim, consumer complaint, or sales or marketing practice. The response shall be more than an acknowledgment that the commissioner's communication has been received, and shall adequately address the concerns stated in the communication. [L 1987, c 347, pt of §2; am L 1988, c 330, §2; am L 1989, c 396, §1; am L 1997, c 83, §4; am L 2000, c 29, §1; am L 2002, c 155, §81 and c 228, §1; am L 2003, c 212, §104; am L 2007, c 257, §3; am L 2008, c 227, §§2, 5; am L 2009, c 11, §22; am L 2010, c 116, §1(24); am L 2014, c 45, §11]

**Case Notes**

Violations of the unfair settlement provision, subsection (a), may be used as evidence to indicate bad faith in accordance with the guidelines of Best Place, Inc. v. Penn America Ins. Co. 27 F. Supp. 2d 1211.

An insurer that does not respond promptly to a party's settlement demand and does not negotiate settlement in good faith may violate subsection (a)(10). 73 H. 412, 835 P.2d 627.

Plaintiff may not maintain a private cause of action for an alleged violation of this section. 28 F. Supp. 2d 588.

Mentioned: 795 F. Supp. 1036; 255 F. Supp. 2d 1149.

Evidence regarding workers' compensation insurer's failure to specifically address questions posed in a letter from claimant's counsel was insufficient to show that insurer failed to respond to communications "with such frequency as to indicate a general business practice" under subsection (a)(11)(B); insurer's failure thus did not violate this section or establish a genuine issue of material fact regarding claimant's allegation that insurer breached its duty to negotiate in good faith. 112 H. 195 (App.), 145 P.3d 738 (2006).

**§431:13-104 Favored producer or insurer; coercion of debtors.** (a) No person may require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such

money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any contract of insurance, or renewal thereof, through a particular insurer or group of insurers or producer or group of producers.

(b) No person who lends money or extends credit may:

(1) Solicit insurance, after a person indicates interest in securing a loan or credit extension, until such person has received a commitment in writing from the lender as to a loan or credit extension. The requirement for a commitment shall not apply in cases where the premium for the required insurance is to be financed as part of the loan or extension of credit involving personal property transactions;

(2) Unreasonably reject a contract of insurance furnished by the borrower where insurance is required by the loan or credit transaction. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for rejection of an insurance contract because the contract contains coverage in addition to that required in the loan or credit transaction;

(3) Require that any borrower, mortgagor, purchaser, insurer, or producer pay a separate charge, in connection with the handling of any contract of insurance required by the loan or credit transaction, or pay a separate charge to substitute the insurance policy of one insurer for that of another. This paragraph does not include the interest which may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document;

(4) Use or disclose information relative to a contract of insurance which is required by, or supplied in response to, the loan or credit transaction, for the purpose of replacing the insurance or soliciting insurance;

(5) Require any procedures or conditions of duly licensed producers or insurers not customarily required of those producers or insurers affiliated or in any way connected with the person who lends money or extends credit.

(c) Every person who lends money or extends credit and who solicits insurance subject to subsection (b) must explain to the borrower in writing that the insurance related to such credit extension may be purchased from an insurer or producer of the borrower's choice, subject only to the lender's right to reject a given insurer or producer as provided in subsection (b)(2). Compliance with disclosures as to insurance required by truth-in-lending laws or comparable state laws shall be in compliance with this paragraph.

(d) The commissioner shall have the power to examine and investigate those insurance related activities of any person whom the commissioner believes may be in violation of this section. Any affected person may submit to the commissioner a complaint or material pertinent to the enforcement of this section.

(e) Nothing in this section shall prevent a person who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

(f) Nothing contained in this section shall apply to credit life or credit disability insurance.

(g) Nothing in this section shall prevent a person who lends money or extends credit from assisting a mortgagor, borrower, or purchaser in obtaining homeowners insurance where the borrower requests such assistance in writing. Nothing in this section shall prevent a person who lends money or extends credit from referring a mortgagor, borrower, or purchaser to the Hawaii hurricane relief fund.

(h) The commissioner shall adopt rules to prevent any bank, or

subsidiary or affiliate thereof, which is engaged in insurance activities, from draining assets to the detriment of the insurance operations; and shall also adopt rules to obtain diverted assets from the bank, subsidiary, or affiliate in the case of insolvency of the insurance operation. [L 1987, c 347, pt of §2; am L 1993, c 339, §6; am L 1996, c 225, §4; am L 2001, c 216, §25; am L 2003, c 3, §14]

**Cross References**

Hawaii hurricane relief fund, see chapter 431P.

**§431:13-105 Power of commissioner.** The commissioner may examine and investigate into the affairs of every person engaged in the business of insurance in this State in order to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by section 431:13-102. [L 1987, c 347, pt of §2]

**§431:13-106 Hearings.** (a) Whenever the commissioner shall have reason to believe that any person has been engaged or is engaging in this State in any unfair method of competition or any unfair or deceptive act or practice, whether or not defined in section 431:13-103, and that a proceeding by the commissioner in respect thereto would be to the interest of the public, the commissioner shall issue and serve upon the person a statement of the charges in that respect and a notice of a hearing to be held at a time and place fixed in the notice, which shall not be less than fifteen days after the date of the service.

(b) At the time and place fixed for the hearing, the person shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring the person to cease and desist from the acts, methods or practices which are the subject of complaint.

(c) Procedures at the hearing shall be governed by chapter 91. [L 1987, c 347, pt of §2]

**§431:13-107 Commissioner's right of action.** All remedies, penalties and proceedings set forth in this article are to be invoked solely and exclusively by the commissioner. [L 1987, c 347, pt of §2]

**Case Notes**

See also notes at end of this chapter.

This article does not authorize a private cause of action. 795 F. Supp. 1036.

**§431:13-108 Reimbursement for accident and health or sickness insurance benefits.** (a) This section applies to accident and health or sickness insurers issuing comprehensive medical plans under part I of article 10A of chapter 431, mutual benefit societies under article 1 of chapter 432, dental service corporations under chapter 423, and health maintenance organizations under chapter 432D.

(b) Unless shorter payment timeframes are otherwise specified in a contract, an entity shall reimburse a claim that is not contested or denied not more than thirty calendar days after receiving the claim filed in writing, or fifteen calendar days after receiving the claim filed

electronically, as appropriate.

(c) If a claim is contested or denied or requires more time for review by an entity, the entity shall notify the health care provider, insured, or member filing a claim from a non-contracted provider in writing or electronically not more than fifteen calendar days after receiving a claim filed in writing, or not more than seven calendar days after receiving a claim filed electronically, as appropriate. The notice shall identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may request additional information; provided that a notice shall not be required if the entity provides a reimbursement report containing the information, at least monthly, to the health care provider.

(d) Every entity shall implement and make accessible to providers a system that provides verification of enrollee eligibility under plans offered by the entity.

(e) If information received pursuant to a request for additional information is satisfactory to warrant paying the claim, the claim shall be paid not more than thirty calendar days after receiving the additional information in writing, or not more than fifteen calendar days after receiving the additional information filed electronically, as appropriate.

(f) Payment of a claim under this section shall be effective upon the date of the postmark of the mailing of the payment, or the date of the electronic transfer of the payment, as applicable.

(g) Notwithstanding section 478-2 to the contrary, interest shall be allowed at a rate of fifteen per cent a year for money owed by an entity on payment of a claim exceeding the applicable time limitations under this section, as follows:

(1) For an uncontested claim:

(A) Filed in writing, interest from the first calendar day after the thirty-day period in subsection (b); or

(B) Filed electronically, interest from the first calendar day after the fifteen-day period in subsection (b);

(2) For a contested claim filed in writing:

(A) For which notice was provided under subsection (c), interest from the first calendar day thirty days after the date the additional information is received; or

(B) For which notice was not provided within the time specified under subsection (c), interest from the first calendar day after the claim is received; or

(3) For a contested claim filed electronically:

(A) For which notice was provided under subsection (c), interest from the first calendar day fifteen days after the additional information is received; or

(B) For which notice was not provided within the time specified under subsection (c), interest from the first calendar day after the claim is received.

The commissioner may suspend the accrual of interest if the commissioner determines that the entity's failure to pay a claim within the applicable time limitations was the result of a major disaster or of an unanticipated major computer system failure.

(h) Any interest that accrues in a sum of at least $2 on a delayed

clean claim in this section shall be automatically added by the entity to the amount of the unpaid claim due the provider.

(i) Prior to initiating any recoupment or offset demand efforts, an entity shall send a written notice to a health care provider at least thirty calendar days prior to engaging in the recoupment or offset efforts. The following information shall be prominently displayed on the written notice:

(1) The patient's name;

(2) The date health care services were provided;

(3) The payment amount received by the health care provider;

(4) The reason for the recoupment or offset; and

(5) The telephone number or mailing address through which a health care provider may initiate an appeal along with the deadline for initiating an appeal. Any appeal of a recoupment or offset shall be made by a health care provider within sixty days after the receipt of the written notice.

(j) An entity shall not initiate recoupment or offset efforts more than eighteen months after the initial claim payment was received by the health care provider or health care entity; provided that this time limit shall not apply to the initiation of recoupment or offset efforts: to claims for self-insured employer groups; for services rendered to individuals associated with a health care entity through a national participating provider network; or for claims for medicaid, medicare, medigap, or other federally financed plan; provided that this section shall not be construed to prevent entities from resolving claims that involve coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability beyond the eighteen month time limit; provided further that in cases of fraud or material misrepresentation, an entity shall not initiate recoupment or offset efforts more than seventy-two months after the initial claim payment was received by the health care provider or health care entity.

(k) In determining the penalties under section 431:13-201 for a violation of this section, the commissioner shall consider:

(1) The appropriateness of the penalty in relation to the financial resources and good faith of the entity;

(2) The gravity of the violation;

(3) The history of the entity for previous similar violations;

(4) The economic benefit to be derived by the entity and the economic impact upon the health care facility or health care provider resulting from the violation; and

(5) Any other relevant factors bearing upon the violation.

(l) As used in this section:

"Acute care hospital" means a hospital that provides inpatient medical care and other related services for surgery or acute medical conditions or injuries (usually for a short-term illness or condition).

"Claim" means any claim, bill, or request for payment for all or any portion of health care services provided by a health care provider of services submitted by an individual or pursuant to a contract or agreement with an entity, using the entity's standard claim form with all required fields completed with correct and complete information.

"Clean claim" means a claim in which the information in the possession of an entity adequately indicates that:

(1) The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract;

(2) The claim has no material defect or impropriety;

(3) There is no dispute regarding the amount claimed; and

(4) The payer has no reason to believe that the claim was submitted fraudulently.

The term does not include:

(1) Claims for payment of expenses incurred during a period of time when premiums were delinquent;

(2) Claims that are submitted fraudulently or that are based upon material misrepresentations;

(3) Claims for self-insured employer groups; claims for services rendered to individuals associated with a health care entity through a national participating provider network; or claims for medicaid, medicare, medigap, or other federally financed plan; and

(4) Claims that require a coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability.

"Contest", "contesting", or "contested" means the circumstances under which an entity was not provided with, or did not have reasonable access to, sufficient information needed to determine payment liability or basis for payment of the claim.

"Deny", "denying", or "denied" means the assertion by an entity that it has no liability to pay a claim based upon eligibility of the patient, coverage of a service, medical necessity of a service, liability of another payer, or other grounds.

"Entity" means accident and health or sickness insurance providers under part I of article 10A of chapter 431, mutual benefit societies under article 1 of chapter 432, dental service corporations under chapter 423, and health maintenance organizations under chapter 432D.

"Fraud" shall have the same meaning as in section 431:2-403.

"Health care facility" shall have the same meaning as in section 323D-2; provided that health care facility shall not include an acute care hospital.

"Health care provider" means a Hawaii health care facility, physician, nurse, or any other provider of health care services covered by an entity. [L 1999, c 99, §§2, 5; am L 2002, c 52, §§2, 3; am L 2003, c 212, §105; am L 2015, c 33, §2; am L 2016, c 141, §9]

**Note**

Section 327D-2 referred to in definition of "health care facility" is repealed.

## PART II. PENALTIES AND JUDICIAL REVIEW

**§431:13-201 Cease and desist and penalty orders; judicial review.** (a) If, after the hearing, the commissioner shall determine that the person charged has engaged in an unfair method of competition or an

unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from engaging in the method of competition, act or practice. If the act or practice is a violation of section 431:13-103, the commissioner may, at the commissioner's discretion, order any one or more of the following:

(1) Payment of a fine of not more than $1,000 for each and every act or violation but not to exceed $10,000, unless the person knew or reasonably should have known that the person was in violation of section 431:13-103, in which case the fine shall be not more than $5,000 for each and every act or violation but not to exceed $50,000 in any six-month period.

(2) Suspension or revocation of the person's license, if the person knew or reasonably should have known that the person was in violation of section 431:13-103.

(b) Any person aggrieved by an order of the commissioner under this section may obtain judicial review of the order in the manner provided for by chapter 91. [L 1987, c 347, pt of §2; am L 2003, c 212, §106]

**§431:13-202 Penalty for violation of cease and desist orders.** (a) Any person who violates a cease and desist order of the commissioner under section 431:13-201 may be subject at the discretion of the commissioner, after notice and hearing and upon order of the commissioner, to either or both of the following:

(1) A fine of not more than $10,000 for each and every act in violation of the cease and desist order; or

(2) Suspension or revocation of the person's license.

(b) No order of the commissioner pursuant to this section or order of court to enforce it shall in any way relieve or absolve any person affected by the order from any other liability, penalty, or forfeiture required by law. [L 1987, c 97, §1 and c 347, pt of §2 and L 1989, c 276, §1]

**Case Notes**

Pursuant to subsection (b), article's administrative remedies not exclusive; bad faith cause of action may be brought by first-party insured for insurer misconduct. 82 H. 120, 920 P.2d 334.

**§431:13-203 Rules.** The commissioner may adopt reasonable rules in accordance with chapter 91, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by section 431:13-103 or 431:13-104, but the rules shall not enlarge upon or extend the provisions of section 431:13-103 or 431:13-104. [L 1987, c 347, pt of §2; am L 2003, c 212, §107]

**§431:13-204 Provisions of sections additional to existing laws.** The powers vested in the commissioner by this article shall be additional to any other power to enforce penalties or fines authorized by law with respect to the methods, acts, and practices hereby declared to be unfair or deceptive. [L 1987, c 347, pt of §2]

# ARTICLE 14
# RATE REGULATION

## PART I. CASUALTY, SURETY, PROPERTY, MARINE AND TRANSPORTATION RATE REGULATION

### Note

### COMMERCIAL LIABILITY INSURANCE; TORT REFORM

The following provisions on liability insurance are excerpts from L Sp 1986, c 2, some provisions of which were scheduled for repeal on October 1, 1995, by L 1993, c 238, §1. L 1995, c 130 deleted this repeal date thereby making the provisions permanent:

"SECTION 1. Legislative findings and purpose. The legislature finds and declares that a solution to the current crisis in liability insurance has created an overpowering public necessity for a comprehensive combination of reforms to both the tort system and the insurance regulatory system. It is the intent of this Act to alleviate the seriousness of the current insurance crisis and to prevent the reoccurrence of such a crisis. The purpose of this Act is to ensure the widest possible availability of liability insurance at reasonable rates, to ensure a stable market for liability insurers, and to provide for means to adjust insurance premium rates in the context of anticipated cost savings from tort reform legislation affecting the affordability and availability of liability insurance. [L Sp 1986, c 2, §1]

SECTION 2. Definitions. As used in sections 3 to 7 of this Act, unless the context otherwise requires:

1. "Authorized insurer" means insurers licensed to do business in the State.
2. "Commercial liability insurance" means insurance written for businesses providing protection for an insured against loss arising from injuries to other persons or damage to their property. It includes but is not limited to policies providing coverage for errors and omissions, and professional malpractice.
3. "Rebate" means an amount refunded to a policyholder by an insurer to reflect a return of excess premiums with interest.
4. "Surcharge" means an amount assessed by an insurer against a policyholder over and above manual rates. [L Sp 1986, c 2, §§2 and 31; am L 1989, c 300, §2; am L 1991, c 62, §1; am L 1993, c 238, §1; am L 1995, c 130, §1]

SECTION 3. Rate reduction; relief. (a) The insurance commissioner shall effect a moratorium and not approve any rate level increase in commercial liability insurance during the period August 1, 1986, to September 30, 1986. Commencing October 1, 1986, all authorized insurers transacting commercial liability insurance in this State shall implement a ten per cent rate reduction from the rates currently on file with the insurance commissioner for all policies containing commercial liability coverage, except motor vehicle and medical malpractice policies, in effect on September 30, 1986, for each new and renewal policy and provide that the new rates will be in effect and filed during the period October 1, 1986, to September 30, 1987. There shall be no exception to the requirements of this subsection, unless the commissioner, pursuant to an insurer's petition, shall find that the use of the rates required herein by an insurer will be inadequate to the extent that such rates jeopardize the solvency of the insurer required to use such rates.

(b) Commencing on October 1, 1987, all authorized insurers providing

commercial liability insurance in this State shall implement a twelve per cent rate reduction for all policies containing commercial liability coverage, except motor vehicle and medical malpractice policies issued by mutual or reciprocal insurers, from the rates in effect on September 30, 1987, for each new and renewal policy, and provide that the new rates will be in effect and filed during the period October 1, 1987, to September 30, 1988.

(c) Commencing on October 1, 1988, all authorized insurers providing commercial liability insurance in this State shall implement a fifteen per cent rate reduction for all policies containing commercial liability coverage, except motor vehicle and medical malpractice policies issued by mutual or reciprocal insurers, from the rates in effect on September 30, 1988, for each new and renewal policy, and provide that the new rates will be in effect and filed during the period October 1, 1988, to September 30, 1989; provided that for purposes of this section, a mutual or reciprocal insurer shall include in any rate filing, information and data regarding the expected impact of the tort reform implemented by sections 11 through 22 of Act 2, First Special Session Laws of Hawaii, 1986.

(d) Except as otherwise provided in this Act, all rates for commercial liability insurance shall comply with the provisions of the casualty rating law contained in chapter 431, Hawaii Revised Statutes. Any insurer which contends that the rate provided for in subsection (b) or (c) is inadequate shall state in its filing the rate it contends is appropriate and shall state with specificity the factors or data which it contends should be considered in order to produce such appropriate rate. The insurer shall be permitted to use all of the generally accepted actuarial techniques in making any filing pursuant to this subsection. It shall be the insurer's or rating organization's burden to actuarially justify any rate increase from the reduced rates provided for in subsection (b) or (c). The insurer or rating organization shall include in the filing the expected impact of the tort reform implemented by Sections 11 to 22 of this Act on losses, expenses and rates. In making this filing as provided for by this subsection, the insurer or rating organization shall comply with the following provisions:

(1) Any rate filing contending that the rates established in subsections (b) or (c) is inadequate shall be filed ninety days prior to October 1, 1987, or October 1, 1988.

(2) The insurance commissioner shall review and approve or disapprove the rate filing thirty days prior to October 1, 1987, or with respect to filings submitted pursuant to subsection (c) thirty days prior to October 1, 1988. A filing shall be deemed to meet the requirements of the casualty rating law unless disapproved by the commissioner within the 60-day waiting period. All filings submitted under this Act shall be deemed public records.

(3) In the event the filing is approved under subsection (d)(2), a contested case hearing in accordance with the provisions of chapter 91, Hawaii Revised Statutes, may be convened. Notwithstanding the provisions of section 431-61, Hawaii Revised Statutes, a petition and demand for hearing shall not stay the implementation of the rate approved by the commissioner or the rates in effect as of September 30, 1986, whichever is higher. A final order of the commissioner may be appealed in accordance with the provisions of section 431-69, Hawaii Revised Statutes.

(4) In the event a filing is disapproved in whole or in part, a petition and demand for a contested case hearing may be filed in accordance with chapter 91, Hawaii Revised Statutes. The insurer

or rating organization shall have the burden of proving that the disapproval is not justified. While the action of the commissioner in disapproving the rate filing is being challenged, the aggrieved insurer shall be entitled to charge the rates established as of September 30, 1986 or the filed rates, whichever is lower.

(5) With respect to any approval or disapproval by the commissioner regarding any rate filing focusing upon the October 1, 1988, reduction, the aggrieved insurer shall be entitled to charge the rates established as of September 30, 1988, while the action of the commissioner is being challenged and contested.

(6) Upon final disposition, pursuant to chapter 91, Hawaii Revised Statutes, or by a court of competent jurisdiction of the insurance commissioner's approval or disapproval of the rates, the insurance commissioner shall immediately determine and order that the insurer make the appropriate rebates of premiums to policyholders or allow the insurer to exact a surcharge on premiums.

(e) The insurance commissioner shall publish a notice of every filing submitted by insurers pursuant to this section in a newspaper of general circulation in the State. [L Sp 1986, c 2, §§3 and 31; am L 1987, c 231, §1; am L 1989, c 300, §2; am L 1991, c 62, §1; am L 1993, c 238, §1; am L 1995, c 130, §1]

SECTION 4. Excessive rates; rebate or credit. In reviewing the information gathered from the closed case reports provided for under Section 26 of this Act, and from any other relevant information, if there is reason to believe that the rates are excessive, the insurance commissioner shall request a hearing to determine the adequate rate. If as a result of the hearing it is determined that insurers are charging excessive rates, the insurance commissioner shall issue an order specifying that a new rate or schedule be filed by the insurer or rating organization which responds to the findings made through the hearing. The insurance commissioner shall further order that premiums charged each policyholder constituting the portion of the rate above that which is actuarially justified be returned to such policyholder in the form of a rebate or credit. [L Sp 1986, c 2, §§4 and 31; am L 1989, c 300, §2; am L 1991, c 62, §1; am L 1993, c 238, §1; am L 1995, c 130, §1]

SECTION 5. Cancellation of policy; prohibition. No policies to which the reductions on insurance rate apply shall be canceled by the insurer prior to the expiration of the agreed term or one year from the effective date of the policy or renewal, whichever is less, except under the following grounds:

(1) Failure to pay a premium when due;

(2) Fraud or material misrepresentation;

(3) Risk hazard increases substantially and the insurer could not have reasonably foreseen the change when entering into the contract;

(4) Substantial breaches of contractual duties, conditions, or warranties;

(5) Violation of any local fire, health, or safety statute or ordinance;

(6) Conviction of the named insured for a crime having as one of its necessary elements, an act increasing any hazard that is insured against;

(7) The insurance commissioner determines that the continuation of the policy places the insurer in violation of chapter 431, Hawaii Revised Statutes;

(8) For any good faith reason with the approval of the insurance commissioner. [L Sp 1986, c 2, §§5 and 31; am L 1989, c 300, §2; am L 1991, c 62, §1; am L 1993, c 238, §1; am L 1995, c 130, §1]

SECTION 6. Cancellation of policies; effective date. In the event there is cancellation pursuant to sections 5 and 7 of this Act, such cancellation will be effective thirty days after the insurer delivers written notice of the cancellation to the policyholder. [L Sp 1986, c 2, §§6 and 31; am L 1989, c 300, §2; am L 1991, c 62, §1; am L 1993, c 238, §1; am L 1995, c 130, §1]

SECTION 7. Nonrenewal of policies; notice. An insurer may refuse to renew a commercial liability policy if notice to the policyholder of the reasons for nonrenewal are provided to the insured forty-five days prior to the intended nonrenewal date. A commercial liability insurance policy, once issued shall not be cancelled or refused renewal by an insurer based upon the mandatory rate reductions as required by this Act." [L Sp 1986, c 2, §§7 and 31; am L 1989, c 300, §2; am L 1991, c 62, §1; am L 1993, c 238, §1; am L 1995, c 130, §1]

**§431:14-101 Purpose.** The purpose of this article is to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in ratemaking and ratemaking related activities and in other matters within the scope of this article. Nothing in this part is intended to:

(1) Prohibit or discourage reasonable competition; or

(2) Prohibit or encourage except to the extent necessary to accomplish the aforementioned purposes, uniformity in insurance rates, rating systems, rating plans, or practices.

This article shall be liberally interpreted to carry into effect the provisions of this section. [L 1987, c 347, pt of §2; am L 1990, c 255, §6]

**§431:14-101.5 Definitions.** As used in this article, unless the context otherwise requires:

"Developed losses" means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss (including loss adjustment expense) payments.

"Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees; provided that no tax credit received by any insurer under section 431:7-207 shall reduce the expenses of the insurer for purposes of determining the insurer's rate under this article for the first year of any insurer's rate which is approved pursuant to this article and for which the insurer submits before July 1, 1993, a filing pursuant to the applicable sections of this code to modify the rate in existence on June 30, 1992.

"Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

"Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

"Rate" means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an

adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premium.

"Supplementary rating information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule, statistical plan, and any other similar information needed to determine the applicable rate in effect or to be in effect.

"Supporting information" means:

(1) The experience and judgment of the filer and the experience or data of other insurers, rating organizations, or advisory organizations relied on by the filer;

(2) The interpretation of any other data relied upon by the filer; and

(3) Descriptions of methods used in making the rates, and any other information required by the commissioner to be filed. [L 1990, c 255, §1; am L 1992, c 236, §8]

**§431:14-102 Scope.** (a) This article shall apply to all classes, types, or forms of general casualty insurance as defined in section 431:1-209, surety insurance as defined in section 431:1-210, motor vehicle insurance, and workers' compensation and employers' liability insurance, on risks or operations in this State, and all classes, types or forms of property insurance as defined in section 431:1-206, and marine and transportation insurance as defined in section 431:1-207, on risks located in this State. Inland marine insurance shall be deemed to include insurance now or hereafter defined as inland marine insurance by:

(1) Statute, or by interpretation thereof;

(2) Ruling of the commissioner, if not defined or interpreted; or

(3) By general custom of the business.

In this article, the terms inland marine insurance and marine insurance are used in their generally accepted trade meanings.

(b) This article shall not apply to:

(1) Reinsurance, other than joint reinsurance to the extent stated in section 431:14-112;

(2) Accident and health or sickness insurance;

(3) Insurance against loss or damage to aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of aircraft;

(4) Insurance of vessels or craft, their cargoes, marine builder's risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies; and

(5) Insurance of hulls of aircraft, including their accessories and equipment, or against liability arising out of the ownership, maintenance, or use of aircraft. [L 1987, c 347, pt of §2; am L 1990, c 255, §7; am L 2002, c 155, §82]

**§431:14-103 Making of rates.** (a) Rates shall be made in accordance with the following provisions:

(1) Rates shall not be excessive, inadequate, or unfairly discriminatory.

(2) Due consideration shall be given to:

(A) Past and prospective loss experience within and outside this State; provided that if the claim does not exceed the selected deductible amount pursuant to section 386-100, and the employer reimburses the insurer for the amount, the claims shall not be calculated in the employer's experience rating or risk category;
(B) The conflagration and catastrophe hazards, if any;
(C) A reasonable margin for underwriting profit and contingencies;
(D) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;
(E) Past and prospective expenses both country-wide and those specially applicable to this State;
(F) Investment income from unearned premium and loss reserve funds; and
(G) All other relevant factors within and outside this State.

(3) In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which that experience is available.

(4) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any insurer or group with respect to any class of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(5) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both. These standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification may be based upon race, creed, national origin, or the religion of the insured.

(6) Manual, minimum, class rates, rating schedules, or rating plans shall be made and adopted, except in the case of:

(A) Special rates where manual, minimum, class rates, rating schedules, or rating plans are not applicable; and
(B) Specifically rated inland marine risks.

(7) No insurer authorized to do business in this State shall issue any policy that provides or makes available to any risks preferred rates based upon any grouping of persons, firms, or corporations by way of membership, license, franchise, contract, agreement, or any other means, other than common majority ownership of the risks, or except where:

(A) A common stock ownership in and management control of the risks are held by the same person, corporation, or firm;
(B) Permitted or authorized by filings in existence as of January 1, 1988, under the casualty rating law and the fire rating law, as these filings may be amended from time to time;
(C) Health care providers, as defined in section 671-1 that could have joined the patients' compensation fund as it existed in chapter 671, part III, prior to May 31, 1984,

joined together with one or more groups of related or unrelated health care providers;

(D) Permitted under article 12; or

(E) Otherwise expressly provided by law.

(b) In cases of workers' compensation insurance, all rates made in accordance with this section shall be given due consideration for good safety records of employers. By premium reductions, dividends, or both, insurance carriers shall recognize good safety performance records of employers in this State.

(c) Upon the issuance of a certificate by a certified safety and health professional to an employer that the employer has an effective safety and health program pursuant to section 396-4.5, the insurer shall provide the employer with a workers' compensation insurance premium discount of at least five per cent; provided that the employer shall maintain the effective safety and health program throughout the policy period. Standards for the issuance of certificates shall be included in rules adopted by the department of labor and industrial relations pursuant to chapter 91.

(d) For the purpose of ratemaking, all insurers shall treat a volunteer firefighter the same as a firefighter employed by a county fire department; provided that the volunteer firefighters are attached to a station where a firefighter or volunteer firefighter who has been trained and certified to drive a commercial motor vehicle by either the state or county government, as appropriate, and who maintains a category (3) license as defined by section 286-102(b)(3) is on duty at all times or at least four firefighters or volunteer firefighters who have been trained and certified to drive a commercial motor vehicle by either the state or county government, as appropriate, and who maintain a category (3) license as defined by section 286-102(b)(3) are members of the volunteer unit.

(e) Except to the extent necessary to meet the provisions of subsection (a)(1), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited. [L 1987, c 347, pt of §2; am L 1990, c 255, §8; am L 1993, c 269, §2; am L 1995, c 234, §18; am L 1997, c 18, §1 and c 72, §1]

**Cross References**

Limited liability of volunteer firefighters, see §663-1.55.

**§431:14-103.3 Rate adjustment mandates.** (a) Except as otherwise provided by law, the commissioner may mandate insurers to submit new filings for any type of insurance under section 431:14-102 when the commissioner has actuarially sound information that current rates may be excessive, inadequate, or unfairly discriminatory.

(b) Insurers shall submit the new rate filings within one hundred twenty days of the commissioner's mandate.

(c) The new rate filings shall be subject to the rate filing requirements under section 431:14-104.

(d) After the commissioner reviews the new rate filings submitted under this section, if the commissioner finds that the rates are excessive, inadequate, or unfairly discriminatory, the commissioner may adjust the rates for any class of insurance for any insurer pursuant to subsections (e) and (f).

(e) If, any time subsequent to the applicable review period provided for in sections 431:14-104 and 431:14-120, the commissioner does

not approve a new rate filing by an insurer, the commissioner shall issue a written notice of disapproval of the filed rate to the insurer. The written notice shall set forth the commissioner's proposed rate and the actuarial, statutory, factual, and legal bases for both the disapproval of the rate filed by the insurer and the commissioner's proposed rate. Within thirty days of the commissioner's written notice of disapproval, the insurer may file a written request to the commissioner for a hearing pursuant to subsection (f); provided that:

(1) If the insurer fails to file a written request for hearing, the commissioner's proposed rate shall become effective sixty days after the expiration of the deadline to file a written request for a hearing; and

(2) If the insurer files a written request for a hearing, the existing effective rate shall remain in effect until sixty days after the final order is rendered by the director of commerce and consumer affairs and the appeals process has been exhausted.

(f) The hearing allowed under subsection (e) shall be conducted under the following procedure:

(1) The hearing shall commence within twenty days of receipt of the written demand for a hearing, and written notice of the hearing shall be provided to the parties not less than ten days prior to the hearing;

(2) The commissioner shall present the commissioner's proposed rate and the insurer shall present its rate filing, in addition to other relevant evidence;

(3) Within fifteen days after the conclusion of the hearing, the hearings officer shall issue a proposed decision; and

(4) The rate found to be in compliance with this article shall be effective sixty days after the final order is rendered by the director of commerce and consumer affairs and the appeals process has been exhausted. [L 1998, c 117, §1; am L 2012, c 258, §3]

**[§431:14-103.5] Contracting classification premium program.** With respect to each classification of risk in the construction industry, the rating organization shall file with the commissioner a contracting classification premium program, which is a method of computing premiums, that does not impose a higher premium solely because of an employer's higher rate of wages. [L 1995, c 234, pt of §5]

**§431:14-104 Rate filings.** (a) Every insurer shall file with the commissioner every manual of classifications, rules, and rates, every rating plan, every other rating rule, and every modification of any of the foregoing that it proposes to use; provided that filings with regard to specific inland marine risks, which by general custom of the business are not written according to manual rate or rating plans, and bail bonds, subject to section 804-62, shall not be required pursuant to this subsection.

Every filing shall:

(1) State its proposed effective date;

(2) Indicate the character and extent of the coverage contemplated;

(3) Include a report on investment income; and

(4) Be accompanied by a $50 fee, payable to the commissioner, to be deposited in the commissioner's education and training fund.

(b) For each filing, an insurer shall submit to the commissioner:

(1) An electronic copy of the filing; or

(2) Two printed copies of the filing.

The commissioner may also request a printed version of an electronic filing to be submitted pursuant to paragraph (1).

(c) At the same time as the filing of the rate, every insurer shall file all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The insurer may satisfy its obligation to file supplementary rating and supporting information by reference to material which has been approved by the commissioner. The information furnished in support of a filing may include or consist of a reference to:

(1) The prospective loss cost filing made by a rating organization or an advisory organization and approved by the commissioner;

(2) The experience or judgment of the insurer or information filed by the rating organization or advisory organization on behalf of the insurer as permitted by section 431:14-104.5;

(3) Its interpretation of any statistical data upon which it relies;

(4) The experience of other insurers, rating organizations, or advisory organizations; or

(5) Any other relevant factors.

(d) When a filing is not accompanied by the information upon which the insurer supports the filing, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this article, the commissioner shall require the insurer to furnish additional information and, in that event, the waiting period shall commence as of the date the information is furnished. Until the requested information is provided, the filing shall not be deemed complete or filed nor available for use by the insurer. If the requested information is not provided within a reasonable time period, the filing may be returned to the insurer as not filed and not available for use.

(e) Except for rates filed in accordance with subsections (k), (l), and (m), a filing and any supporting information shall be open to public inspection upon filing with the commissioner.

(f) Specific inland marine rates on risks specially rated, made by a rating organization or advisory organization, shall be filed with the commissioner.

(g) An insurer may satisfy its obligation to make the filings by becoming a member of, or a subscriber to, a licensed rating organization or advisory organization that makes the filings, except for those lines of insurance for which the commissioner determines individual insurer rate filings shall be made. Nothing contained in this article shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization or advisory organization.

(h) After reviewing an insurer's filing, the commissioner may require that the insurer's rates be based upon the insurer's own loss and expense information. If the insurer's loss or allocated loss adjustment expense information is not actuarially credible, as determined by the

commissioner, the insurer may use or supplement its experience with information filed with the commissioner by a rating organization or advisory organization. At the commissioner's request, each insurer utilizing the services of a rating organization or advisory organization must submit with its rate filing, a description of the rationale for that use, including the insurer's own information and method of utilizing the rating or advisory organization's information.

(i) The commissioner shall review filings as soon as reasonably possible after they have been made to determine whether they meet the requirements of this article. The commissioner shall calculate the investment income and accuracy of loss reserves upon which filings are based, and the insurer shall provide the information necessary to make the calculation.

(j) Except as provided herein and in subsections (k) and (l) and section 431:14-120, each filing shall be on file for a waiting period of thirty days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the insurer, rating organization, or advisory organization that made the filing that the commissioner needs the additional time for the consideration of the filing. Upon the written application by the insurer, rating organization, or advisory organization, the commissioner may authorize a filing that the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner, as provided in section 431:14-106, within the waiting period or any extension thereof.

(k) The following rates shall become effective when filed:

(1) Specific inland marine rates on risks specially rated by a rating organization or advisory organization;

(2) Any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order or rule of a public body, not covered by a previous filing; and

(3) Any special filing with respect to any class of insurance, subdivision, or combination thereof that is subject to individual risk premium modification and has been agreed to by an insured under a formal or informal bid process.

The rates shall be deemed to meet the requirements of this article until the time the commissioner reviews the filing and so long as the filing remains in effect.

(l) The commissioner, by written order, may suspend or modify the requirement of filing as to any class of insurance, subdivision, or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. The orders shall be made known to the affected insurers, rating organizations, and advisory organizations. The commissioner may make examinations as the commissioner may deem advisable to ascertain whether any rates affected by the order meet the standards set forth in section 431:14-103(a)(1).

(m) The commissioner may approve a rate on any specific risk in excess of that set by an applicable rate filing, provided the insured files with the commissioner a written application stating the insured's reasons for consenting to the excess rate. Upon approval by the commissioner, the rate shall be deemed effective retroactive to the date of the insured's application.

(n) No insurer shall make or issue a contract or policy except in accordance with filings which are in effect for the insurer as provided in this article or in accordance with subsections (k), (l), or (m). This

subsection shall not apply to contracts or policies for inland marine risks as to which filings are not required. [L 1987, c 347, pt of §2 as superseded by c 348, §19; am L 1990, c 255, §9; am L 1993, c 205, §§31, 32; am L 1995, c 234, §19; am L 1997, c 81, §1; am L 1999, c 5, §2; am L 2004, c 122, §60; am L 2006, c 154, §39; am L 2009, c 77, §10; am L 2012, c 258, §4]

**Cross References**

Commissioner's education and training fund, see §431:2-214.

**§431:14-104.5 Loss cost filings.** When required by the commissioner, the rating organization or advisory organization shall file for approval all prospective loss costs, and all supplementary rating information and every change or amendment or modification of any of the foregoing proposed for use in this State. The filings shall be subject to section 431:14-104 and section 431:14-106 and other provisions of article 14 relating to filings made by insurers. [L 1990, c 255, §2]

**§431:14-105 Policy revisions that alter coverage.** (a) Any policy revisions that alter coverage in any manner shall be filed with the commissioner and shall include an analysis of the impact of each revision on rates.

(b) A filing shall consist of either:

(1) An electronic copy of the filing; or

(2) Two printed copies of the filing.

The commissioner may also request a printed version of an electronic filing to be submitted pursuant to paragraph (1).

(c) After review by the commissioner, the commissioner shall determine whether a rate filing for the policy revision must be submitted in accordance with section 431:14-104. [L 1987, c 349, §9; am L 2005, c 132, §4; am L 2009, c 77, §11]

**§431:14-105.5 Standing to intervene in rate filing and ratemaking proceedings.** In any workers' compensation insurance rate filing and ratemaking proceeding before the commissioner under article 14, an insured who is covered by workers' compensation insurance shall have the right to intervene and participate as a party in interest. [L 1989, c 195, §6]

**§431:14-106 Disapproval of filings.** (a) If, within the waiting period or any extension of the waiting period as provided in section 431:14-104(j), the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall send to the insurer, rating organization, or advisory organization that made the filing, written notice of disapproval of the filing specifying in what respects the filing fails to meet the requirements of this article, specifying the actuarial, statutory, factual, and legal bases for the disapproval, including an explanation of the application thereof that resulted in

disapproval, and stating that the filing shall not become effective.

(b) If, within thirty days:

(1) After a specific inland marine rate on a risk specially rated by a rating organization or advisory organization subject to section 431:14-104(k) has become effective; or

(2) After a special surety or guaranty filing subject to section 431:14-104(k) has become effective;

the commissioner finds that the filing does not meet the requirements of this article, the commissioner shall send to the insurer, rating organization, or advisory organization that made the filing, written notice of disapproval of the filing specifying in what respects the filing fails to meet the requirements of this article and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. The disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice.

(c) If, any time subsequent to the applicable review period provided for in subsections (a) or (b), the commissioner finds that a filing does not comply with the requirements of this article, the commissioner shall order a hearing upon the filing. The hearing shall be held upon not less than ten days' written notice to every insurer, rating organization, or advisory organization that made the filing. The notice shall specify the matters to be considered at the hearing and specify the actuarial, statutory, factual, and legal bases for the commissioner's finding of noncompliance. If, after a hearing, the commissioner finds that a filing does not meet the requirements of this article, the commissioner, within thirty days of the hearing, shall issue an order specifying in what respects the filing fails to meet the requirements, and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. Copies of the order shall be sent to every such insurer, rating organization, or advisory organization whose filing is affected by the order. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(d) If a filing is disapproved, in whole or in part, a written request for a hearing may be filed pursuant to section 431:14-118. The insurer shall bear the burden of proving that the filing meets the requirements of this article.

(e) Any person or organization aggrieved with respect to any filing that is in effect may make written demand to the commissioner for a hearing thereon; provided that:

(1) The insurer, rating organization, or advisory organization that made the filing shall not be authorized to proceed under this subsection;

(2) The demand shall specify the grounds to be relied upon by the aggrieved person or organization, and the demand shall show that the person or organization has a specific economic interest affected by the filing;

(3) If the commissioner finds that the demand is made in good faith, that the applicant would be so aggrieved if the person's or organization's grounds are established, and that the grounds otherwise justify a hearing, the commissioner, within thirty days after receipt of the demand, shall hold a hearing. The hearing shall be held upon not less than ten days' written notice to the aggrieved party and to every insurer, rating organization, or advisory organization that made the filing. The aggrieved party shall bear the burden of proving that the filing fails to meet the standards set forth in section 431:14-103(a)(1); and

(4) If, after the hearing, the commissioner finds that the filing does not meet the requirements of this article, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this article, and stating when, within a reasonable period, the filing shall be deemed no longer

effective. Copies of the order shall be sent to the applicant and to every such insurer, rating organization, or advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(f) No manual of classifications, rules, rating plan, or any modification of any of the foregoing that establishes standards for measuring variations in hazards or expense provisions, or both, and that has been filed pursuant to the requirements of section 431:14-104 shall be disapproved if the rates thereby produced meet the requirements of this article.

(g) The notices, hearings, orders, and appeals referred to in this section are in all applicable respects subject to chapter 91, unless expressly provided otherwise. [L 1987, c 347, pt of §2; am L 1990, c 255, §10; am L 2004, c 122, §61; am L 2012, c 258, §5]

**§431:14-107 Rating organizations.** (a) A corporation, an unincorporated association, a partnership, or an individual, whether located within or outside this State, may make application to the commissioner for license as a rating organization for such classes of insurance or subdivision or class of risk, or a part or combination thereof, as are specified in its application and shall file the following with the application:

(1) A copy of its constitution, charter, its articles of organization, agreement, association, or incorporation, and a copy of its bylaws, plan of operation, and any other rules and regulations governing the conduct of its business;

(2) A list of its members and subscribers;

(3) The name and address of a resident of this State upon whom notices or orders of the commissioner or process affecting the rating organization may be served;

(4) A statement of its qualifications as a rating organization;

(5) A biography of the ownership and management of the organization; and

(6) Any other relevant information and documents that the commissioner may require.

(b) If the commissioner finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of organization, agreement, association, or incorporation, and its bylaws, rules and regulations governing the conduct of its business conform to the requirements of law, the commissioner shall issue a license specifying the classes of insurance or subdivision or class of risk, or part or combination thereof, for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the commissioner within sixty days of the date of its filing with the commissioner. Licenses issued pursuant to this section shall remain in effect for three years unless sooner suspended or revoked by the commissioner. The fee for the license shall be $37.50. Licenses issued pursuant to this section may be suspended or revoked by the commissioner after hearing upon notice, in the event the rating organization ceases to meet the requirements of subsections (a) and (b).

(c) Every rating organization shall notify the commissioner promptly of every material change in the documents or information filed

pursuant to subsection (a).

(d) (1) Subject to rules that have been approved by the commissioner as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any class of insurance or subdivision or class of risk, or a part or combination thereof, for which it is authorized to act as a rating organization. Notice of proposed changes in the rules shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

(2) The reasonableness of any rule in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commissioner at a hearing held upon at least ten days' written notice to such rating organization and to the subscriber or insurer. If the commissioner finds that the rule is unreasonable in its application to subscribers, the commissioner shall order that the rule shall not be applicable to subscribers.

(3) If the rating organization fails to grant or reject an insurer's application for subscribership within thirty days after it was made, the insurer may request a review by the commissioner, in accordance with paragraph (2), as if the application had been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, the commissioner shall order the rating organization to admit the insurer as a subscriber. If the commissioner finds that the action of the rating organization was justified, the commissioner shall make an order affirming its action.

(e) No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(f) Cooperation among rating organizations or among rating organizations and insurers in matters within the scope of this article is authorized, provided the filings resulting from the cooperation are subject to all the provisions of this article which are applicable to filings generally. The commissioner may review the cooperative activities and practices and if, after a hearing, the commissioner finds that any activity or practice is unfair or unreasonable or otherwise inconsistent with this article, the commissioner may issue a written order specifying in what respects the activity or practice is unfair or unreasonable or otherwise inconsistent with this article, and requiring the discontinuance of the activity or practice.

(g) Any rating organization may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements, or other evidences of insurance, or the cancellation thereof, and may make reasonable rules governing their submission. The rules shall contain a provision that in the event any insurer does not within sixty days furnish satisfactory evidence to the rating organization of the correction of any error or omission previously called to its attention by the rating organization, it shall be the duty of the rating organization to notify the commissioner thereof. All information submitted for examination shall be confidential.

(h) Any rating organization may subscribe for or purchase actuarial, technical or other services, and such services shall be available to all members and subscribers without discrimination. [L 1987, c 347, pt of §2; am L 1990, c 255, §11; am L 1993, c 205, §33; am L 2004, c 122, §62]

**§431:14-107.1 Rating and advisory organizations, permitted activity.** In addition to other activities not expressly prohibited by this article, rating organizations and advisory organizations are authorized, on behalf of their members and subscribers, to:

(1) Develop statistical plans including territorial and class definitions;

(2) Collect statistical data from members, subscribers, or any other source;

(3) Prepare and distribute prospective loss costs;

(4) Prepare and distribute factors, calculations or formulas pertaining to classification, territory, increased limits, and other variables;

(5) Prepare and distribute manuals of rating rules and rating schedules that do not include final rates, expenses provisions, profit provisions, or minimum premiums;

(6) Distribute information that is required or directed to be filed with the commissioner;

(7) Conduct research and on-site inspections in order to prepare classifications of public fire defenses;

(8) Consult with public officials regarding public fire protection as it would affect members, subscribers, and others;

(9) Conduct research and collect statistics in order to discover, identify, and classify information relating to causes or prevention of losses;

(10) Prepare policy forms and endorsements and consult with members, subscribers, and others relative to their use and application;

(11) Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;

(12) Collect, compile, and distribute past and current prices of individual insurers and publish that information;

(13) File final rates, at the direction of the commissioner, for residual market mechanisms; and

(14) Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section. [L 1990, c 255, §3]

**§431:14-107.2 Insurers and organizations, prohibited activity.** (a) Except as permitted in this article, no insurer, rating organization, or advisory organization shall:

(1) Attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market; or

(2) Engage in a boycott, on a concerted basis, of an insurance market.

(b) Except as permitted in this article, no insurer shall agree with any other insurer or with a rating organization or with an advisory organization to mandate adherence to or to mandate use of any rate, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection, or similar material, except as needed to develop statistical plans permitted by section 431:14-107.1. The fact that two or more insurers, whether or not members or subscribers of a rating organization or advisory organization, use consistently or intermittently the same rates, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections, or similar materials is not sufficient in itself to support

a finding that an agreement exists. Two or more insurers having a common ownership or operating in this State under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this article as if they constituted a single insurer.

(c) Except as permitted in this article, no insurer, rating organization, or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance. [L 1990, c 255, §4; am L 1993, c 205, §34]

**§431:14-107.3 Rating or advisory organizations, prohibited activity.** Except as specifically permitted under this article or any rule adopted thereunder, no rating or advisory organization shall compile or distribute recommendations relating to rates that include expenses (other than loss adjustment expenses) or profit. [L 1990, c 255, §5]

**§431:14-108 Deviations.** (a) Except for those lines of insurance for which the commissioner determines that individual rate filings shall be made, every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by the organization, except that any insurer may make written application to the commissioner to file a deviation from the class rates, schedules, rating plans, or rules respecting any class of insurance, or class of risk within a class of insurance, or combination thereof. The application shall specify the basis for the deviation and shall be accompanied by the data upon which the applicant relies. A copy of the application and data shall be sent simultaneously to the rating organization.

(b) The commissioner shall set a time and place for a hearing at which the insurer and the rating organization may be heard, and shall give them not less than ten days' written notice thereof. In the event the commissioner is advised by the rating organization that it does not desire a hearing, the commissioner may, upon the consent of the applicant, waive the hearing.

(c) In considering the application to file a deviation the commissioner shall give consideration to the available statistics and the principles for ratemaking as provided in section 431:14-103. The commissioner shall issue an order permitting the deviation to be filed if the commissioner finds it to be justified. The deviation shall become effective upon issuance of the commissioner's order. The commissioner shall issue an order denying the application if the commissioner finds that the deviation is not justified or that the resulting premiums would be excessive, inadequate or unfairly discriminatory. Each deviation permitted to be filed shall be effective for a period of one year from the date of the order unless terminated sooner with the approval of the commissioner. [L 1987, c 347, pt of §2; am L 1993, c 205, §35]

**§431:14-109 Appeal by minority.** Any member of or subscriber to a rating organization may appeal to the commissioner from the action or decision of the rating organization in approving or rejecting any proposed change in or addition to the filings of the rating organization. The commissioner shall, after a hearing held upon not less than ten days' written notice to the appellant and to the rating organization, issue an order approving the action or decision of the

rating organization or directing it to give further consideration to the proposal.

(1) If the appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, the commissioner may issue an order directing the rating organization to make an addition to its filings, on behalf of its members and subscribers, provided the commissioner finds that the action or decision was unreasonable. The rating organization shall make an addition to its filings within a reasonable time after the issuance of the order and in a manner consistent with the commissioner's findings.

(2) The commissioner shall order the rating organization to make the requested filing for use by the appellant if the appeal is:

(A) Based upon the failure of the rating organization to make a filing on behalf of the member or subscriber which is based on a system of expense provisions differing from the system of expense provisions included in the rating organization's filing, and
(B) Granted by the commissioner.

In deciding the appeal the commissioner shall apply the standards set forth in section 431:14-103. [L 1987, c 347, pt of §2]

**Revision Note**

Subsection designation deleted.

**§431:14-110 Information to be furnished insureds; hearings and appeals of insureds.** (a) Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charges as it may make, furnish to any insured affected by a rate made by it or to the authorized representative of the insured, all pertinent information as to the rate.

(b) Every rating organization and every insurer which makes its own rates shall provide within this State reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by an authorized representative, on such person's written request to review the manner in which the rating system has been applied in connection with the insurance afforded that person. If the rating organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of the rating organization or the insurer on such request may appeal to the commissioner within thirty days after written notice of such action. The commissioner, after a hearing held upon not less than ten days' written notice to the appellant and to the rating organization or insurer, may affirm or reverse the action. [L 1987, c 347, pt of §2]

**[§431:14-110.5] Disclosure of workers' compensation premium information.** (a) All policies issued to employers for workers' compensation insurance shall disclose clearly to employers as separate figures the portion of the premium charged for:

(1) Medical care, services, and supplies;

(2) Wage loss benefits including temporary total, temporary partial, and permanent total disability benefits and their related benefits;

(3) Indemnity benefits for permanent partial disability; and

(4) Death benefits.

In addition, a disclosure statement shall indicate to the employer the portion of the premium attributable to loss control and administrative costs, attorney's fees of the insurer, the cost of employer requested medical examinations, and private investigation costs.

(b) When a policy is issued to employers for workers' compensation insurance, it shall be accompanied by a statement disclosing the percentages of premiums expended during the previous year by the insurer for claims paid in the categories specified in subsection (a), including loss control and administrative costs, attorney's fees of the insurer, the cost of employer requested medical examinations, and private investigation costs.

(c) The information provided to employers by insurers pursuant to this section shall be provided on an annual basis to the director of labor and industrial relations and to the commissioner.

(d) Any insurer found in violation of this section shall pay a fine of $5,000 per violation to the insured, plus attorney's fees and costs to the insured for enforcing this section. [L 1995, c 234, pt of §5]

**[§431:14-110.8] Publication of homeowners insurance premium information.** (a) Upon the commissioner's request, all homeowners insurers shall provide homeowners insurance premium information to the commissioner within thirty days of the request.

(b) The commissioner shall publish annually, by electronic or online publication on the official website of the insurance division, a list of all homeowners insurers with representative annual premiums for homeowners insurance.

(c) As used in this section:

"Homeowners insurance" means an insurance policy for any residential property in the State that combines:

(1) Indemnity from destruction or damage of the insured's property by various designated perils; and

(2) Indemnity for legal liability of the insured for death, injury, or disability of any human being or for damage to property.

"Homeowners insurer" means an insurer holding a valid certificate of authority to engage in the business of making contracts of homeowners insurance in this State. [L 2012, c 258, §1]

**§431:14-111 Advisory organizations.** (a) Every group, association or other organization of insurers, whether located within or outside this State, which assists insurers which make their own filings or rating organizations in ratemaking, by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but which does not make filings under this article, shall be known as an advisory organization.

(b) Every advisory organization shall file with the commissioner:

(1) A copy of its constitution, its articles of agreement or association, or its certificate of incorporation and of its bylaws, rules and regulations governing its activities;

(2) A list of its members;

(3) The name and address of a resident of this State upon whom notices or orders of the commissioner or process issued at the commissioner's direction may be served; and

(4) An agreement that the commissioner may examine the advisory organization in accordance with section 431:14-113.

(c) If, after a hearing, the commissioner finds that the furnishing of such information or assistance by the advisory organization involved any act or practice which is unfair or unreasonable or otherwise inconsistent with this article, the commissioner may issue a written order specifying in what respects the act or practice is unfair or unreasonable or otherwise inconsistent with this article, and requiring the discontinuance of the act or practice.

(d) No insurer which makes its own filings, nor any rating organization, shall support its filings by statistics or adopt ratemaking recommendations furnished to it by an advisory organization which has not complied with this section or with an order of the commissioner involving the statistics or recommendations issued under subsection (c). If the commissioner finds such insurer or rating organization to be in violation of this subsection, the commissioner may issue an order requiring the discontinuance of such violation. [L 1987, c 347, pt of §2]

**§431:14-112 Joint underwriting or joint reinsurance.** (a) Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulation as provided below, subject:

(1) With respect to joint underwriting, to all other provisions of this article, and

(2) With respect to joint reinsurance, to section 431:14-113, section 431:14-117 and section 431:14-118.

(b) If, after a hearing, the commissioner finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise inconsistent with this article, the commissioner may issue a written order specifying in what respects the activity or practice is unfair or unreasonable or otherwise inconsistent with this article, and requiring the discontinuance of such activity or practice. [L 1987, c 347, pt of §2]

**§431:14-113 Examination.** (a) The commissioner may, as often as the commissioner may deem it expedient, make or cause to be made an examination of each rating organization referred to in section 431:14-107, each advisory organization referred to in section 431:14-111 and of each group, association or other organization referred to in section 431:14-112. The reasonable costs of any such examination shall be paid by the rating organization, advisory organization, or group, association, or other organization examined upon presentation to it of a detailed account of such costs. The officer, manager, agents, and employees of the rating organization, advisory organization, or group, association, or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. In lieu of any such examination, the commissioner may accept the report of an examination made by the insurance supervisory official of any state, pursuant to the laws of such

state.

(b) The commissioner shall furnish the organization examined a copy of the examination report not fewer than sixty days prior to the filing of the report for public inspection in the insurance division. If the organization so requests in writing during the sixty-day period, the commissioner shall hold a hearing to consider the organization's objections to the report as proposed, and shall not file the report until after the hearing and until after any modifications in the report deemed necessary by the commissioner have been made. If the organization does not request a hearing on the report, the examination report shall be filed at the end of sixty days.

(c) Once filed, the report shall be available for public inspection and shall be admissible as a public record, except that the commissioner or the commissioner's examiners may at any time testify and offer other proper evidence as to information secured during the course of an examination, regardless of whether a written report of the examination has at that time been either made, served, or filed in the insurance division. [L 1987, c 347, pt of §2; am L 1990, c 255, §12; am L 2004, c 122, §63]

**§431:14-114 Rate administration.** (a) The commissioner may promulgate reasonable rules and statistical plans, which may be modified from time to time, and which shall be used by each insurer in the recording and reporting of its loss and country- wide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner in determining whether rating systems comply with the standards set forth in section 431:14-103. The rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this State and are not susceptible of determination by a prorating of country-wide expense experience. In promulgating such rules and plans, the commissioner shall give due consideration to:

(1) The rating systems on file with the commissioner; and

(2) The rules and the form of the plans used for such rating system in other states, in order that the rules and plans may be as uniform as is practicable among the several states and this State.

No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The commissioner may designate one or more rating organizations or other agencies to assist the commissioner in gathering the experience and compiling the information. The compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(b) Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

(c) In order to further the uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers, and rating organizations in any state and may consult with them with respect to ratemaking and the application of rating systems.

(d) The commissioner may make reasonable rules and regulations necessary to effect the purposes of the rating laws. [L 1987, c 347, pt

of §2]

**§431:14-115 False or misleading information.** No person or organization shall wilfully withhold information from or knowingly give false or misleading information to the commissioner, any statistical agency designated by the commissioner, any rating organization, or any insurer, which will affect the rates or premiums chargeable under this article. Violation of this section shall subject the one guilty of such violation to the penalties provided in section 431:14-117. [L 1987, c 347, pt of §2]

**§431:14-116 Assigned risks.** Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure, such insurance through ordinary methods and the insurers may agree among themselves on the use of reasonable rate modifications for such insurance, the agreements and rate modifications to be subject to the approval of the commissioner; provided that this section shall not apply to workers' compensation insurance after December 31, 1996, or the date the domestic mutual insurance company established pursuant to [section] 431:14A-103 writes its first policy, whichever is later. [L 1987, c 347, pt of §2; am L 1996, c 261, §3]

**Note**

For contingent repeal and reenactment, see L 1996, c 261, §10.

**Cross References**

Discontinuation of assigned risks, see §431:14A-119.

**[§431:14-116.5] Assigned risk pool; experience rating plan.** No employer shall be placed in an assigned risk pool for workers' compensation insurance that does not utilize an experience rating plan that includes:

(1) Reasonable eligibility standards;

(2) Incentives for loss prevention;

(3) Sufficient premium differentials to encourage safety; and

(4) Provisions for reasonable and equitable limitations on the ability of policyholders to avoid the impact of past adverse claims experience through change of ownership, control, management, or operation. [L 1995, c 234, pt of §20]

**§431:14-116.6 Assigned risk pool; residual market plan.** (a) The commissioner shall establish a residual market plan to provide equitable apportionment of insurance that may be afforded to applicants who are in good faith entitled to, but who are unable to procure, such insurance through ordinary methods. The residual market plan shall include rules for classification of risks and rates.

(b) Any insured placed with the plan shall be notified that

insurance coverage is being afforded through the plan and not through the private market. Written notification shall be given to the insured within ten days of placement with the plan.

(c) To ensure that plan rates are made adequate to pay claims and expenses, insurers shall develop a means of obtaining loss and expense experience at least annually. Each insurer shall submit a report on loss and expense experience, when available, with the department in sufficient detail to make a determination of rate adequacy.

(d) The plan shall provide a formula allowing an insurer who voluntarily removes an insured risk from the residual market to be eligible for a take-out credit applicable against that insurer's residual market assessment base levied by the plan. The terms and conditions of the take-out credit shall be as follows:

(1) An insurer shall receive a credit against its assessment base for the amount of the annual premium reflected in its financial statements for the respective calendar year. This reported premium shall be stated on the same financial basis as the premiums that are reported for use in determining each insurer's residual market assessment base and shall be subject to subsequent adjustments and audits;

(2) The credit applicable to the residual market assessment base shall be as follows:

First year: $2 credit for every $1 of premium removed;

Second year: $1 credit for every $1 of premium removed; and

Third year: $1 for every $1 of premium removed;

(3) If the insurer keeps the insured risk out of the residual market for three years, that insurer shall receive credit for each of three years. If the insurer does not write the business for three years, it shall receive credit only for the period of time that it covered the risk in the voluntary market. Under no circumstances shall an insurer receive credit for risks returned to the residual market within one policy year;

(4) An insurer shall not return an insured taken from the residual market to the residual market after one year of coverage to subsequently reissue insurance to the insured to obtain the higher credit established for the first year of residual market removal in paragraph (2);

(5) There shall be no maximum limit on credits received; provided that the credits shall not reduce the insurer's assessment base below zero;

(6) The kind and amount of coverage to be offered to voluntary risks shall not be less than those afforded by the policy being replaced, unless the kinds and amounts are refused by the insureds;

(7) The commissioner may approve loss sensitive rating plans for larger companies that generate more than $150,000 in insurance premiums; and

(8) The commissioner may adjust or terminate the credit program depending on market conditions, provided that any adjustment or termination shall not affect any credit earned prior to the adjustment or termination.

(e) The commissioner may adopt rules in accordance with chapter 91 to effectuate the purposes of this section.

(f) As used in this section, unless the context otherwise requires:

"Plan" means the residual market plan.

"Residual market assessment base" means the basis for assessing insurers for losses from the residual market, as provided for in a residual market plan. [L 1995, c 234, pt of §20; am L 1996, c 224, §2]

**Cross References**

Discontinuation of residual market plan, see §431:14A-118.
Pooled insurance policies, see §431:10-222.5.

**§431:14-117 Penalties.** (a) The commissioner, if the commissioner finds any person or organization has violated any provision of this article, may impose a penalty of not more than $500 for each violation, but if the commissioner finds the violation to be wilful the commissioner may impose a penalty of not more than $5,000 for each such violation. The penalties may be in addition to any other penalty provided by law. For purposes of this section, any insurer using a rate for which the insurer has failed to file the rate, supplementary rating information, underwriting rules or guides, or supporting information as required by this article, shall have committed a separate violation for each day such failure to file continues.

(b) The commissioner may suspend the license of any rating organization or insurer which fails to comply with an order of the commissioner within the time limited by the order, or any extension thereof which the commissioner may grant. The commissioner shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal from the order has expired or, if an appeal has been taken, until the order has been affirmed. The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds such suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

(c) No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner, stating the commissioner's findings, made after a hearing held upon not less than ten days' written notice to the person or organization specifying the alleged violation. [L 1987, c 347, pt of §2; am L 1990, c 255, §13]

**§431:14-118 Hearing procedure and judicial review.** (a) Any insurer or rating organization aggrieved by any order or decision of the commissioner made without a hearing, may, within thirty days after notice of the order to the insurer or organization, make written request to the commissioner for a hearing. The commissioner shall hold a hearing within twenty days after receipt of the request, and shall give not less than ten days' written notice of the time and place of the hearing. Within fifteen days after the hearing, the commissioner shall affirm, reverse, or modify the commissioner's previous action, specifying the reasons for the commissioner's decision. Pending the hearing and decision, the commissioner may suspend or postpone the effective date of the commissioner's previous action.

(b) Any final order or decision of the commissioner may be reviewed in the circuit court of the first circuit, and an appeal from the decision of the court shall lie to the intermediate appellate court, subject to chapter 602. The review shall be taken and had in the manner provided in chapter 91. [L 1987, c 347, pt of §2; am L 2004, c 202, §49; am L 2006, c 94, §1; am L 2010, c 109, §1]

**§431:14-119 REPEALED.** L 1997, c 81, §3.

**§431:14-120 Additional powers for workers' compensation rate filing and ratemaking.** (a) The commissioner shall review filings as soon as reasonably possible after they have been made to determine whether they meet the requirements of this article.

(b) Except as provided herein, each filing shall be on file for a waiting period of ninety days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the insurer, rating organization, or advisory organization that made the filing that the commissioner needs the additional time for the consideration of the filing. Upon the written application by the insurer, rating organization, or advisory organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the waiting period or any extension thereof.

(c) The commissioner may institute proceedings for appropriate relief including but not limited to proceedings to roll back current rates whenever it appears to the commissioner that an insurer or other interested persons regulated by this article affecting workers' compensation insurance rates has:

(1) Violated or failed to comply with any provisions of this part or of any state or federal law;

(2) Failed to comply with any rule, regulation, or other requirement of any other state or federal agency which affects workers' compensation insurance rates;

(3) Failed to comply with any provision of its charter or franchise;

(4) Set or applied any rates, classification, charges, or rules affecting workers' compensation insurance that are unreasonable or are unreasonably discriminatory;

(5) Failed to give appropriate consideration to investment income earned or realized by insurers, including investment income earned from unearned premium and loss reserve funds in making rates; or

(6) Failed to recognize good safety performance records of employers in setting premium rates and levels. [L 1987, c 347, pt of §2; am L 1997, c 81, §2; am L 1998, c 71, §3; am L 2000, c 264, §2]

## ARTICLE 14A
## HAWAII EMPLOYERS' MUTUAL INSURANCE COMPANY

**§431:14A-101 Purpose.** The Hawaii employers' mutual insurance company is established to provide workers' compensation coverage to employers of the State at the highest level of service with the lowest possible cost, consistent with reasonable and applicable actuarial standards and the sound financial integrity of the company. The purposes of the company are to provide the highest standard of workplace safety and loss prevention, to encourage employer involvement, and to be responsive to each policyholder's experience, practice, and operating effectiveness. Nothing in this article shall create any implied third-party duty or impose additional legal liability for the company toward its members or beneficiaries beyond that explicitly created by this chapter, chapter 386, or common law, and generally applicable to all issuers of workers' compensation insurance in this State. [L 1996, c 261, pt of §2; am L 2010, c 52, §1]

**§431:14A-102 Definitions.** As used in this article:

"Administrator" means the chief executive officer of the Hawaii employers' mutual insurance company.

"Board" means the board of directors of the Hawaii employers' mutual insurance company.

"Company" means the Hawaii employers' mutual insurance company established by this article.

"Council" means the Hawaii employers' mutual insurance company oversight council.

"Investment manager" means any fiduciary, who has been designated by the board to manage, acquire, or dispose of the company's assets, a bank as defined by law, or an insurance company qualified to perform services under the laws of more than one state.

"Qualified actuary" means a member of the American Academy of Actuaries who is either a fellow of the Casualty Actuarial Society or an Associate of the Casualty Actuarial Society who has five or more years of experience. [L 1996, c 261, pt of §2; am L 1998, c 252, §3; am L 2010, c 52, §2]

**§431:14A-103 Hawaii employers' mutual insurance company, established.** (a) The Hawaii employers' mutual insurance company is established as an independent corporation to provide workers' compensation insurance and related services to Hawaii employers. The company may be reorganized as a nonprofit corporation under chapter 414D.

(b) The company shall be organized and operated as a domestic mutual insurance company. The company shall comply with, unless specifically excluded, all requirements of the insurance code regarding a domestic mutual insurance company. The company shall not be an agency of the State. The company or its liabilities shall not be deemed to constitute debts or liabilities of the State of Hawaii or pledges of the full faith and credit of the State. The company shall write workers' compensation insurance policies covering Hawaii employers as required or authorized by law and employers' liability to the same extent as any other private insurer. The company shall not write other lines of insurance, reinsurance, or excess insurance.

(c) The company may insure Hawaii employers against their liability for compensation or damages for injury or death under the United States Longshoremen's and Harbor Workers' Compensation Act or federal or maritime laws like any other private insurer.

(d) The company's assets shall consist of real and personal property and shall include all premiums and other moneys paid to the company, all property, and other income acquired, earned, or otherwise gained by the use of premiums and other moneys paid to the company by deposits, investments, exchanges, and other transactions. The company's assets shall be the sole property of the company and shall be used exclusively by the company for the operation and obligations of the company.

(e) Notwithstanding any other law to the contrary, the company shall be excluded from the surplus requirements of domestic mutual insurers from January 1, 1997, through December 31, 2007. The company is also excluded during this time period from any assessments by the Hawaii hurricane relief fund otherwise required by section 431P-5(b)(8);

provided that the exclusion shall apply to the first $25,000,000 of written premiums in each calendar year; and provided further that annual written premiums in excess of $25,000,000 shall be assessed in accordance with section 431P-5(b)(8).

(f) The company is exempt from participation, and shall not join, contribute financially to, nor be entitled to the protection of, any plan, association, guaranty, insolvency fund, or education and training fund authorized or required by this chapter. Notwithstanding the foregoing exemptions, beginning January 1, 2008, the company shall participate in the property and liability insurance guaranty association, pursuant to sections 431:16-101 to 431:16-117; provided that the company shall meet the surplus requirements applicable to all other domestic insurers under chapter 431 effective January 1, 2008.

(g) On or after January 1, 1997, the company shall provide workers' compensation coverage to Hawaii employers otherwise entitled to coverage but not able to or not electing to purchase coverage in the voluntary insurance market, and not authorized, either individually or as a part of a group, to self-insure. An authorized self-insured is eligible for coverage upon termination of self-insurance. [L 1996, c 261, pt of §2; am L 1997, c 300, §§3, 4; am L 1998, c 252, §4; am L 1999, c 18, §13; am L 2002, c 40, §70; am L 2004, c 122, §64]

**§431:14A-104 Company divisions.** (a) For purposes of providing representation on the board, the company shall consist of industry divisions and a high risk division. Assignments to each division shall be made by the administrator with the approval of the board. The initial company divisions shall include:

(1) Manufacturing and producers;

(2) Services, entertainment, and amusement;

(3) Professions;

(4) Construction;

(5) Wholesale and retail sales;

(6) Transportation and public utilities;

(7) Finance, insurance, and real estate; and

(8) High risk.

(b) An employer with two or more lost-time claims greater than $10,000, and a loss ratio greater than 1.0, over the immediately preceding three years shall be placed in the high risk division.

(c) The administrator, with the approval of the board, shall modify the requirements for placing employers in the high risk division if the qualifications result in the high risk division being limited to only those employers with measurable adverse loss ratios, demonstrated accident frequency records, or a demonstrated attitude of noncompliance with workplace safety and health programs or claims management requirements.

(d) The company shall give notice to each employer in the high risk division not less than thirty days prior to the policy renewal date requesting a report on the employer's lost-time claims for the policy

year. The report shall be used to determine the employer's qualification for placement in the high risk division.

(e) The company may apply a rating differential and charge a surcharge to any employer placed in the high risk division. The company may make multiple rate filings, consistent with sound actuarial judgment for each classification. These rate filings may be applied to risks in any division.

(f) The contingent liabilities of members provided in section 431:4-317 may be separated so that members assigned to the high risk division have a further contingent liability for deficits in the high risk division; provided that no contingent liability shall be in the aggregate for more than five times the annual premium rate of the member's policy nor for a term of more than one year. [L 1996, c 261, pt of §2; am L 1997, c 300, §5]

**§431:14A-105 Board of directors, established.** (a) The board of directors of the company shall be responsible for the organization, management, policies, and activities of the company. The board shall consist of nine voting members and one nonvoting member. The voting members shall consist of the following:

(1) Eight directors who shall be owners, officers, or employees of policyholders of the company and shall represent each of the company divisions; and

(2) One director who shall be a public, at-large member elected by the board of directors.

The administrator shall be the nonvoting member of the board.

(b) The initial eight division directors shall be appointed by the governor within sixty days of June 19, 1996, and shall serve for terms of one year each. The governor shall ensure adequate representation from the major sectors of the economy and workforce in the State.

The public, at-large member initially elected by the board shall serve for a term of one year.

The initial board of directors shall determine the staggering and length of future directors' terms; provided that no term shall exceed three years. Upon the expiration of the terms of the initial division directors, the company's policyholders in the division represented by the director shall elect the directors. Each director shall serve for terms as specified by the board unless sooner removed for cause pursuant to rules adopted by the board. Each director shall hold office until a successor is elected as provided in this section. No person shall serve more than two consecutive full terms as director. Any other law to the contrary notwithstanding, the election and composition of the board of directors as provided in this section shall be deemed adequate to qualify the company as a mutual insurer under chapter 431.

(c) A vacancy on the board shall be filled by appointment of the governor or insurance commissioner in the case of appointed directors, or by election by the company division's policyholders or the board of directors in the case of positions formerly occupied by a director elected by the company division's policyholders or by the board of directors, respectively. The person appointed to fill a vacancy shall serve for the remainder of the term of the person's predecessor.

(d) Within one year after appointment, each director shall be a member or an employee of a policyholder of the company and shall continue in such status during the director's term of office. Any director representing a member that fails to maintain workers' compensation insurance from the company shall be disqualified from serving on the

board.

(e) Each director shall receive necessary traveling and board expenses incurred in the performance of duty as director and a fee commensurate with the duties expected of actual attendance at board meetings.

(f) No person shall be a director who has a direct and substantial interest in a competing insurer as:

(1) A stockholder (excluding the holding of less than one per cent of the outstanding shares in a publicly traded insurer);

(2) An employee;

(3) An attorney; or

(4) A contracting party (excluding an independent contractor or business owner who does less than twenty- five per cent of its total annual volume of business per year with competing insurers). [L 1996, c 261, pt of §2; am L 1997, c 300, §6; am L 2010, c 52, §3]

**Revision Note**

"June 19, 1996," substituted for "the effective date of this section".

**[§431:14A-106] Powers; generally.** Except as otherwise limited by this chapter, the company may:

(1) Sue, be sued, complain, and defend, in its corporate name;

(2) Have a corporate seal, which may be altered at pleasure, and use the seal by causing it, or a facsimile thereof, to be impressed, affixed, or in any other manner reproduced;

(3) Purchase, take, receive, lease, take by gift, devise, or bequest, or otherwise acquire, own, hold, improve, use, and otherwise deal in and with real or personal property, or any interest therein, wherever situated;

(4) Sell, convey, mortgage, pledge, lease, exchange, transfer, and otherwise dispose of all and any part of its property and assets;

(5) Make contracts and incur liabilities, borrow money at such rates of interest as the board may determine, issue guaranty capital shares and surplus notes, require capital contributions, issue its notes, debenture bonds, and other obligations, secure any of its obligations by mortgage or pledge of all or any portion of its property or income, and secure financing by any board approved mechanism;

(6) Allocate fiduciary responsibilities among the directors and designate other persons to carry out fiduciary responsibilities;

(7) Collect, receive, hold, and disburse all money payable to or by the company;

(8) Deposit the company's money in banks or depositories selected by the board and withdraw the company's money from such banks or depositories; provided that the withdrawal shall be made or authorized only upon the signatures of at least two persons approved by the board;

(9) Pay money from the company to effectuate the company's purpose and administration, including amounts for costs incurred to establish the company; and

(10) Exercise all powers necessary or convenient to effect the purposes of the company. [L 1996, c 261, pt

of §2]

**§431:14A-107 Duties and responsibilities.** (a) All corporate powers shall be exercised by or under the authority of the board, unless otherwise provided in this chapter or in the articles of incorporation.

(b) The board shall discharge its duties:

(1) In accordance with the company's purpose;

(2) With the care, skill, prudence, and diligence under the circumstances that a prudent director, acting in a like capacity and familiar with such matters would use in conducting a similar enterprise and purpose;

(3) By diversifying the company's investments to minimize the risk of losses, unless it is prudent not to do so;

(4) In accordance with governing legal documents;

(5) By having an annual audit of the company by an independent certified public accountant;

(6) By securing a fidelity bond for the administrator and in its discretion for other agents dealing with the company's assets at the company's expense;

(7) By purchasing liability insurance for errors and omissions for the board, each director, and any other fiduciary employed or contracted by the company to cover liability or losses caused by the act or omission of a fiduciary;

(8) By maintaining proper books of accounts and records of the company's administration;

(9) By carrying out the reporting and disclosure requirements required by law;

(10) By appointing a qualified actuary to develop and recommend a responsible schedule of premium rates with consideration of the company's investment income or refunds, or both, and to provide actuarial certification of the company's loss reserves; and

(11) By cooperating with and assisting the council in its duties and responsibilities.

(c) Except as otherwise provided by law, the board may:

(1) Transact workers' compensation insurance policies required or authorized by state law to the same extent as any other insurer;

(2) Provide the terms and conditions of an insurance policy;

(3) Provide that any written instrument be executed for the company by the administrator or the administrator's agent;

(4) Enter into agreements to reinsure all or part of the company's exposure to loss and to limit the risk to the company; and

(5) Employ persons to administer the company, including legal counsel, accountants, insurance consultants, administrators, qualified actuaries, investment managers, adjustors, other experts, and clerical employees and pay compensation and expenses in connection therewith. [L 1996, c 261, pt of §2; am L 1998, c 252, §5]

**§431:14A-108 Administrator; appointment; duties.** (a) The board shall hire an administrator who shall serve at the pleasure of the

board. The administrator shall be the chief executive officer and shall be responsible for the day-to-day operations and management of the company.

(b) The administrator shall have proven, successful experience as an executive at the general management level in the insurance business. The administrator shall manage and conduct the business of the company according to the board's direction and policies. The administrator shall receive compensation authorized by the board.

(c) Before entering the duties of office, the administrator shall give a fidelity bond in an amount and with sureties approved by the board. The premium for the bond shall be paid by the company.

(d) The administrator shall be an ex officio, nonvoting member of the board. [L 1996, c 261, pt of §2; am L 2004, c 122, §65; am L 2010, c 52, §4]

**[§431:14A-109] Financial management.** (a) The board shall select a custodial trustee to collect, receive, hold, or disburse moneys payable to or by the company.

(b) The board shall invest the company's principal and income without distinction between principal and income and keep the company's assets invested in real or personal property or other securities. The board may retain cash temporarily awaiting investment or to meet contemplated payments without liability for interest thereon.

(c) The board shall manage the company's assets, except to the extent that the authority to manage the company's assets is delegated to other qualified investment managers. The board may appoint investment managers to manage, acquire, or dispose of any of the company's assets. An investment manager may be designated as an "investment agent". The investment manager shall acknowledge in writing that he or she is a fiduciary under the company.

(d) The board may:

(1) Sell the company's securities. No purchaser of the company's securities is bound to see to the application of the purchase money or inquire as to the validity of such sale;

(2) Vote on behalf of any stocks, bonds, or securities of any corporation or issuer held in the company or request any action to such corporation or issuer. The board may give general or special proxies or powers of attorney with or without powers of substitution;

(3) Participate in reorganizations, recapitalization, consolidations, mergers, and similar transactions for stocks, bonds, or other securities of any corporation that are held by the company, and accept and retain any property received thereunder for the company;

(4) Exercise any subscription rights and conversion privileges for the company's stocks or securities;

(5) Compromise, compound, and settle any debt or obligation due to or from the company; reduce the amount of principal and interest, damages, and costs of collection in settling such debts;

(6) Cause securities held by it to be registered in its own name or in the name of a nominee without indicating that the securities are held in a fiduciary capacity and to hold any securities in bearer form. The company's records, however, shall show that such investments are part of the company;

(7) Delegate its investment powers to investment managers of the company to expedite the purchase and sale of securities. The purchase or sale of securities by these managers shall be in the name selected by the board. The authority of these managers to purchase or sell securities for the company shall be evidenced by written authority executed by the administrator. The board shall require these managers to keep it currently informed as to the nature and amount of the investments made for the company by them. The board may

enter into appropriate agreements with these managers setting forth their investment powers and limitations. The board may terminate the services of these managers. These managers shall be subject to the board's instructions;

(8) Pay taxes or assessments that are assessed against the company;

(9) Require any applicant or policyholder to furnish the board with such information necessary for the company's administration; and

(10) Delegate its authority to the administrator or any authorized representative to maintain any legal proceedings necessary to protect the company or the directors or to secure payment due to the company. In connection with this delegation, the board or the administrator or their representative may compromise, settle, or release claims on behalf of or against the company or the board. [L 1996, c 261, pt of §2]

**[§431:14A-109.5] Oversight council.** (a) There is established the Hawaii employers' mutual insurance company oversight council which shall meet at least once annually. For administrative purposes only, the council shall be assigned to the department of commerce and consumer affairs. The council shall oversee the activities of the company to ensure that the company fulfills its purpose as set forth in this article.

(b) The council shall consist of five members who shall include:

(1) A member of the senate appointed by the president of the senate;

(2) A member of the house of representatives appointed by the speaker of the house of representatives;

(3) The director of the department of labor and industrial relations;

(4) The director of the department of commerce and consumer affairs; and

(5) An at-large member who is an owner, officer, or employee of the company policyholder appointed by the governor;

provided that if any designee under paragraphs (1) to (4) does not meet the test in subsection (c), the president of the senate, speaker of the house, or governor, as applicable, shall designate an appropriate representative. Section 26-34 shall not apply to appointments under this section.

(c) No person shall serve on the council who within the second degree of consanguinity or affinity has a direct and substantial interest in an insurer that competes with the company, including but not limited to:

(1) A stockholder of a competing company (excluding a holder of less than one per cent of the outstanding shares in a publicly traded company);

(2) An employee of a competing company;

(3) An attorney who represents a competing company; or

(4) A party who contracts with a competing company (excluding an independent contractor or business owner who does less than twenty-five per cent of its total annual volume of business per year with competing insurers).

(d) Members of the council shall serve without compensation, but shall be reimbursed for reasonable expenses necessary for the performance

of their duties.

(e) The administrator shall serve as liaison officer to the council. Not later than sixty days after July 20, 1998 and every June 15 thereafter, the board shall provide to the council any and all data and information the council may require, including but not limited to:

(1) The company's statutorily required annual financial statement;

(2) Copies of any reports issued by the insurance division in connection with the triennial examination of the company; and

(3) Actuarial certification of loss reserves.

(f) After receipt of the data and information required pursuant to subsection (e), the council shall review the activities of the company and determine whether the company is fulfilling its purpose as set forth in this article. The council shall promptly, but in no event later than October 15, 1998, and every October 15 thereafter, submit a report to the governor with a copy to the board of directors, stating whether the company is fulfilling its purpose as set forth in this article. If the council determines that there are any deficiencies in the company's fulfillment of its purposes as set forth in this article, it shall include in its report a detailed description of any deficiencies. Within a time frame established by the council, but in no event later than six months after delivery of the council's report in accordance with this section, the company shall respond in writing to any deficiencies identified in the council's report. The Hawaii employers' mutual insurance company shall provide staff support to the council.

(g) If the governor determines that corrective action is appropriate after reviewing the council's report and the company's response, the governor shall inform the legislature, and the legislature shall consider what action is needed. [L 1998, c 252, §2]

**Revision Note**

"July 20, 1998" substituted for "passage of this Act".

**[§431:14A-110] Premium rates, determination.** (a) The board shall establish the premium rates to be charged for insurance sold by the company. The company shall comply with the requirements set forth in article 14 of this chapter. Premium rates shall be set at levels sufficient, when invested, to carry all claims to maturity, to meet the reasonable expenses for administering the company, and to maintain a reasonable surplus.

(b) The board shall hire a qualified actuary to assist with the development of sound premium rates. [L 1996, c 261, pt of §2]

**[§431:14A-111] Reserves, investment.** The board may invest or reinvest any surplus or reserves within the limitations established for insurance companies under chapter 431. [L 1996, c 261, pt of §2]

**[§431:14A-112] Financial statements and other reports.** (a) The company shall submit to the commissioner an annual statement of financial condition audited by an independent certified accountant. The audit report shall contain an actuarial opinion prepared by a qualified actuary

on the company's claims reserves and expenses. The financial statement shall be on a form prescribed by the commissioner and shall include actuarially appropriate reserves for:

(1) Known claims and associated expenses;

(2) Claims incurred but not reported and associated expenses;

(3) Unearned premiums; and

(4) Bad debts, reserves for which shall be shown as liabilities.

(b) The company shall compile and maintain statistical and actuarial data relating to the determination of premium rate levels, the incidence of work-related injuries, the cost of injuries, and other data relating to work injuries. The compiled information shall be submitted annually to the commissioner and to the director of labor and industrial relations. [L 1996, c 261, pt of §2]

**[§431:14A-113] Annual accounting; dividends.** (a) The company shall conduct an annual accounting of its incurred loss experience and expenses.

(b) The board may declare and apportion reasonable dividends to policyholders, determined by an actuarial opinion prepared by a qualified actuary after evaluating the impact of the dividends on the solvency of the company. The dividends may be paid or credited to policyholders according to classifications of policies established by the board.

(c) No dividends shall be:

(1) Paid or credited in a manner that unfairly discriminates between policies within the same classification;

(2) Made contingent upon payment of any renewal premium on any policy; or

(3) Paid or credited in the first three years of operation of the company. [L 1996, c 261, pt of §2]

**[§431:14A-114] Audits.** The administrator, or designated representative, shall have reasonable access to any policyholder's payroll and employment records during regular working hours to carry out audits of payroll reported, the number of employees on the payroll, and other information necessary for the administration of this article. [L 1996, c 261, pt of §2]

**[§431:14A-115] Denial, cancellation, and termination.** The company may deny coverage or renewal of an existing policy or may terminate an existing policy of a policyholder or applicant for:

(1) Nonpayment of an undisputed premium;

(2) Refusal to permit on-site workplace safety examinations;

(3) Failure to comply with workplace safety and health programs required by the company; or

(4) Failure to accurately disclose information concerning the applicant's or policyholder's ownership, change of ownership, operations, or payroll, including the allocation of payroll among state and federal

compensation programs, and other information necessary for the board to determine premium rates. [L 1996, c 261, pt of §2]

**[§431:14A-116] Wilful misrepresentation and fraud.** (a) Any person who wilfully makes a false statement or representation for the purpose of directly obtaining any compensation or payment or for the purpose of avoiding any compensation or payment under this article shall be subject to the penalties in section 386-98.

(b) The company shall develop and implement a program to identify and investigate fraudulent insurance acts. [L 1996, c 261, pt of §2]

**§431:14A-117 Workplace safety and health programs.** (a) The company shall work with policyholders, health care providers, and employees to develop, implement, and monitor workplace safety and health and return to work programs. The programs shall include the development of a workplace accident and injury reduction plan that promotes safe working conditions.

(b) The company shall promote safety programs to policyholders through programs and activities which may include:

(1) Analyzing reports of industrial accidents of members to help determine the cause of those accidents;

(2) Conducting studies for risk and hazard identification and assessments by safety and medical professionals;

(3) Conducting educational programs designed to prevent frequently recurring industrial accidents; and

(4) Inspecting work sites and investigating unsafe working conditions to promote job safety and eliminate hazards.

(c) Company representatives shall have reasonable access to the premises of any policyholder or applicant during regular working hours to carry out workplace evaluations.

(d) Where the company finds, upon the completion of a detailed inspection that an insured has policies and practices in place that demonstrate a high regard for employee work safety, the company may apply a deviation to the insured's rate structure, noting special recognition of those efforts.

(e) The company shall not incur additional legal liability toward its members or beneficiaries as a result of any action taken or not taken pursuant to this chapter beyond that explicitly created by this chapter, chapter 386, or common law, and generally applicable to the acts or omissions of all issuers of workers' compensation insurance in this State. [L 1996, c 261, pt of §2; am L 2010, c 52, §5]

**[§431:14A-118] Discontinuation of residual market plan.** (a) The residual market plan, as authorized by section 431:14-116.6, is discontinued effective December 31, 1996, or the date the company writes its first policy, whichever date is later, except for dissolution of any obligations for claims arising out of any policies written pursuant to the plan with inception dates of or before December 31, 1996, or the date the company writes its first policy, whichever date is later. It is the intent of this section to provide for an orderly transfer of policies

from the residual market plan as authorized by section 431:14-116.6 to the company.

(b) The residual market plan shall continue its operation for all policies with inception dates of or before December 31, 1996, or the date the company writes its first policy, whichever date is later. All policies written thereunder shall be for one-year terms, and shall not be terminated prior to expiration except for cause. In no case shall policies with inception dates of January 1, 1997, or the date the company writes its first policy, whichever date is later, be provided under the residual market plan authorized by section 431:14-116.6. [L 1996, c 261, pt of §2]

**Note**

For contingent repeal, see L 1996, c 261, §10.

**[§431:14A-119] Discontinuation of assigned risks.** (a) Assigned risk coverage, as authorized by section 431:14-116, is discontinued effective December 31, 1996, or the date the company writes its first policy, whichever date is later, except for dissolution of any obligations for claims arising out of any policies written pursuant to section 431:14-116 with inception dates on or before December 31, 1996, or the date the company writes its first policy, whichever date is later. It is the intent of this section to provide for an orderly transfer of assigned risks as authorized by section 431:14-116 to the company.

(b) Assigned risk coverage, as authorized under section 431:14-116 shall continue operation for all policies with inception dates of or before December 31, 1996, or the date the company writes its first policy, whichever date is later. All policies written thereunder shall be for one-year terms, and shall not be terminated prior to expiration except for cause. In no case shall policies with inception dates of January 1, 1997, or the date the company writes its first policy, whichever date is later, be provided for assigned risks authorized by section 431:14-116. [L 1996, c 261, pt of §2]

**Note**

For contingent repeal, see L 1996, c 261, §10.

## ARTICLE 14F
## HEALTH INSURANCE RATE REGULATION--REPEALED

**§§431:14F-101 to 431:14F-113 REPEALED.** L 2002, c 74, §6.

**Note**

The purported repeal of the L 2004, c 202, §50 amendment to §431:14F-113 on June 30, 2010, by L 2006, c 94, §1, was deleted by L 2010, c 109, §1.

L 2006, c 154, §40 purports to amend §431:14F-105(a).

## [ARTICLE 14G]
## HEALTH INSURANCE RATE REGULATION

**[§431:14G-101] Scope and purpose.** (a) This article shall apply to all types of health insurance offered by managed care plans.

(b) The purpose of this article is to promote the public welfare by regulating health insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory. Nothing in this article is intended to:

(1) Prohibit or discourage reasonable competition; or

(2) Prohibit or encourage, except to the extent necessary to accomplish the aforementioned purposes, uniformity in insurance rates, rating systems, rating plans, or practices.

This article shall be liberally interpreted to carry into effect this section. [L 2007, c 175, pt of §2]

**[§431:14G-102] Definitions.** As used in this article:

"Commissioner" means the insurance commissioner.

"Enrollee" means a person who enters into a contractual relationship or who is provided with health care services or benefits through a managed care plan.

"Managed care plan" or "plan" means a health plan as defined in section 431:10A, or chapter 432 or 432D, regardless of form, offered or administered by a health care insurer, including but not limited to a mutual benefit society or health maintenance organization, or voluntary employee beneficiary associations, but shall not include disability insurers licensed under chapter 431.

"Rate" means every rate, charge, classification, schedule, practice, or rule. The definition of "rate" excludes fees and fee schedules paid by the insurer to providers of services covered under this article.

"Supplementary rating information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule, statistical plan, and any other similar information needed to determine the applicable rates in effect or to be in effect.

"Supporting information" means:

(1) The experience and judgment of the filer and the experience or data of other organizations relied on by the filer;

(2) The interpretation of any other data relied upon by the filer; and

(3) Descriptions of methods used in making the rates and any other information required by the commissioner to be filed. [L 2007, c 175, pt of §2]

**[§431:14G-103] Making of rates.** (a) Rates shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable in relation to the costs of the benefits provided.

(b) Except to the extent necessary to meet subsection (a), uniformity among managed care plans in any matters within the scope of this section shall be neither required nor prohibited. [L 2007, c 175, pt of §2]

**[§431:14G-103.5] Rerating.** No person, business, or entity may

change or rerate any rate approved by the commissioner in any subsequent transfer, sale, resale, or pass through of health insurance issued by a managed care plan. [L 2015, c 63, §22]

**[§431:14G-104] Rate adjustment mandates.** (a) Except as otherwise provided by law, the commissioner may mandate filings for health insurance under section 431:14G-105 when the commissioner has actuarially sound information that current rates may be excessive, inadequate, or unfairly discriminatory.

(b) Managed care plans shall submit the rate filings within one hundred twenty days of the commissioner's mandate.

(c) The rate filings shall be subject to the rate filing requirements under section 431:14G-105. [L 2007, c 175, pt of §2]

**§431:14G-105 Rate filings.** (a) Every managed care plan shall file with the commissioner every rate, charge, classification, schedule, practice, or rule and every modification of any of the foregoing that it proposes to use. Every filing shall:

(1) State its proposed effective date;

(2) Indicate the character and extent of the coverage contemplated;

(3) Include a report on investment income; and

(4) Be accompanied by a $50 fee payable to the commissioner which shall be deposited in the commissioner's education and training fund.

(b) For each filing, an insurer shall submit to the commissioner:

(1) An electronic copy of the filing; or

(2) Two printed copies of the filing;

provided that the commissioner may request an insurer that submits an electronic copy of the filing pursuant to paragraph (1) to also submit a printed copy of the electronic filing.

(c) At the same time as the filing of the rate, every managed care plan shall file all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The managed care plan may satisfy its obligation to file supplementary rating and supporting information by reference to material that has been approved by the commissioner. The information furnished in support of a filing may include or consist of a reference to:

(1) Its interpretation of any statistical data upon which it relies;

(2) The experience of other managed care plans; or

(3) Any other relevant factors.

(d) When a filing is not accompanied by supporting information or the commissioner does not have sufficient information to determine whether the filing meets the requirements of this article, the commissioner shall require the managed care plan to furnish additional information and, in that event, the waiting period shall commence as of

the date the information is furnished. Until the requested information is provided, the filing shall not be deemed complete or filed and the filing shall not be used by the managed care plan. If the requested information is not provided within a reasonable time period, the filing may be returned to the managed care plan as not filed and not available for use. Rates shall be open to public inspection upon filing with the commissioner; provided that the commissioner establishes rules to ensure that confidential and proprietary information is protected and shall not be subject to public inspection.

(e) Rates shall be established in accordance with actuarial principles, based on reasonable assumptions, and supported by adequate supporting and supplementary rating information. After reviewing a managed care plan's filing, the commissioner may require that the managed care plan's rates be based upon the managed care plan's own loss and expense information.

(f) The commissioner shall review filings promptly after the filings have been made to determine whether the filings meet the requirements of this article.

(g) Except as provided herein, each filing shall be on file for a waiting period of sixty days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the managed care plan that made the filing, that the commissioner needs the additional time for the consideration of the filing. Upon written application by the managed care plan, the commissioner may authorize a filing that the commissioner has reviewed, to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner, as provided in section 431:14G-107, within the waiting period or any extension thereof. The rates shall be deemed to meet the requirements of this article until the time the commissioner reviews the filing and so long as the filing remains in effect.

(h) If the commissioner finds that a filing does not meet the requirements of this article, the commissioner, as provided in section 431:14G-107, shall send the managed care plan a notice of disapproval within the applicable sixty-day period or fifteen-day extension provided by subsection (g).

(i) The commissioner, by written order, may suspend or modify the requirement of filing as to any class of health insurance, subdivision, or combination thereof, or as to classes of risks, the rates which cannot practicably be filed before they are used. The order shall be made known to the affected managed care plan. The commissioner may make examinations that the commissioner deems advisable to ascertain whether any rates affected by the order meet the standards set forth in section 431:14G-103.

(j) No managed care plan shall make or issue a contract or policy except in accordance with filings that are in effect for the managed care plan as provided in this article.

(k) The commissioner may make the following rate effective when filed: any special filing with respect to any class of health insurance, subdivision, or combination thereof that is subject to individual risk premium modification and has been agreed to under a formal or informal bid process.

(l) For managed care plans having annual premium revenues of less than $10,000,000, the commissioner may adopt rules and procedures that will provide the commissioner with sufficient facts necessary to

determine the reasonableness of the proposed rates without unduly burdening the managed care plan and its enrollees; provided that the rates meet the standards of section 431:14G-103.

(m) Subsections (a) through (l) shall not apply to third party administrator services, prepaid dental insurance offered by managed care plans, prepaid vision insurance offered by managed care plans and disability insurers licensed under chapter 431. For managed care plans with rates based totally or in part on the individual group's claims experience, insurers subject to this subsection shall submit to the commissioner for approval descriptions of the methodology to be used in creating rates and every modification thereof that it proposes to use. The description of methodology shall contain specific information allowing a determination of rates that meet the standards of section 431:14G-103(a) and supporting information and justification. Every filing shall state its proposed effective date and shall indicate the character and extent of the coverage contemplated. Complete supporting and supplementary rating information for rates shall be maintained and made available to the commissioner upon request. [L 2007, c 175, pt of §2; am L 2011, c 81, §9]

**[§431:14G-106] Policy revisions that alter coverage.** All plan revisions that alter coverage in any manner shall be filed with the commissioner. After review by the commissioner, the commissioner shall determine whether a rate filing for the plan revision must be submitted in accordance with section 431:14G-105. [L 2007, c 175, pt of §2]

**[§431:14G-107] Disapproval of filings.** (a) If, within the waiting period or any extension of the waiting period as provided in section 431:14G-105, the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall send to the managed care plan that made the filing, written notice of disapproval of the filing specifying in what respects the filing fails to meet the requirements of this article, specifying the actuarial, statutory, and regulatory basis for the disapproval, including an explanation of the application thereof that resulted in disapproval, and stating that the filing shall not become effective.

(b) Whenever a managed care plan has no legally effective rates as a result of the commissioner's disapproval of rates, a finding pursuant to subsection (c) that a filing is no longer effective, or other act, interim rates shall be established within ten days of disapproval, or other act, as follows:

(1) The commissioner shall specify interim rates sufficient to protect the interests of the managed care plan and its enrollees, ensure the solvency of the managed care plan, maintain the plan's health care delivery, and prevent any impairment of enrollees' health care benefits. When a new rate becomes legally effective and the new rate is higher than the interim rate, the commissioner shall allow the managed care plan to retroactively adjust the premiums to the time when the interim rate was first imposed. If the new rate is lower than the interim rate, the commissioner may order that the difference be applied to stabilize future rates or be refunded to current enrollees of the managed care plan;

(2) If a filing is disapproved, in whole or in part, a petition and demand for a contested case hearing may be filed in accordance with chapter 91. The managed care plan shall have the burden of proving that the disapproval is not justified; or

(3) If a filing is approved, a contested case hearing in accordance with chapter 91 may be convened

pursuant to subsection (c) to determine if the approved rates comply with the requirements of this article. If an appeal is taken from the commissioner's approval or if subsequent to the approval the commissioner convenes a hearing pursuant to subsection (c), the filing of the appeal or the commissioner's notice of hearing shall not stay the implementation of the rates approved by the commissioner, or the rates currently in effect, whichever is higher.

(c) If at any time subsequent to the applicable review period provided for in section 431:14G-105, the commissioner finds that a filing does not comply with the requirements of this article, the commissioner shall order a hearing upon the filing. The hearing shall be held upon not less than ten days' written notice to every managed care plan that made such a filing. The notice shall specify the matters to be considered at the hearing and state the specific factual and legal grounds to support the commissioner's finding of noncompliance. If, after a hearing the commissioner finds that a filing does not meet the requirements of this article, the commissioner within thirty days of the hearing, shall issue an order specifying in what respects the filing fails to meet the requirements, and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. Copies of the order shall be sent to each managed care plan whose rates are affected by the order. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(d)(1) Any enrollee of a managed care plan or organization that purchases health insurance from a managed care plan aggrieved with respect to any filing that is in effect may make a written demand to the commissioner for a hearing thereon; provided that the managed care plan that made the filing shall not be authorized to proceed under this subsection;

(2) The demand shall specify the grounds to be relied upon by the aggrieved enrollee or organization and the demand shall show that the enrollee or organization has a specific economic interest affected by the filing;

(3) If the commissioner finds that:

(A) The demand is made in good faith;
(B) The applicant would be so aggrieved if the enrollee's or organization's grounds are established; and
(C) The grounds otherwise justify a hearing;

the commissioner, within thirty days after receipt ofthe demand, shall hold a hearing. The hearing shall be held upon not less than ten days' written notice to the aggrieved party and to every managed care plan that made the filing. The aggrieved party shall bear the burden of proving that the filing fails to meet the standards set forth in section 431:14G-103; and

(4) If, after the hearing, the commissioner finds that the filing does not meet the requirements of this article, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this article, and stating when, within a reasonable period, the filing shall be deemed no longer effective. Copies of the order shall be sent to the applicant and to every affected managed care plan. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(e) The notices, hearings, orders, and appeals referred to in this section, in all applicable respects, shall be subject to chapter 91, unless expressly provided otherwise. [L 2007, c 175, pt of §2]

**[§431:14G-108] Managed care plans; prohibited activity.** (a)

Except as permitted in this article, no managed care plan shall:

(1) Attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market; or

(2) Engage in a boycott, on a concerted basis, of an insurance market.

(b) Except as permitted in this article, no managed care plan shall make any arrangement with any other person that has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance. [L 2007, c 175, pt of §2]

**[§431:14G-109] Information to be furnished enrollees; hearings and appeals of enrollees.** Every managed care plan that makes its own rates, within a reasonable time after receiving written request therefore and upon payment of reasonable charges as it may make, shall furnish to any enrollee affected by a rate made by it or to the authorized representative of the enrollee, all pertinent information as to the rate; provided that the managed care plan shall not be required to disclose supporting information and supplementary rating information protected pursuant to section 431:14G-105(d). [L 2007, c 175, pt of §2]

**[§431:14G-109.5] Publication of premium information.** (a) Upon the commissioner's request, all managed care plans shall provide health insurance premium information to the commissioner within thirty days of the request.

(b) The commissioner shall publish annually, by electronic or online publication on the official website of the insurance division, a list of all managed care plans with representative annual premiums for health insurance. The commissioner shall have information on premiums for health insurance, which shall be available to the public on request. [L 2014, c 66, §1]

**[§431:14G-110] False or misleading information.** No person or organization shall wilfully withhold information from or knowingly give false or misleading information to the commissioner, any statistical agency designated by the commissioner, or any managed care plan, which will affect the rates or premiums chargeable under this article. Violation of this section shall subject the one guilty of the violation to the penalties provided in section 431:14G-111. [L 2007, c 175, pt of §2]

**[§431:14G-111] Penalties.** (a) If the commissioner finds that any person or organization has violated any provision of this article, the commissioner may impose a penalty of not more than $500 for each violation; provided that if the commissioner finds the violation to be wilful, the commissioner may impose a penalty of not more than $5,000 for each violation. The penalties may be in addition to any other penalty provided by law. For purposes of this section, any managed care plan using a rate for which the managed care plan has failed to file the rate, supplementary rating information, underwriting rules or guides, or supporting information as required by this article, shall have committed a separate violation for each day the failure to file continues.

(b) The commissioner may suspend the license or operating authority of any managed care plan that fails to comply with an order of the commissioner within the time limited by the order, or any extension thereof that the commissioner may grant. The commissioner shall not suspend the license of any managed care plan for failure to comply with an order until the time prescribed for an appeal from the order has expired or, if an appeal has been taken, until the order has been affirmed. The commissioner may determine when a suspension of license or operating authority shall become effective and it shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

(c) No penalty shall be imposed and no license or operating authority shall be suspended or revoked except upon a written order of the commissioner, stating the commissioner's findings, made after a hearing held upon not less than ten days' written notice to the person or organization. The notice shall specify the alleged violation. [L 2007, c 175, pt of §2]

**[§431:14G-112] Hearing procedure and judicial review.** (a) Any managed care plan aggrieved by any order or decision of the commissioner made without a hearing, within thirty days after notice of the order to the managed care plan, may make written request to the commissioner for a hearing. The commissioner shall hold a hearing within twenty days after receipt of the request, and shall give not less than ten days' written notice of the time and place of the hearing. The commissioner shall promptly conduct and complete the hearing. Within fifteen days after the hearing is completed, the commissioner shall affirm, reverse, or modify the commissioner's previous action, specifying the reasons for the commissioner's decision. Pending the hearing and decision, the commissioner may suspend or postpone the effective date of the commissioner's previous action.

(b) Any final order or decision of the commissioner may be reviewed in the circuit court of the first circuit and an appeal from the decision of the court shall lie to the supreme court. The review shall be taken and had in the manner provided in chapter 91. [L 2007, c 175, pt of §2]

# ARTICLE 15
# INSURERS SUPERVISION, REHABILITATION AND LIQUIDATION

## Case Notes

Under §§431:15-310 and 431:15-313, the commissioner has exclusive standing under this article to assert claims arising out of the liquidation or rehabilitation of an insurance company on behalf of not only the insolvent insurer, but also its policyholders, creditors, and all other interested parties. 89 H. 427, 974 P.2d 1017.

This article applies to mutual benefit societies. 99 H. 53, 52 P.3d 823.

## PART I. GENERAL PROVISIONS

**§431:15-101 Construction and purpose.** (a) This article shall be cited as the Insurers Supervision, Rehabilitation and Liquidation Act.

(b) This article shall not be interpreted to limit the powers granted the commissioner by other provisions in this code.

(c) This article shall be liberally construed to effect the purpose stated in subsection (d).

(d) The purpose of this article is the protection of the interests of insureds, claimants, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

(1) Early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures;

(2) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

(3) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(4) Equitable apportionment of any unavoidable loss;

(5) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this State; and

(6) Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business. [L 1987, c 347, pt of §2]

**§431:15-102 Persons covered.** The proceedings authorized by this article may be applied to:

(1) All insurers and reinsurers who are doing, or have done, an insurance business in this State, and against whom claims arising from that business may exist now or in the future;

(2) All insurers who purport to do an insurance business in this State;

(3) All insurers who have insureds resident in this State;

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this State;

(5) All nonprofit service plans and all fraternal benefit societies and beneficial societies subject to chapter 432, Benefit Societies; and

(6) All title insurance companies, subject to article 20. [L 1987, c 347, pt of §2]

**Case Notes**

This section creates an exception to the general rule established by §432:1-101 that mutual benefit societies are typically exempt from provision of the Insurance Code; thus, this article applies to mutual benefit societies. 99 H. 53, 52 P.3d 823.

**§431:15-103 Definitions.** (a) For the purposes of this article:
"Ancillary state" means any state other than a domiciliary state.
"Creditor" means a person having any claim, whether matured or

unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

"Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer, and any summary proceeding under section 431:15-201 or 431:15-202.

"Doing business" means transacting the business of insurance as defined in section 431:1-215, or operating, whether by mail or otherwise, as an insurer under a license or certificate of authority issued by the insurance division.

"Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

"Fair consideration" means consideration given for property or obligation:

(1) When in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(2) When such property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

"Foreign country" means any other jurisdiction not in any state.

"Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

"General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, general assets includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

"Guaranty association" means the Hawaii insurance guaranty association created by part I of article 16, the Hawaii life and disability insurance association created by part II of article 16, and any other similar entity now or hereafter created by the legislature of this State for the payment of claims of insolvent insurers. Foreign guaranty association means any similar entities created by the legislature of any other state.

"Insolvency" or "insolvent" means:

(1) For an insurer issuing only assessable fire insurance policies:

(A) The inability to pay any obligation within thirty days after it becomes payable; or

(B) If an assessment be made within thirty days after such date, the inability to pay such obligation thirty days following the date specified in the first assessment notice issued after the date of loss pursuant to this code;

(2) For any other insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(A) Any capital and surplus required by law for its

organization; or

(B) The total par or stated value of its authorized and issued capital stock; and

(3) As to any insurer licensed to do business in this State as of July 1, 1988, who does not meet the standard established under subparagraph (B), the term insolvency or insolvent shall mean, for a period not to exceed three years from July 1, 1988, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the commissioner under provisions of this code.

"Insurer" means any person who has done, purports to do, is doing or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by any insurance commissioner. For purposes of this article, any other persons included under section 431:15-102 shall be deemed to be insurers.

"Liabilities" include but are not limited to reserves required by statute, insurance division rules, or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

"Preferred claim" means any claim with respect to which the terms of this article accord priority of payment from the general assets of the insurer.

"Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

"Reciprocal state" means any state other than this State in which in substance and effect sections 431:15-307(a), 431:15-403, 431:15-404, and 431:15-406 through 431:15-408 are in force, and in which provisions are in force requiring the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

"Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims that have become liens upon specific assets by reason of judicial process.

"Secured deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

"State" means any state, district, or territory of the United States and the Panama Canal Zone.

"Transfer" means every method, direct or indirect, of disposing of property, of an interest in property, of the possession of property, of fixing a lien upon property, or upon an interest in property, absolutely or conditionally, voluntarily or involuntarily, by or without judicial proceedings. The retention of a security interest in or title to property delivered to a debtor is considered a transfer by the debtor.

(b) If the subject of a rehabilitation or liquidation proceeding under this article is an insurer engaged in a surety business, then as used in this article:

(1) Policy includes a bond issued by a surety;

(2) Policyholder includes a principal on a bond;

(3) Beneficiary includes an obligee of a bond; and

(4) Insured includes both the principal and obligee of a bond. [L 1987, c 347, pt of §2; am L 1996, c 121, §1; am L 2004, c 122, §66]

**§431:15-103.5 Standards and authority.** (a) The following standards, either singly or in a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting insurance business in this State may be deemed to be hazardous to its policyholders, its creditors, or the general public:

(1) Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports, or summaries;

(2) The National Association of Insurance Commissioners' insurance regulatory information system and its other financial analysis solvency tools and reports;

(3) Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts;

(4) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

(5) Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than fifty per cent of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(6) Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty per cent of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(7) Whether a reinsurer, obligor, or any entity within the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations and which in the opinion of the commissioner may affect the solvency of the insurer;

(8) Contingent liabilities, pledges, or guaranties that, either individually or collectively, involve a total amount that, in the opinion of the commissioner, may affect the solvency of the insurer;

(9) Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer;

(10) The age and collectibility of receivables;

(11) Whether management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position;

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

(13) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner;

(14) Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released any false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

(15) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

(16) Whether the company has experienced, or will experience in the foreseeable future, cash flow or liquidity problems;

(17) Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles, and standards of practice;

(18) Whether management persistently engages in material under reserving that results in adverse development;

(19) Whether transactions among affiliates, subsidiaries, or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity, or diversity to assure the insurer's ability to meet its outstanding obligations as they mature; and

(20) Any other finding determined by the commissioner to be hazardous to the insurer's policyholders, creditors, or the general public.

(b) For the purposes of making a determination of an insurer's financial condition under this part, the commissioner may:

(1) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(2) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates consistent with the National Association of Insurance Commissioners' accounting practices and procedures manual, state laws, and rules;

(3) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(4) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

(c) If the commissioner determines that the continued operation of the insurer licensed to transact business in this State may be hazardous to its policyholders, its creditors, or the general public, the commissioner may, upon the commissioner's determination, issue an order requiring the insurer to:

(1) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(2) Reduce, suspend, or limit the volume of business being accepted or renewed;

(3) Reduce general insurance and commission expenses by specified methods;

(4) Increase the insurer's capital and surplus;

(5) Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

(6) File reports in a form acceptable to the commissioner concerning the market value of the insurer's

assets;

(7) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

(8) Document the adequacy of premium rates in relation to the risks insured;

(9) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such forms as approved by the commissioner;

(10) Correct corporate governance practice deficiencies and adopt and utilize governance practices acceptable to the commissioner;

(11) Provide a business plan to the commissioner in order to continue to transact business in the State; or

(12) Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any non-life insurance product written by the insurer that the commissioner considers necessary to improve the financial condition of the insurer.

If the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

(d) Any insurer subject to an order under subsection (c) may request a hearing to review that order pursuant to chapter 91. [L 1993, c 321, §3; am L 2013, c 190, §3]

**§431:15-104 Jurisdiction and venue.** (a) Except as provided in subsection (b), no delinquency proceeding may be commenced under this article by anyone other than the commissioner of this State.

(b)(1) Three or more judgment creditors holding unrelated judgments against an insurer, which judgments aggregate more than $5,000 in excess of any security held by those creditors may commence proceedings against the insurer under the conditions and in the manner prescribed in this subsection, by serving notice upon the commissioner and the insurer of intention to file a petition for liquidation under section 431:15-305 or 431:15-402. Each of the judgments:

(A) Shall have been rendered against the insurer by a court in this State having jurisdiction over the subject matter and the insurer;
(B) Shall have been entered more than sixty days before the service of notice under this subsection;
(C) May not be the subject of a valid contract between the insurer and any judgment creditor for payment of the judgment, unless that contract has been breached by the insurer;
(D) May not have been satisfied in full;
(E) May not be a judgment assigned to institute proceedings under this subsection; and
(F) May not be a judgment on which an appeal or review is pending or may yet be brought.

(2) If any one of the judgments in favor of a petitioning creditor remains unpaid for thirty days after service of the notice under this subsection, and the commissioner has not then filed a petition for liquidation, the creditor may file a verified petition for liquidation of the insurer in the manner prescribed by section 431:15-305 or 431:15-402, alleging the conditions stated in this subsection. The commissioner shall be served and joined in the action.

(c) No court of this State has jurisdiction to entertain, hear or

determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to that type of proceedings other than in accordance with this article.

(d) Venue for proceedings arising under this article shall be laid initially as specified in the sections providing for those proceedings. All other actions and proceedings initiated by the receiver may be commenced and tried where the delinquency proceedings are then pending, or where venue would be laid by applicable state law. All other actions and proceedings against the receiver shall be commenced and tried in the county where the delinquency proceedings are pending. Upon motion of any party, venue may be changed by order of the court or the presiding judge of the court to any other circuit court in this State, whenever the convenience of the parties and witnesses and the ends of justice requires it. This subsection relates only to venue and is not jurisdictional.

(e) In addition to other grounds for jurisdiction provided by the law of this State, a court of this State having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Hawaii Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this State:

(1) If the person served is obligated to the insurer in any way as an incident to any agency or brokerage arrangement that may exist or has existed between the insurer and the producer, in any action on or incident to the obligation;

(2) If the person served is a reinsurer who has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, or is a producer of or for the reinsurer, in any action on or incident to the reinsurance contract; or

(3) If the person served is or has been an officer, manager, trustee, organizer, promoter, or person in a position of comparable authority or influence in an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, in any action resulting from such a relationship with the insurer.

(f) If the court on the motion of any party finds that any action commenced under subsection (e) should, as a matter of substantial justice, be tried in a forum outside this State, the court may enter an order to stay further proceedings on the action in this State.

(g) All actions herein authorized shall be brought in the circuit court of the first circuit. [L 1987, c 347, pt of §2; am L 2002, c 155, §83; am L 2004, c 122, §67]

**Case Notes**

Shareholder did not have standing to oppose petition to liquidate insurer in delinquency proceedings. 80 H. 339, 910 P.2d 110.

**§431:15-105 Injunctions and orders.** (a) Any receiver appointed in a proceeding under this article may, at any time apply for and the circuit court of the first circuit may grant, under the relevant provisions of the Hawaii Rules of Civil Procedure, any injunctions, any restraining orders, and other orders as may be deemed necessary and proper to prevent:

(1) The transaction of further business;

(2) The transfer of property;

(3) Interference with the receiver or with a proceeding under this article;

(4) Waste of the insurer's assets;

(5) Dissipation and transfer of bank accounts;

(6) The institution or further prosecution of any actions or proceedings;

(7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders;

(8) The levying of execution against the insurer;

(9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(10) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this article.

(b) The receiver may apply to any court outside of this State for the relief described in subsection (a). [L 1987, c 347, pt of §2]

**§431:15-106 Cooperation of officers and employees.** (a) Any officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other persons with authority over, or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner or the receiver in any proceeding under this article or any investigation preliminary to the proceeding. The term person as used in this section, shall include any person who exercises control directly or indirectly over activities of an insurer through any holding company or other affiliate of the insurer. To cooperate shall include, but shall not be limited to the following:

(1) To reply promptly in writing to any inquiry from the commissioner or the receiver requesting such a reply; and

(2) To make available and deliver to the commissioner or receiver any books, accounts, documents, or other records, or information or property of or pertaining to the insurer and in its possession, custody or control.

(b) No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(c) This section does not make it illegal to resist by legal proceedings the petition for liquidation or other delinquency proceedings, or other orders.

(d) Any person included within subsection (a) who fails to cooperate with the commissioner, or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order the commissioner issued validly under this article may:

(1) Be sentenced to pay a fine not exceeding $10,000 or to be imprisoned for a term of not more than one year, or both; or

(2) After a hearing, be subject to the imposition by the commissioner, of a civil penalty not to exceed $10,000 and shall be subject further to the revocation or suspension of any insurance licenses issued by the commissioner. [L 1987, c 347, pt of §2]

**§431:15-107 Commissioner's reports.** The commissioner shall make and file annual reports and any other required reports for the companies proceeded against under this article in the manner and form and within the time required by law of insurers authorized to do business in this State. [L 1987, c 347, pt of §2]

**§431:15-108 Continuation of delinquency proceedings.** This article applies to proceedings commenced after July 1, 1988. [L 1987, c 347, pt of §2]

**Revision Note**

"July 1, 1988" substituted for "the effective date of the insurance code".

## PART II. SUMMARY PROCEEDINGS AND SUPERVISORY PROCEEDINGS

**§431:15-201 Commissioner's summary orders and supervision proceedings.** (a) If, upon examination or at any other time, the commissioner finds that any domestic insurer requires supervision because it is in such condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if the domestic insurer gives its consent, then the commissioner shall issue a supervision order and shall:

(1) Notify the insurer of the commissioner's order; and

(2) Furnish to the insurer a written list of the commissioner's requirements to abate the commissioner's order. The commissioner shall also proceed, if necessary, against the insurer pursuant to section 431:2-203.

(b) During the period of supervision, the commissioner may appoint a supervisor to supervise the insurer. The order appointing a supervisor shall direct the supervisor to enforce orders issued under subsection (a) and also may require that the insurer shall not do any of the following things during the period of supervision without the prior written approval of the commissioner or the supervisor:

(1) Dispose of, convey or encumber any of its assets or its business in force;

(2) Withdraw from any of its bank accounts;

(3) Lend any of its funds;

(4) Invest any of its funds;

(5) Transfer any of its property;

(6) Incur any debt, obligation or liability;

(7) Merge or consolidate with another company;

(8) Enter into any new reinsurance contract or treaty; or

(9) Write any new or renewal business.

(c) Any insurer subject to an order under this section shall comply with the requirements of the commissioner within sixty days from the date the supervision order is served. If the insurer fails to comply within the time specified, the commissioner may institute proceedings under section 431:15-301 or section 431:15-306 to have a rehabilitator or liquidator appointed, or seek to enforce the order pursuant to section 431:2-203.

(d) Any insurer subject to an order under this section may request a hearing to review the order. The hearing shall be held as provided in chapter 91, but the request for a hearing shall not stay the effect of the order. The insurer, at any time, may waive said hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies.

(e) During the period of supervision the insurer may request the commissioner to review an action taken or proposed to be taken by the supervisor, specifying where the action complained of is believed not to be in the best interest of the insurer.

(f) If any person has violated any supervision order issued under this section which as to the person was then still in effect, the person shall pay a penalty imposed by the circuit court of the first judicial circuit of this State not to exceed $10,000 for each violation.

(g) The commissioner may apply for, and the court may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to enforce a supervision order.

(h) If any person:

(1) With authority over or in charge of any segment of the insurer's affairs; or

(2) Who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer;

knowingly violates any valid order of the commissioner issued under this section and, as a result of the violation, the net worth of the insurer is reduced or the insurer suffers loss it would not otherwise have suffered, the person shall become personally liable to the insurer for the amount of the reduction or loss. The commissioner or supervisor may bring an action on behalf of the insurer in the circuit court of the first judicial circuit of this State to recover the amount of the reduction or loss together with any costs. [L 1987, c 347, pt of §2]

**§431:15-202 Court's seizure order.** (a) The commissioner may file in the circuit court of the first judicial circuit of this State a petition alleging, with respect to a domestic insurer:

(1) That there exist any grounds that would justify a court order for a formal delinquency proceeding against an insurer under section 431:15-301 or section 431:15-306;

(2) That the interests of policyholders, creditors or the public will be endangered by delay; and

(3) The contents of an order deemed necessary by the commissioner.

(b) Upon a filing under subsection (a), the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of the insurer, and of the premises occupied by it for transaction of its business, and until further order of the court, enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from transaction of its business except with the written consent of the commissioner.

(c) The court shall specify in the order what its duration shall be, which shall be the time as the court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court from time to time may hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under section 431:15-301 or section 431:15-306 after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under section 431:15-301 or section 431:15-306 shall vacate the seizure order.

(d) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(e) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of the order for a hearing and review of the order. The court shall hold the hearing and review not more than fifteen days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

(f) If, at any time after the issuance of an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall stay the effect of an order previously issued by the court. [L 1987, c 347, pt of §2]

**§431:15-203 Confidentiality of hearings.** In all proceedings and judicial reviews thereof under section 431:15-201 and section 431:15-202, all records of the insurer, other documents, and all files, court records, and papers of the insurance division of the department of commerce and consumer affairs, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless the circuit court of the first judicial circuit of this State, after hearing arguments from the parties in chambers, orders otherwise, or unless the insurer requests that the matter be made public. Until the court order, all papers filed with the court shall be confidential. [L 1987, c 347, pt of §2]

**Case Notes**

Section establishes a duty governing the conduct of the insurance commissioner and court personnel who are involved in investigations conducted by the commissioner and cannot form a basis for the imposition of liability upon third parties who may inadvertently come into possession of material deemed "confidential" pursuant to this section's terms. 89 H. 254, 971 P.2d 1089.

## PART III. FORMAL PROCEEDINGS

**§431:15-301 Grounds for rehabilitation.** (a) The commissioner may apply by petition to the circuit court of the first judicial circuit for an order authorizing the commissioner to rehabilitate a domestic insurer or an alien insurer domiciled in this State, on any one or more of the following grounds whenever the commissioner reasonably believes that the insurer may be successfully rehabilitated without substantial increase in the risk of loss to the insurer's policyholders, creditors, or to the public:

(1) The insurer is insolvent;

(2) The insurer is in such condition that the further transaction of business would be hazardous, financially, to its policyholders, creditors or the public;

(3) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer;

(4) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business;

(5) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy;

(6) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this State or elsewhere, and after reasonable notice of the fact the insurer has failed promptly and effectively to terminate the employment and status of the person and all such person's influence on management;

(7) After demand by the commissioner under article 2 or under this article, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer;

(8) Without first obtaining the written consent of the commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to article 11 or section 431:3-215, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate or reinsure substantially its entire property or business in or with the property or business of any other person;

(9) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator, or similar fiduciary of the insurer or its property, otherwise than as authorized under the insurance laws of this State, and such appointment has been made or is imminent, and such appointment might oust the courts of this State of jurisdiction or might prejudice orderly delinquency proceedings under this article;

(10) Within the previous four years the insurer has wilfully violated its charter or articles of incorporation, its bylaws, any insurance law of this State, or any valid order of the commissioner under section 431:15-201;

(11) The insurer has failed to pay within sixty days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter, except that such nonpayment shall not be a ground until sixty days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has established general business practices which attempt to

compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full;

(12) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to give an adequate explanation immediately; or

(13) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities request or consent to rehabilitation under this article.

(b) Nothing herein contained shall be construed as creating or enlarging any of the duties of the guaranty associations as may be set forth in article 16. [L 1987, c 347, pt of §2]

**§431:15-302 Rehabilitation orders.** (a) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this State, shall appoint the commissioner and the commissioner's successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the circuit court of the first judicial circuit or at the bureau of conveyances, shall impart the same notice as evidence of title. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(b) Any order issued under this section shall require accounting to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in its order.

(c) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer. [L 1987, c 347, pt of §2]

**§431:15-303 Powers and duties of the rehabilitator.** (a) The commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ such counsel, clerks, and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, with the approval of the court, and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance division. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance division out of the first available moneys of the insurer.

(b) The rehabilitator may take such action as the rehabilitator deems necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator shall have full powers to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and

business of the insurer.

(c) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, producer, employee, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

(d) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(e) The rehabilitator shall have the power under section 431:15-315 and section 431:15-316 to avoid fraudulent transfers. [L 1987, c 347, pt of §2; am L 2002, c 155, §84]

**§431:15-304 Actions by and against rehabilitator.** (a) Any court in this State before which any action or proceeding in which the insurer is a party or is obligated to defend a party is pending when a rehabilitation order against the insurer is entered, shall stay the action or proceeding for ninety days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as the rehabilitator deems necessary in the interests of justice and for the protection of creditors, policyholders and the public. The rehabilitator shall immediately consider all litigation pending outside this State and shall petition the courts having jurisdiction over the litigation for stays whenever necessary to protect the estate of the insurer.

(b) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order [of] rehabilitation is entered or the petition is denied. [L 1987, c 347, pt of §2]

**§431:15-305 Termination of rehabilitation.** (a) Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders or the public, or would be futile, the commissioner may petition the circuit court of the first judicial circuit for an order of liquidation. A petition under this subsection shall have the same effect as a petition under section 431:15-306. The court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer

of such costs and other expenses of defense as justice may require.

(b) The rehabilitator may at any time petition the court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer, and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 431:15-301 no longer exist, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make that finding and issue that order at any time upon its own motion. [L 1987, c 347, pt of §2]

**§431:15-306 Grounds for liquidation.** The commissioner may petition the circuit court of the first judicial circuit for an order directing the commissioner to liquidate a domestic insurer or an alien insurer domiciled in this State on any ground on which the commissioner may apply for an order of rehabilitation under section 431:15-301, whenever the commissioner believes that attempts to rehabilitate the insurer would substantially increase the risk of loss to its creditors, its policyholders or the public, or would be futile, or that rehabilitation would serve no useful purpose, whether or not there has been a prior order directing the rehabilitation of the insurer. [L 1987, c 347, pt of §2]

**§431:15-307 Liquidation orders.** (a) An order to liquidate the business of a domestic insurer shall appoint the commissioner and the commissioner's successors in office liquidator, and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the circuit court of the first judicial circuit and at the bureau of conveyances shall impart the same notice as evidence of title.

(b) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in section 431:15-308 and section 431:15-327.

(c) An order to liquidate the business of an alien insurer domiciled in this State shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(d) At the time of petitioning for an order of liquidation, or at any time thereafter, the commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper the court may make the declaration.

(e) Any order issued under this section shall require accounting to the court by the liquidator. Accountings shall be at such intervals as the court specifies in its order. [L 1987, c 347, pt of §2]

**§431:15-308 Continuance of coverage.** (a) All policies, other than life or accident and health or sickness insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(1) A period of thirty days from the date of entry of the liquidation orders;

(2) The expiration of the policy coverage;

(3) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or

(4) The liquidator has effected a transfer of the policy obligation pursuant to section 431:15-310(a)(8).

(b) An order of liquidation under section 431:15-307(a) shall terminate coverages at the time specified in subsection (a) for purposes of any other statute.

(c) Policies of life or accident and health or sickness insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty fund or association, or foreign guaranty fund or association. Policies of life or accident and health or sickness insurance or annuities or any period or coverage of such policies not covered by a guaranty fund or association or foreign guaranty fund or association shall terminate under subsections (a) and (b). [L 1987, c 347, pt of §2; am L 2003, c 212, §108]

**§431:15-309 Dissolution of insurer.** The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this State at the time the commissioner applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner, upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent, but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason. [L 1987, c 347, pt of §2]

**§431:15-310 Powers of liquidator.** (a) The liquidator shall have the power to:

(1) Appoint a special deputy to act for the liquidator under this article, and to determine the special deputy's reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator;

(2) Employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and such other personnel as the liquidator deems necessary to assist in the liquidation;

(3) Fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers, and consultants with the approval of the court;

(4) Pay reasonable compensation to persons appointed, and defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. If the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs incurred out of any

appropriation for the maintenance of the insurance division. Any amounts advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance division out of the first available moneys of the insurer;

(5) Hold hearings, including but not limited to hearings convened for the purpose of receiving testimony and evidence to determine whether any assets of the insurer have been concealed, misappropriated, or improperly transferred from the insurer. Prior to or at any hearing convened by the liquidator, the liquidator may subpoena witnesses to compel their attendance, administer oaths, examine any person under oath, and compel any party to subscribe to their testimony after it has been correctly reduced to writing, and in connection therewith require the production of any books, papers, records, or other documents that the liquidator deems relevant to the inquiry;

(6) Collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose to:

(A) Institute timely action in other jurisdictions, to forestall garnishment and attachment proceedings against such debts;
(B) Do such other acts as are necessary or expedient to collect, conserve, or protect its assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon such terms and conditions as the liquidator deems best; and
(C) Pursue any creditor's remedies available to enforce the creditor's claims;

(7) Conduct public and private sales of the property of the insurer;

(8) Use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 431:15-332;

(9) Acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. The liquidator shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation;

(10) Borrow money on the security of the insurer's assets, or without security, and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation;

(11) Enter into such contracts as are necessary to carry out the order to liquidate, and affirm or disavow any contracts to which the insurer is a party;

(12) Continue to prosecute and institute in the name of the insurer or in the liquidator's own name any and all suits and other legal proceedings in this State or elsewhere, and abandon the prosecution of claims the liquidator deems unprofitable to pursue further. If the insurer is dissolved under section 431:15-309, the liquidator shall have the power to apply to any court in this State or elsewhere for leave to substitute the liquidator for the insurer as plaintiff;

(13) Prosecute any action that may exist on behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer, or any other person;

(14) Remove any or all records and property of the insurer to the offices of the commissioner or to another place that may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations;

(15) Deposit in one or more banks in this State sums that are required for meeting current administration expenses and dividend distributions;

(16) Invest all sums not currently needed, unless the court orders otherwise;

(17) File any necessary documents for recordation in the bureau of conveyances or other appropriate office or elsewhere where property of the insurer is located;

(18) Assert all defenses available to the insurer against third persons, including statutes of limitations, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to the obligation and may defend only in the absence of a defense by the guaranty associations;

(19) Exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with sections 431:15-315 to 431:15-317;

(20) Intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and act as the receiver or trustee whenever the appointment is offered;

(21) Enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states; and

(22) Exercise all powers now held or hereafter conferred upon receivers by the laws of this State not inconsistent with the provisions of this article.

(b) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon the liquidator, nor shall it exclude in any manner the liquidator's right to do such other acts not herein specifically enumerated, or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation. [L 1987, c 347, pt of §2; am L 2004, c 122, §68; am L 2005, c 132, §5]

**Case Notes**

Under §431:15-313 and this section, the commissioner has exclusive standing under this article to assert claims arising out of the liquidation or rehabilitation of an insurance company on behalf of not only the insolvent insurer, but also its policyholders, creditors, and all other interested parties. 89 H. 427, 974 P.2d 1017.

**§431:15-311 Notice to creditors and others.** (a) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible by:

(1) First class mail and by telegram, telephone, or other electronic communication to the commissioner of each jurisdiction in which the insurer is doing business;

(2) First class mail to any guaranty association or foreign guaranty association who is or may become obligated as a result of the liquidation;

(3) First class mail to all insurance producers of the insurer;

(4) First class mail to all persons known or reasonably expected to have claims against the insurer including all policyholders, at their last known address as indicated by the records of the insurer; and

(5) Publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(b) Notice to potential claimants under subsection (a) shall require claimants to file with the liquidator their claims together with proper proofs thereof under section 431:15-326, on or before a date the liquidator shall specify in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(c) If notice is given in accordance with this section, the distribution of assets of the insurer under this article shall be conclusive with respect to all claimants, whether or not they received notice. [L 1987, c 347, pt of §2; am L 2002, c 155, §85; am L 2003, c 212, §109]

**§431:15-312 Duties of producers.** (a) Every person who receives notice in the form prescribed in section 431:15-311 that an insurer whom the producer represents is the subject of a liquidation order, shall within fifteen days of such notice give notice of the liquidation order. The notice shall be sent by first class mail to the last address contained in the producer's records to each policyholder or other person named in any policy issued through the producer by the insurer, if the producer has a record of the address of the policyholder or other person. A policy shall be deemed issued through a producer if the producer has a property interest in the expiration of the policy, or if the producer has had possession of a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another. The written notice shall include the name and address of the insurer, the name and address of the producer, identification of the policy impaired and the nature of the impairment including termination of coverage, as described in section 431:15-308. Notice by a producer satisfies the notice requirement for any producers under contract to it. Each producer obligated to give notice under this section shall file a report of compliance with the liquidator.

(b) Any producer failing to give notice or file a report of compliance as required in subsection (a) may be subject to payment of a penalty of not more than $1,000 and such producer's license may be suspended, the penalty to be imposed after a hearing held by the commissioner.

(c) The liquidator may waive the duties imposed by this section if the liquidator determines that other notice to the policyholders of the insurer under liquidation is adequate. [L 1987, c 347, pt of §2; am L 2002, c 155, §86]

**§431:15-313 Actions by and against liquidator.** (a) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this State, no action at law or equity shall be brought against the insurer or liquidator, whether in this State or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this State shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states.

Whenever in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this State, the liquidator may intervene in the action. The liquidator may defend any action in which the liquidator intervenes under this section at the expense of the estate of the insurer.

(b) The liquidator may, upon or after an order for liquidation, within two years or such time in addition to two years as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition, the liquidator, may, for the benefit of the estate, take any such action or do any such act, required of or permitted to the insurer, within a period of 180 days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(c) No statute of limitations or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the petition is denied.

(d) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation. [L 1987, c 347, pt of §2]

**Case Notes**

Under §431:15-310 and this section, the commissioner has exclusive standing under this article to assert claims arising out of the liquidation or rehabilitation of an insurance company on behalf of not only the insolvent insurer, but also its policyholders, creditors, and all other interested parties. 89 H. 427, 974 P.2d 1017.

**§431:15-314 Collection and list of assets.** (a) As soon as practicable after the liquidation order, but not later than one hundred twenty days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the clerk of the circuit court of the first judicial circuit and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(b) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(c) A submission to the court for disbursement of assets in accordance with section 431:15-324 fulfills the requirements of subsection (a). [L 1987, c 347, pt of §2]

**§431:15-315 Fraudulent transfers prior to petition.** (a) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this article is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this article, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor or obligee for a present fair equivalent value, and except that any purchaser, lienor or obligee, who in good faith has given a consideration less than fair for such transfer, lien or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor or obligee.

(b)(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under section 431:15-317(c).

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (a) if:

(1) The transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and

(2) Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced. [L 1987, c 347, pt of §2]

**§431:15-316 Fraudulent transfer after petition.** (a) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or

liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the bureau of conveyances. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(b) After a petition for rehabilitation or liquidation has been filed, and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred.

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon the receiver's order, with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(4) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(c) Nothing in this article shall impair the negotiability of currency or negotiable instruments. [L 1987, c 347, pt of §2]

**§431:15-317 Voidable preferences and liens.**

(a)(1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this article, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if:

(A) The insurer was insolvent at the time of the transfer;
(B) The transfer was made within four months before the filing of the petition;
(C) The creditor receiving it or to be benefited thereby or the creditor's agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or
(D) The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not the creditor held such position, or any shareholder holding directly or indirectly more than five per centum of any class of any equity security issued by

the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, the liquidator shall have a lien upon the property to the extent of the consideration actually given by the liquidator. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(b)(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(c)(1) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry of docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(2) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (b), if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lien holder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (b) through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(d) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (b) to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchaser's rights are performed within twenty-one days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(e) If any lien deemed voidable under subsection (a)(2) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing

of a petition under this article which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(f) The property affected by any lien deemed voidable under subsections (a) and (e) shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(g) The circuit court of the first judicial circuit shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnified or than the amount of the lien, the transferee or lien holder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(h) The liability of a surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or where the property is retained under subsection (g) to the extent of the amount paid to the liquidator.

(i) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from the creditor.

(j) If an insurer shall, directly or indirectly, within four months before the filing of a successful petition for liquidation under this article, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transaction may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefit of the estate provided that where the attorney is in a position of influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by subsection (a)(2)(D).

(k)(1) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when such person has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is reasonable cause to so believe if the transfer was made within four months before the date of filing of this successful petition for liquidation.

(2) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (a) shall be personally liable therefor and shall be bound to account to the liquidator.

(3) Nothing in this subsection shall prejudice any other claim by the liquidator against any person. [L 1987, c 347, pt of §2; am L 2004, c 122, §69]

**§431:15-318 Claims of holders of void or voidable rights.** (a) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance, voidable under this article, shall be allowed unless the creditor surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under subsection (a) by reason of the avoidance, whether voluntary or involuntary, of a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under section 431:15-325 if filed within thirty days from the date of the avoidance, or within the further time allowed by the court under subsection (a). [L 1987, c 347, pt of §2]

**§431:15-319 Setoffs and counterclaims.** (a) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) and section 431:15-323.

(b) No setoff or counterclaim shall be allowed in favor of any person where:

(1) The obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(2) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

(3) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

(4) The obligation of the person is to pay premiums whether earned or unearned, to the insurer. [L 1987, c 347, pt of §2]

**§431:15-320 Assessments.** (a) As soon as practicable but not more than two years from the date of an order of liquidation under section 431:15-307 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(1) The reasonable value of the assets of the insurer;

(2) The insurer's probable total liabilities;

(3) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(4) A recommendation as to whether or not an assessment should be made and in what amount.

(b)(1) Upon the basis of the report provided in subsection (a), including any supplements and amendments thereto, the circuit court of the first judicial circuit may levy one or more assessments against all members of the insurer who are subject to assessment.

(2) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(c) After levy of assessment under subsection (b) the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order, to show cause why the liquidator should not pursue a judgment therefor.

(d) The liquidator shall give notice of the order to show cause by publication and by first class mail to each member liable thereunder, mailed to each member's last known address as it appears on the insurer's records, at least twenty days before the return day of the order to show cause.

(e)(1) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (c), the court shall make an order adjudging the member liable for the amount of the assessment against the member, pursuant to subsection (c), together with costs, and the liquidator shall have a judgment against the member therefor.

(2) If on or before such return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(f) The liquidator may enforce any order or collect any judgment under subsection (e) by any lawful means. [L 1987, c 347, pt of §2]

**§431:15-321 Reinsurer's liability.** The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation. [L 1987, c 347, pt of §2]

**§431:15-322 Applicability of claims settlement provisions to loss claims.** Section 431:15-310(a)(18), section 431:15-325 through section 431:15-328, section 431:15-333, section 431:15-403(c), section 431:15-406, and section 431:15-407 do not apply to loss claims to the extent that they are subject to article 16 or to corresponding laws of other states. [L 1987, c 347, pt of §2]

**§431:15-323 Recovery of premiums owed.** (a) A producer, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay upon written demand by the liquidator any unpaid collected premium held by the person,

whether earned or unearned, as shown on the records of the insurer. A producer, premium finance company, or any other person shall have no obligation to pay an uncollected, unpaid, unearned premium to the liquidator. The liquidator shall also have the right to recover from the person any part of an unearned premium that represents commission actually paid or credited to the person. Credits or setoffs or both shall not be allowed to a producer or premium finance company for any amounts advanced to the insurer by the producer or premium finance company on behalf of, but in the absence of a payment by, the insured. An insured shall be obligated to pay, upon written demand by the liquidator, any unpaid, earned premium due the insurer as shown on the records of the insurer.

(b) The circuit court of the first judicial circuit shall have original but not exclusive jurisdiction of all civil proceedings to hear and determine the rights of any producer, premium finance company, insured, liquidator, or any other person under this section. The circuit court of the first judicial circuit may provide that any and all proceedings arising under this section shall be referred to the judge presiding over the delinquency proceeding of the insurer. In lieu of a separate action for the collection of unpaid premiums, a producer, premium finance company, insured, or any other person who contests their liability for unpaid premiums may voluntarily submit their claim and dispute to the judge presiding over the delinquency proceeding of the insurer for summary disposition.

(c) The commissioner may take administrative action in accordance with applicable law against a producer, premium finance company, or any other person the commissioner believes is in violation of subsection (a) by suspending, revoking, or refusing to renew an insurance license, or by levying a civil penalty in an amount not to exceed $1,000 for each violation.

(d) Any appeal of the commissioner’s decision pursuant to subsection (c) shall be made pursuant to chapter 91 to the circuit court of the first judicial circuit. [L 1987, c 347, pt of §2; am L 1993, c 165, §1; am L 2002, c 155, §87; am L 2005, c 132, §6]

**Case Notes**

As proceedings under this section are not in the nature of assumpsit, trial court did not err in denying insurance commissioner attorneys' fees under §607-14 in suit against customer of liquidated mutual benefit society. 99 H. 53, 52 P.3d 823.

Nothing in the language of §478-3 or this section precluded an award of post-judgment interest to insurance commissioner upon final judgment awarding commissioner the unpaid premiums from customer of liquidated mutual benefit society. 99 H. 53, 52 P.3d 823.

**§431:15-324 Domiciliary liquidator's proposal to distribute assets.** (a) Within one hundred twenty days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this State, the liquidator shall make application to the court for approval of a proposal, subject to the priority schedule stated in section 431:15-332, to disburse assets out of marshaled assets, from time to time as the assets become available. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(b) The proposal shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in section 431:15-332, classes 1, 2 and 3;

(2) Disbursement of the assets marshaled to date and subsequent disbursement of assets as they become available;

(3) Equitable allocation of disbursements to each of the classes entitled thereto;

(4) The securing by the liquidator from each of the classes entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section 431:15-332 in accordance with the priorities. No bond shall be required of any of the classes; and

(5) A full report to be made by each class to the liquidator accounting for all assets so disbursed to the class, all disbursements made therefrom, any interest earned by the class on the assets and any other matter as the court may direct.

(c) The liquidator's proposal shall provide for disbursements to the guaranty funds or associations in amounts estimated at least equal to the claim payments made or to be made thereby for which the funds or associations could assert a claim against the liquidator, and shall provide further that if the assets available for disbursement from time to time do not equal the amount of the claim payments made or to be made by the fund or association then disbursements shall be in the amount of available assets.

(d) The liquidator's proposal, with respect to an insolvent insurer writing life or accident and health or sickness insurance or annuities, shall provide for disbursements of assets to any guaranty fund or association, or any foreign guaranty fund or association covering life or accident and health or sickness insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating such funds or associations.

(e) Notice of the application shall be given to the classes affected, the guaranty fund or association in, and to the commissioners of insurance of, each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mail, first class postage prepaid, at least thirty days prior to submission of the application to the court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the liquidator's proposal complies with subsections (b)(1) and (2). [L 1987, c 347, pt of §2 as superseded by c 349, §10; am L 2003, c 212, §110]

**§431:15-325 Filing of claims.** (a) Proof of all claims shall be filed with the liquidator in the form required by section 431:15-326 on or before the last day for filing specified in the notice required under section 431:15-311, except that proof of claims for cash surrender values or other investment value in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(b) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if the claimant were not late, to the extent that any such payment will not prejudice the

orderly administration of the liquidation, under the following circumstances:

(1) The existence of the claim was not known to the claimant and that the claimant filed such claim as promptly as reasonably possible after learning of it;

(2) A transfer to a creditor was avoided under section 431:15-315 through section 431:15-317, or was voluntarily surrendered under section 431:15-318, and that the filing satisfies the conditions of section 431:15-318; and

(3) The valuation under section 431:15-331, of security held by a secured creditor shows a deficiency, which is filed within thirty days after the valuation.

(c) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty fund or association, or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

(d) The liquidator may consider any claim filed late which is not covered by subsection (b), and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late filing claimant shall receive, at each distribution, the same percentage of the amount allowed on the claimant's claim as is then being paid to claimants of any lower priority. This shall continue until the claimant's claim has been paid in full.

(e) Claims by guaranty funds or associations, or foreign guaranty funds or associations shall be filed periodically by the funds or associations pursuant to rules adopted by the commissioner. These claims shall share in all subsequently declared distributions as if they were not late. [L 1987, c 347, pt of §2]

**§431:15-326 Proof of claim.** (a) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(1) The particulars of the claim including the consideration given for it;

(2) The identity and amount of the security on the claim;

(3) The payments made on the debt, if any;

(4) That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;

(5) Any right of priority of payment or other specific right asserted by the claimant;

(6) A copy of the written instrument which is the foundation of the claim; and

(7) The name and address of the claimant and the attorney who represents the claimant, if any.

(b) No claim need be considered or allowed if it does not contain all the information in subsection (a) which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(c) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (a) and may take testimony under oath, require production of affidavits

or depositions, or otherwise obtain additional information or evidence.

(d) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion need be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within four months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

(e) All claims of a guaranty fund or association or foreign guaranty fund or association shall be in such form and contain such substantiation as may be agreed to by the fund or association and the liquidator. [L 1987, c 347, pt of §2]

**§431:15-327 Special claims.** (a) The claim of a third party which is contingent only on first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(b) Any claim that would have become absolute if there had been no termination of coverage under section 431:15-308, and that was not covered by insurance acquired to replace the terminated coverage, shall be allowed as if the coverage had remained in effect, unless at least ten days before the insured event occurred either the claimant had actual notice of the termination or notice was mailed to the claimant as prescribed by section 431:15-311. If allowed, the claim shall share in distributions under section 431:15-332(7).

(c) A claim may be allowed even if it is contingent, if it is filed in accordance with section 431:15-326(b). It may be allowed and may participate in all distributions declared after it is filed, to the extent that it does not prejudice the orderly administration of the liquidation.

(d) Claims that are due except for the passage of time are treated as absolute claims, except that where justice requires the liquidator may discount them at the rate of interest available on United States treasury securities of approximately the same maturity.

(e) A guaranty fund or association, or foreign guaranty association may file a claim with the liquidator for all claims to which the fund or association has been subrogated.

(f) Claims made under employment contracts by directors, principal officers, or persons who, in fact, perform similar functions or have similar powers, are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under section 431:15-302 or section 431:15-307. [L 1987, c 347, pt of §2; am L 2004, c 122, §70]

**§431:15-328 Provisions for third party claims.** (a) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(b) Whether or not the third party files a claim, the insured may file a claim on its own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty days after mailing of the notice required by section 431:15-311, whichever is later, it is an unexcused late filer.

(c) The liquidator shall make recommendations to the court under section 431:15-332, for the allowance of an insured's claim under subsection (b) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable

damages recoverable in the action and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, the liquidator shall reconsider the claim on the basis of additional information and amend the liquidator's recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of:

(1) The amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expenses of defense, or

(2) The amount allowed on the claims by the court.

After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(d) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (c). If any insured's claim is subsequently reduced under subsection (c), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(e) No claim may be presented under this section if it is covered by any guaranty fund or association, or foreign guaranty association. [L 1987, c 347, pt of §2]

**§431:15-329 Disputed claims.** (a) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or the claimant's attorney by first class mail at the address shown in the proof of claim. Within sixty days from the mailing of the notice, the claimant may file any objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(b) Whenever objections are filed with the liquidator and the liquidator does not alter the denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or the claimant's attorney and to any other persons directly affected, not less than ten nor more than thirty days before the date of the hearing. The matter may be heard by the court or by a court appointed referee who shall submit findings of fact along with such referee's recommendations. [L 1987, c 347, pt of §2]

**§431:15-330 Claims of surety.** Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of

the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that the other person discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution, however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by the creditor in trust for such other person. The term other person as used in this section is not intended to apply to a guaranty fund or association, or foreign guaranty association. [L 1987, c 347, pt of §2]

**§431:15-331 Secured creditor's claims.** (a) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(1) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

(2) By agreement, arbitration, compromise or litigation between the creditor and the liquidator.

(b) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender this security to the liquidator, the entire claim shall be allowed as if unsecured. [L 1987, c 347, pt of §2]

**§431:15-332 Priority of distribution.** The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) Class 1. The costs and expenses of administration, including but not limited to the following:

(A) The actual and necessary costs of preserving or recovering the assets of the insurer;
(B) Compensation for all services rendered in the liquidation;
(C) Any necessary filing fees;
(D) The fees and mileage payable to witnesses;
(E) Reasonable attorney's fees; and
(F) The reasonable expenses of a guaranty fund or association, or foreign guaranty association in handling claims.

(2) Class 2. All claims under policies for losses incurred, including third party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, claims under nonassessable policies for unearned premium or other premium refunds, and all claims of a guaranty fund or association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to its employee shall be treated as a gratuity.

Notwithstanding the foregoing, the following claims shall be excluded from class 2:

(A) Obligations of the insolvent insurer arising out of reinsurance contracts;

(B) Obligations incurred after the expiration date of the insurance policy or after the policy has been replaced by the insured or canceled at the insured's request or after the policy has been canceled as provided in this section. Notwithstanding this paragraph, earned premium claims on policies, (other than reinsurance agreements) shall not be excluded;

(C) Obligations to insurers, insurance pools, or underwriting associations, and their claims for contribution, indemnity, or subrogation, equitable or otherwise;

(D) Any claim that is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer; and

(E) Any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy.

(3) Class 3. Claims of the federal government.

(4) Class 4. Debts due to employees for services performed to the extent that they do not exceed $1,000 and represent payment for services performed within one year before the filing of the petition for liquidation. Officers and directors shall not be entitled to the benefit of this priority. The priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(5) Class 5. Claims of general creditors.

(6) Class 6. Claims of any state or local government. Claims including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of the claims shall be postponed to the class of claims under paragraph (8).

(7) Class 7. Claims filed late or any other claims other than claims under paragraphs (8) and (9).

(8) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with the law.

(9) Class 9. The claims of shareholders or other owners. [L 1987, c 347, pt of §2 as superseded by c 349, §11; am L 1996, c 121, §2]

**§431:15-333 Liquidator's recommendations to the court.** (a) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as the liquidator shall deem necessary. The liquidator may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court, except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty fund or association, or foreign guaranty fund or association. Unresolved disputes shall be determined under section 431:15-329. As soon as practicable, the liquidator shall present to the court a report of the claims against the insurer with the liquidator's recommendations. The report shall include the name and address of each claimant and the amount

of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values of other investment value and the amounts owed.

(b) The court may approve, disapprove or modify the report on claims by the liquidator. Such reports as are not modified by the court within a period of sixty days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to section 431:15-329. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits. [L 1987, c 347, pt of §2]

**§431:15-334 Distribution of assets.** (a) Subject to any instructions the court may give, the liquidator shall make distributions pursuant to section 431:15-332 in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court in advance of the distribution.

(b) The liquidator shall make distributions to guaranty funds or associations, or foreign guaranty funds or associations pursuant to the priority schedule of section 431:15-332 to satisfy their claims under article 16 or similar laws of other states, if the claims have been filed pursuant to section 431:15-325. The liquidator may protect against inequitable allocations by making payments to funds and associations subject to binding agreements by them to repay any portions of the distributions that are later found to be in excess of an equitable allocation. If assets are available, the liquidator may also lend to guaranty funds and associations, subject to express advance court approval.

(c) The liquidator shall report to the court within four months after the issuance of the liquidation order under section 431:15-307, and every three months thereafter on the status of the assets and the payment of distributions and loans under subsection (b). The court may order the liquidator to make distributions to guaranty funds and associations under subsection (b) more expeditiously to minimize the need for assessments under article 16 or similar laws of other states.

(d)(1) Upon liquidation of a domestic nonlife mutual insurance company, any assets held in excess of its liabilities and the amounts which may be paid to its members as provided under subsection (d)(2) shall be paid into the state compliance resolution fund.

(2) The maximum amount payable upon liquidation to any member for and on account of such member's membership in a domestic nonlife mutual insurance company, in addition to the insurance benefits promised in the policy, is the total of all premium payments made by the member within the past five years with interest at the legal rate compounded annually. [L 1987, c 347, pt of §2; am L 1999, c 163, §15(1); am L 2002, c 39, §15; am L 2004, c 122, §71]

**§431:15-335 Unclaimed and withheld funds.** (a) All unclaimed funds subject to distribution remaining in the liquidator's hands when the liquidator is ready to apply to the court for discharge, including the

amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the director of finance, and shall be paid without interest except in accordance with section 431:15-332 to the person entitled thereto or the person's legal representative upon proof satisfactory to the director of finance of the person's right thereto. Any amount on deposit not claimed within six years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the general fund.

(b) All funds withheld under section 431:15-327 and not distributed, shall upon discharge of the liquidator be deposited with the compliance resolution fund and paid by the liquidator in accordance with section 431:15-332. Any sums remaining that under section 431:15-332 would revert to the undistributed assets of the insurer shall be transferred to the compliance resolution fund and become the property of the State under subsection (a), unless the commissioner in the commissioner's discretion petitions the court to reopen the liquidation under section 431:15-337. [L 1987, c 347, pt of §2; am L 1999, c 163, §15; am L 2000, c 182, §14; am L 2002, c 39, §16]

**§431:15-336 Termination of proceedings.** (a) When all assets justifying the expense of collection and distribution have been collected and distributed under this article, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute as may be deemed appropriate.

(b) Any other person may apply to the court at any time for an order under subsection (a). If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee. [L 1987, c 347, pt of §2]

**§431:15-337 Reopening liquidation.** After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the circuit court of the first judicial circuit to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order. [L 1987, c 347, pt of §2]

**§431:15-338 Disposition of records during and after termination of liquidation.** Whenever it shall appear to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, the commissioner may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed. [L 1987, c 347, pt of §2]

## PART IV. INTERSTATE RELATIONS

**§431:15-401 Conservation of property of foreign or alien insurers found in this State.** (a) If a domiciliary liquidator has not been appointed, the commissioner may apply to the circuit court of the first judicial circuit by verified petition for an order directing the commissioner to act as conservator to conserve the property of an alien

insurer not domiciled in this State or a foreign insurer on any one or more of the following grounds:

(1) Any of the grounds in section 431:15-301;

(2) That any of its property has been sequestered by official action in its domiciliary state, or in any other state;

(3) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent; or

(4) That its certificate of authority to do business in this State has been revoked or that none was ever issued, and that there are residents of this State with outstanding claims or outstanding policies.

(b) When an order is sought under subsection (a), the court may require an appropriate notice to the insurer and a hearing and may issue the order in whatever terms it considers appropriate. The filing or recording of the order with the bureau of conveyances imparts the same notice as an evidence of title.

(c) The conservator may at any time petition for and the court may grant an order under section 431:15-402 to liquidate assets of a foreign or alien insurer under conservation, or if appropriate, for an order under section 431:15-404, to be appointed ancillary receiver.

(d) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs, including the reasonable attorney's fee of the conservator, shall be assessed against such party. [L 1987, c 347, pt of §2]

**§431:15-402 Liquidation of property of foreign or alien insurers found in this State.** (a) If no domiciliary receiver has been appointed, the commissioner may apply to the circuit court of the first judicial circuit by verified petition for an order directing the commissioner to liquidate the assets found in this State of a foreign insurer, or an alien insurer not domiciled in this State, on any of the following grounds:

(1) Any of the grounds in section 431:15-301 or section 431:15-306; or

(2) Any of the grounds specified in section 431:15-401(a)(2) through (a)(4).

(b) When an order is sought under subsection (a), the court may require an appropriate notice to the insurer and hearing. If it appears to the court that the best interests of creditors, policyholders, and the public so require, the court may issue an order to liquidate the insurer in whatever terms it considers appropriate. The filing or recording of the order with the bureau of conveyances imparts the same notice as an evidence of title.

(c) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 431:15-404. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission

to act as ancillary receiver under section 431:15-404.

(d) On the same grounds as specified in subsection (a), the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and creditors in this State.

(e) The court may order the commissioner, when the commissioner has liquidated assets of a foreign or alien insurer under this section, to pay claims of residents of this State against the insurer under such rules as to the liquidation of insurers under this article as are otherwise compatible with the provisions of this section. [L 1987, c 347, pt of §2]

**§431:15-403 Domiciliary liquidators in other states.** (a) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under section 431:15-404(c), be vested by operation of law with the title to all of the assets, property, contracts, and rights of action, producers' balances, and all of the books, accounts, and other records of the insurer located in this State. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from producers and to obtain possession of the books, accounts, and other records of the insurer located in this State. The domiciliary liquidator shall also have the right to recover all other assets of the insurer located in this State, subject to section 431:15-404.

(b) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this State shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books, accounts and other records of the insurer located in this State, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this State may petition for a conservation or liquidation order under section 431:15-401 or section 431:15-402, or for an ancillary receivership under section 431:15-404, or after approval by the circuit court of the first judicial circuit, may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(c) Claimants residing in this State may file claims with the liquidator or ancillary receiver, if any, in this State or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings. [L 1987, c 347, pt of §2; am L 2002, c 155, §88]

**§431:15-404 Ancillary formal proceedings.** (a) If a domiciliary liquidator has been appointed for an insurer not domiciled in this State, the commissioner may file a petition with the circuit court of the first judicial circuit requesting appointment as ancillary receiver in this State:

(1) If the commissioner finds that there are sufficient assets of the insurer located in this State to justify

the appointment of an ancillary receiver; or

(2) If the protection of creditors or policyholders in this State so requires.

(b) The court may issue an order appointing an ancillary receiver on whatever terms it considers appropriate. The filing or recording of the order with the bureau of conveyances imparts the same notice as evidence of title.

(c) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this State may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this State. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this State, and shall pay the necessary expenses of the proceedings. The ancillary receiver shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and the receiver's deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this State.

(d) When a domiciliary liquidator has been appointed in this State, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (c) for ancillary receivers appointed in this State. [L 1987, c 347, pt of §2]

**§431:15-405 Ancillary summary proceedings.** The commissioner, in the commissioner's sole discretion, may institute proceedings under section 431:15-201 through section 431:15-203 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this State. [L 1987, c 347, pt of §2]

**§431:15-406 Claims of nonresidents against insurers domiciled in this State.** (a) In a liquidation proceeding begun in this State against an insurer domiciled in this State, claimants residing in foreign countries or in states not reciprocal states must file claims in this State, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this State as provided in this article, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this State as provided in section 431:15-407(b) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under section 431:15-332. [L 1987, c 347, pt of §2]

**§431:15-407 Claims of residents against insurers domiciled in reciprocal states.** (a) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this State may file claims either with the ancillary receiver, if any, in this State, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in this State may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this State. If a claimant elects to prove a claim in this State, the claimant shall file a claim with the liquidator in the manner provided in section 431:15-325 and section 431:15-326. The ancillary receiver shall make a recommendation to the court as under section 431:15-333. The ancillary receiver shall also arrange a date for hearing if necessary under section 431:15-329 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of the domiciliary liquidator's intention to contest the claim, the domiciliary liquidator shall be entitled to appear or to be represented in any proceeding in this State involving the adjudication of the claim.

(c) The final allowance of the claim by the court of this State shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this State. [L 1987, c 347, pt of §2]

**§431:15-408 Attachment, garnishment and levy of execution.** During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this State against the delinquent insurer or its assets. [L 1987, c 347, pt of §2]

**§431:15-409 Interstate priorities.** (a) In a liquidation proceeding in this State involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this State and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where those assets are located.

(b) The owners of special deposit claims against an insurer, for which a liquidator is appointed in this State or any other state, shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit so that the claims secured by it are not fully discharged from it, the claimants may claim against a guaranty fund or association or may share in the general assets, but the claim shall be limited and the sharing shall be deferred until the general creditors having the same priority, and also the claimants against other special deposits sharing the same priority who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secured claim against an insurer for which a liquidator has been appointed in this State or any other state may surrender the security for the claim and file the claim as a general creditor, or the claim may be discharged by resort to the security in accordance with section 431:15-331, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. [L 1987, c 347, pt of §2]

**§431:15-410 Subordination of claims for noncooperation.** If an ancillary receiver in another state or foreign country, whether called an ancillary receiver or not, fails to transfer to the domiciliary liquidator in this State any assets within the ancillary receiver's control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, then the claims filed in the ancillary receivership, or with the guaranty fund or association in that jurisdiction, other than special deposit claims or secured claims, shall be placed in the class of claims under section 431:15-332(8). [L 1987, c 347, pt of §2; am L 2004, c 122, §72]

**§431:15-411 Separability.** If any provision of this article or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the article and the application of such provision to other persons or circumstances shall not be affected thereby. [L 1987, c 347, pt of §2]

## ARTICLE 16
## GUARANTY ASSOCIATIONS

### PART I. PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION

**§431:16-101 Title.** This part shall be known as the Hawaii Insurance Guaranty Association Act. [L 1987, c 347, pt of §2]

**§431:16-102 Purpose.** The purpose of this part is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and, to the extent provided in this part, to minimize financial loss to claimants or policyholders because of the insolvency of an insurer. [L 1987, c 347, pt of §2; am L 2000, c 93, §1]

**Case Notes**

Insurer which was never a member of insurance association, was not regulated by the insurance commissioner, nor subject to examination of its financial condition was not an authorized insurer. 70 H. 406, 772 P.2d 1193.

**§431:16-103 Scope.** This part shall apply to all types of direct insurance, but shall not apply to the following:

(1) Life, annuity, or accident and health or sickness insurance;

(2) Mortgage guaranty, financial guaranty, or any other forms of insurance offering protection against investment risks;

(3) Fidelity or surety bonds, or any other bonding obligations;

(4) Credit insurance, vendors' single interest insurance, collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

(5) Insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, for indemnification for the repair, replacement, or service for the operational or structural failure of the goods or property due to a defect in materials, artisanship, or normal wear and tear, or for reimbursement for the liability incurred by the issuer of agreements or service contracts that provide those benefits;

(6) Title insurance;

(7) Ocean marine insurance;

(8) Any transaction or combination of transactions between a person (including affiliates of the person) and an insurer (including affiliates of the insurer) that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

(9) Any insurance provided by or guaranteed by government. [L 1987, c 347, pt of §2; am L 2000, c 93, §2; am L 2002, c 155, §89; am L 2003, c 212, §111]

**§431:16-104 Construction.** This part shall be construed to effect the purpose under section 431:16-102 which will constitute an aid and guide to interpretation. [L 1987, c 347, pt of §2; am L 2000, c 93, §3]

**§431:16-105 Definitions.** As used in this part:

"Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.

"Association" means the Hawaii insurance guaranty association created under section 431:16-106.

"Claimant" means any insured making a first party claim or any person instituting a liability claim; provided that no person who is an affiliate of the insolvent insurer may be a claimant.

"Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten per cent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

"Covered claim":

(1) Means an unpaid claim, including one for unearned premiums, submitted by a claimant, that arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this part applies issued by an insurer, if the insurer becomes an insolvent insurer after July 1, 2000, and:

(A) The claimant or insured is a resident of this State at the

time of the insured event; provided that for entities other than an individual, the residence of a claimant, insured, or policyholder is the state in which its principal place of business is located at the time of the insured event; or

(B) The claim is a first party claim for damage to property with a permanent location in this State; and

(2) Shall not include:

(A) Any amount awarded as punitive or exemplary damages;

(B) Any amount sought as a return of premium under any retrospective rating plan;

(C) Any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise;

(D) Any first party claims by an insured whose net worth exceeds $25,000,000 on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis;

(E) Any first party claims by an insured who is an affiliate of the insolvent insurer;

(F) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(G) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(H) Any claims for interest; or

(I) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred but not reported losses.

"Insolvent insurer" means an insurer licensed to transact insurance in this State, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation has been entered after May 16, 2000 with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

"Insured" means any named insured, any additional insured, any vendor, any lessor, or any other party identified as an insured under the policy.

"Member insurer" means any person who:

(1) Writes any kind of insurance to which this part applies under section 431:16-103, including the exchange of reciprocal or inter-insurance contracts; and

(2) Is licensed to transact insurance in this State.

An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its certificate of authority to transact the kinds of insurance to which this part applies. However,

the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied either prior to or after the termination or expiration of its certificate of authority, even though the insurer became insolvent before the termination or expiration of its certificate of authority.

"Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this part applies, including policy and membership fees, less the following amounts:

(1) Return premiums;

(2) Premiums on policies not taken; and

(3) Dividends paid or credited to policyholders on such direct business.

Net direct written premiums shall not include premiums on contracts between insurers or reinsurers.

"Person" means any individual, corporation, partnership, association, or voluntary organization.

"Receiver" includes liquidator, rehabilitator, conservator, or ancillary receiver, as applicable.

"Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance. [L 1987, c 347, pt of §2; am L 2000, c 93, §4; am L 2012, c 250, §1]

**Revision Note**

"May 16, 2000" substituted for "the effective date of this Act".

**Case Notes**

In light of the legislature's silence on the meaning and means of valuing "net worth" under this section, "net worth" may be "book" or "balance sheet" net worth as governed by generally accepted accounting principles. 123 H. 135 (App.), 231 P.3d 60 (2010).

**§431:16-106 Creation of association.** There is created a nonprofit unincorporated legal entity to be known as the Hawaii insurance guaranty association. All insurers defined as member insurers in section 431:16-105 shall be and remain members of the association as a condition of their authority to transact the business of insurance in this State. The association shall perform its function under a plan of operation established and approved under section 431:16-109 and shall exercise its powers through a board of directors established under section 431:16-107. [L 1987, c 347, pt of §2; am L 2000, c 93, §5]

**§431:16-107 Board of directors.** (a) The board of directors of the association shall consist of not less than five nor more than nine persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the commissioner.

(b) In approving selections to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors. [L 1987, c 347, pt of §2; am L 2000, c 93, §6]

**§431:16-108 Powers and duties of the association.** (a) The association shall:

(1) Be obligated to the extent of the covered claims existing prior to the order of liquidation and arising within thirty days after the order of liquidation, or before the policy expiration date if less than thirty days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

(A) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;
(B) An amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium; or
(C) An amount not exceeding $300,000 per claim for all other covered claims.

In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the stated policy limit of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provisions of this part, a covered claim shall not include a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit;

(2) Be deemed the insurer, but only to the extent of its obligation on covered claims and to that extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association;

(3) Assess insurers amounts necessary to pay the obligations of the association under paragraph (1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under section 431:l6-113, and other expenses authorized by this part. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year an amount greater than two per cent of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the companies, credited against future assessments. Each member insurer may set off against any assessment payments authorized by the administrator of the association to be made on covered claims and expenses incurred in the payment of the claims by the member insurer;

(4) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases, and judgments may be properly contested. The association may appoint or substitute and direct legal counsel retained under liability insurance policies for the defense of covered claims;

(5) Notify the persons as the commissioner directs under section 431:16-ll0(b)(l);

(6) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer;

(7) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and pay the other expenses of the association authorized by this part; and

(8) Have the authority, notwithstanding sections 43l:10C-ll0 and 43l:10C-111, to cancel all policies issued by an insolvent insurer. Covered claims under these policies shall be paid by the association in an amount not to exceed the stated policy limit of the insolvent insurer under the policy from which the claim arises, or as provided under paragraph (1)(A) to (C), whichever is less.

(b) The association may:

(1) Employ or retain the persons as are necessary to handle claims and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this part in accord with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to the contracts as are necessary to carry out the purpose of this part; and

(5) Perform all other acts as are necessary or proper to effectuate the purpose of this part.

(c) Except for actions by the receiver, all actions relating to or arising out of this part against the association shall be brought in the courts in this State. The courts in this State shall have exclusive jurisdiction over all actions relating to or arising out of this part against the association.

The exclusive venue in any action by or against the association shall be the circuit court of the first judicial circuit of this State. The association, at its option, may waive this venue as to specific actions. [L 1987, c 347, pt of §2 as superseded by c 348, §20; am L 2000, c 93, §7; am L 2012, c 250, §2]

**§431:16-109 Plan of operation.**

(a)(1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner.

(2) If the association fails to submit a suitable plan of operation within ninety days following May 25, 1971, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner, after notice and hearing, shall adopt, pursuant to chapter 91, such rules as are necessary to

effectuate this part. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall:

(1) Establish the procedures whereby all the powers and duties of the association under section 431:16-108 shall be performed;

(2) Establish procedures for handling assets of the association;

(3) Establish procedures for the disposition of liquidating dividends or other moneys received from the estate of the insolvent insurer;

(4) Establish the amount and method of reimbursing members of the board of directors under section 431:16-107(c);

(5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of the claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator;

(6) Establish regular places and times for meetings of the board of directors;

(7) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty days after the action or decision;

(9) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner; and

(10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(d) The plan of operation may provide that any or all powers and duties of the association, except those under section 431:16-108(a)(3) and (b)(2), are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this part. [L 1987, c 347, pt of §2 as superseded by c 349, §12; am L 2000, c 93, §8]

**§431:16-110 Duties and powers of the commissioner.** (a) The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer not later than three days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction.

(2) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(b) The commissioner may:

(1) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this part. The notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(2) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. The fine shall not exceed five per cent of the unpaid assessment per month, except that no fine shall be less than $100 per month.

(3) Revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(c) Any final action or order of the commissioner under this part shall be subject to judicial review by the circuit court of the first judicial circuit. [L 1987, c 347, pt of §2; am L 2000, c 93, §9]

**§431:16-111 Effect of paid claims.** (a) Any person recovering under this part shall be deemed to have assigned the person's rights under the policy to the association to the extent of the person's recovery from the association. Every insured or claimant seeking the protection of this part shall cooperate with the association to the same extent as that person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except any causes of action that the insolvent insurer would have had if those sums had been paid by the insolvent insurer and except as provided in subsection (b). In the case of an insolvent insurer operating as an assessable mutual company on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator, or statutory successor for unpaid assessment.

(b) The association shall have the right to recover from the following persons the amount of any covered claim paid on behalf of such person pursuant to this part:

(1) Any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds fifty million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part; and

(2) Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part.

(c) The association and a similar organization in another state shall be recognized as claimants in the liquidation of an insolvent insurer for any amounts paid by them on covered claims as determined under this part or similar laws in other states and shall receive dividends and any other distributions at the priority set forth in section 431:15-332. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by determinations of covered claim eligibility under this part and by settlements of claims by the

association or a similar organization in another state to the extent the determinations or settlements satisfy obligations of the association. The receiver shall not be bound in any way by the determinations or settlements to the extent there remains a claim against the insolvent insurer. The court having jurisdiction shall grant such claims priority equal to that to which the claimant would have been entitled in the absence of this part against the assets of the insolvent insurer.

(d) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association, which shall preserve the rights of the association against the assets of the insolvent insurer. [L 1987, c 347, pt of §2; am L 2000, c 93, §10]

**§431:16-112 Exhaustion of other coverage.** (a) Any person having a claim against an insurer whether or not the insurer is a member insurer under any provision in an insurance policy other than a policy of an insolvent insurer that is also a covered claim, shall be required to exhaust first the person's rights under the policy. Any amount payable on a covered claim under this part shall be reduced by the amount of any recovery under the insurance policy. If there are any other policies issued by an insolvent insurer applicable to the covered claim, then all such policies shall be exhausted before any claim can be deemed a covered claim subject to being covered by the association.

(1) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with a person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the association.

(2) A claim under an insurance policy other than a life insurance policy shall include, but is not limited to:

(A) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation, or disability insurance policy; and
(B) Any amount payable by or on behalf of a self-insurer.

(3) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.

(b) Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if the claim is a first-party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. For a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this part shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent. [L 1987, c 347, pt of §2; am L 2000, c 93, §11; am L 2012, c 250, §3]

**§431:16-113 Prevention of insolvencies.** To aid in the detection and prevention of insurer insolvencies:

(1) The board of directors, upon majority vote, may make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency; and

(2) At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may prepare a report on the history and causes of the insolvency, based on the information available to the association, and submit the report to the commissioner. [L 1987, c 347, pt of §2; am L 2000, c 93, §12]

**§431:16-114 Tax exemption.** The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property. [L 1987, c 347, pt of §2]

**§431:16-115 Recoupment of assessment.** (a) Each member insurer shall annually recoup the assessments paid in the preceding years by the insurer under this part. The recoupment shall be recovered by means of a surcharge on premiums charged for policies for all kinds of insurance, except life, title, surety, accident and health or sickness, credit mortgage guaranty, and ocean marine. Prior to recoupment, each member insurer shall submit its plan for recoupment to the commissioner for approval. The surcharge shall be at a uniform percentage rate reasonably calculated to recoup the assessment paid by the member insurer. Any excess recovery by a member insurer shall be credited pro rata to that member insurer's policyholders' premiums in the succeeding year unless there has been a subsequent assessment, in which case the excess will be used to pay the amount of the subsequent assessment. If a member insurer fails to recoup the entire amount of its assessment in the first year under the procedure provided in this section, it may repeat the procedure in succeeding years until the full assessment is recouped.

(b) Each insurer shall provide to the Hawaii insurance guaranty association an accounting of its recoupments. The Hawaii insurance guaranty association shall compile the insurers' accountings and submit it as part of its annual report to the commissioner.

(c) The amount of and reason for any surcharge shall be separately stated on any billing sent an insured. The surcharge shall not be considered premiums for any other purpose, including the computation of gross premium tax or the determination of producer commissions. [L 1987, c 347, pt of §2; am L 1995, c 232, §18; am L 2002, c 155, §90; am L 2003, c 212, §112]

**§431:16-116 Immunity.** There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors, any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this part. [L 1987, c 347, pt of §2; am L 2000, c 93, §13]

**Case Notes**

Where plaintiff's alleged tortious breach of contract, emotional distress, and bad faith claims were based on actions of Hawaii insurance guaranty association, through its agents and employees, in addressing

plaintiff's claim for underinsured motorist benefits, claims barred by this section. 87 H. 14, 950 P.2d 1214.

**§431:16-117 Stay of proceedings.** (a) All proceedings in which the insolvent insurer is a party, or is obligated to defend a party in any court in this State, subject to waiver by the association in specific cases involving covered claims, shall be stayed for up to six months, and any additional time thereafter as may be determined by the court, from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action. As to any covered claims arising from a judgment or under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the association, either on its own behalf or on behalf of the insured, may apply to have such judgment, order, decision, verdict, or finding set aside by the same court, administrator, or other entity that made the judgment, order, decision, verdict, or finding and shall be permitted to defend the claim on the merits.

(b) The liquidator, receiver, or statutory successor of an insolvent insurer covered by this part shall permit access by the board of directors or its authorized representative to the insolvent insurer's claim records that are necessary for the board in carrying out its functions under this part with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board of directors or its representative with copies of those records upon the request by the board and at the expense of the board. [L 1987, c 347, pt of §2; am L 2000, c 93, §14; am L 2004, c 122, §73]

## PART II. LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

**§431:16-201 Title.** This part shall be known as the Hawaii Life and Disability Insurance Guaranty Association Act. [L 1987, c 347, pt of §2]

**§431:16-202 Purpose.** (a) The purpose of this part is to protect, subject to certain limitations, the persons specified in section 431:16-203 against failure in the performance of contractual obligations, under life and accident and health or sickness insurance policies and annuity contracts specified in section 431:16-203(b), because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(b) To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of this part. [L 1987, c 347, pt of §2; am L 2002, c 155, §91]

**§431:16-203 Coverage and limitations.** (a) This part shall provide coverage for the policies and contracts specified in subsection (b) to:

(1) Persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under paragraph (2);

(2) Persons who are owners of or certificate holders under such policies or contracts, except structured

settlement annuities, and who:

(A) Are residents of this State; or
(B) Are not residents; provided that:
(i) The insurer that issued the policies or contracts is domiciled in this State;
(ii) The state in which the persons reside has associations similar to the association created by this part; and
(iii) The persons are not eligible for coverage by an association in any other state because the insurer was not licensed in the state at the time specified in the state's guaranty association law;

(3) For structured settlement annuities specified in subsection (b), paragraphs (1) and (2) of this subsection shall not apply, and this part, except as provided in paragraphs (4) and (5) of this subsection, shall provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident of this State, regardless of where the contract owner resides; or
(B) Is not a resident; provided that:
(i) The contract owner of the structured settlement annuity is a resident and neither the payee, beneficiary, nor contract owner is eligible for coverage by the association in the state in which the payee or contract owner resides; or
(ii) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this State and the state in which the contract owner resides has an association similar to the association created by this part, and neither the payee, beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(4) This part shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this State, if the payee or beneficiary is afforded any coverage by the association of another state; and

(5) This part is intended to provide coverage to a person who is a resident of this State and, in certain circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person shall not be provided coverage under this part. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one association.

(b)(1) This part shall provide coverage to the persons specified in subsection (a) for direct, nongroup life, accident and health or sickness, or annuity policies or contracts, for certificates under direct group life, accident and health or sickness, or annuity policies or contracts, and for supplemental contracts to any of these, in each case issued by member insurers except as limited by this part. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(2) This part shall not provide coverage for:

(A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(B) Any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(C) Any portion of a policy or contract to the extent that the rate of interest on which it is based:

(i) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(ii) On or after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(D) Any portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, accident and health or sickness, or annuity benefits to its employees, members, or other persons to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(i) A Multiple Employer Welfare Arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(E) Any portion of a policy or contract to the extent that it provides dividends, experience rating credits, or voting rights, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract;

(F) Any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this State;

(G) Any portion of a policy or contract to the extent that the assessments required by this part with respect to the policy or contract are preempted or otherwise not permitted by federal or state law;

(H) Any obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders, or other documents that were issued by the insurer without

meeting applicable policy form filing or approval requirements;

(iii) Misrepresentations of or regarding policy benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages;

(I) Any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(J) Any unallocated annuity contract;

(K) Any portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this part. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under section 431:16-403(b)(2)(L), the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency and shall not be subject to forfeiture; or

(L) Any policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to part C or part D of subchapter XVIII, chapter 7, title 42 of the United States Code, commonly known as medicare part C and D, or any regulations adopted pursuant thereto.

(c) The benefits for which the association may become liable shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer, or

(2) With respect to any one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(B) In accident and health or sickness insurance benefits:

(i) $100,000 for coverages not defined as disability insurance or basic hospital, medical, and surgical insurance, or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(ii) $300,000 for disability insurance and $300,000 for long-term care insurance; or

(iii) $500,000 for basic hospital, medical, and surgical insurance or major medical insurance;

(C) $250,000 in the present value of annuity benefits,

including net cash surrender and net cash withdrawal values; or

(D) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

(d) In no event shall the association be obligated to cover more than:

(1) An aggregate of $300,000 in benefits with respect to any one life under subsection (c) except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under subsection (c)(2)(B), in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual; or

(2) $5,000,000 in benefits with respect to one owner or multiple non-group policies of life insurance, regardless of:

(A) The number of policies and contracts held by the owner;

(B) Whether the policy owner is an individual, firm, corporation, or other person; and

(C) Whether the persons insured are officers, managers, employees, or other persons.

(e) The limitations set forth in this section are limitations on the benefits for which the association is obligated before taking into account its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(f) In performing its obligations to provide coverage under section 431:16-208, the association shall not be required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract. [L 1987, c 347, pt of §2; am L 2002, c 155, §92; am L 2003, c 212, §113; am L 2012, c 250, §4]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

Section 431:16-403(b)(2)(L), referred to in subsection (b)(2)(K), does not exist.

**§431:16-204 Construction.** This part shall be liberally construed to effect the purpose under section 431:16-202 which shall constitute an aid and guide to interpretation. [L 1987, c 347, pt of §2]

**§431:16-205 Definitions.** As used in this part:

"Account" means any of the three accounts created under section 431:16-206(a).

"Association" means the Hawaii life and disability insurance guaranty association created under section 431:16-206.

"Authorized assessment" or "authorized" when used in the context of assessments means a resolution by the board of directors that has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount.

"Called assessment" or "called" when used in the context of assessments means a notice that has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice.

"Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 431:16-203.

"Covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided under section 431:16-203.

"Extra-contractual claims" shall include, but not be limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

"Impaired insurer" means a member insurer that after July 1, 1988, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Insolvent insurer" means a member insurer that after July 1, 1988, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Member insurer" means any insurer licensed or who holds a certificate of authority to transact in this State any kind of insurance for which coverage is provided under section 431:16-203, and includes any insurer whose license or certificate of authority in this State may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(1) A nonprofit hospital or medical service organization;

(2) A health maintenance organization;

(3) A fraternal benefit society;

(4) A mandatory state pooling plan;

(5) A mutual assessment company or any entity that operates on an assessment basis;

(6) An insurance exchange;

(7) An organization that has a certificate or license limited to the issuance of charitable gift annuities; or

(8) Any entity similar to any of the above.

"Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

"Owner", "policy owner", or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms "owner", "contract owner", and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

"Person" means any individual, corporation, limited liability

company, partnership, association, governmental body or entity, or voluntary organization.

"Premiums" means amounts and considerations received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. Premiums does not include any amounts or consideration received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 431:16-203(b) except that assessable premium shall not be reduced on accounts under section 431:16-203(b)(2)(C) relating to interest limitations and section 431:16-203(c)(2) relating to limitations with respect to any one life and any one contract holder. Premiums shall also not include:

(1) Premiums on an unallocated annuity contract; or

(2) Premiums in excess of $5,000,000, regardless of:

(A) The number of policies or contracts held by the owner, with respect to multiple non-group policies of life insurance owned by one owner;
(B) Whether the policy owner is an individual, firm, corporation, or other person; and
(C) Whether the persons insured are officers, managers, employees, or other persons.

"Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

"Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States who are:

(1) Residents of foreign countries; or

(2) Residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this part,

shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

"State" means a state, the District of Columbia, Puerto Rico, or a United States possession, territory, or protectorate.

"Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

"Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or life, health, or annuity contract.

"Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate. [L 1987, c 347, pt of §2; am L 2004, c 122, §74; am L 2012, c 250, §5]

**Note**

The 2012 amendment shall not apply to proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

**§431:16-206 Creation of the association.** (a) There is created a nonprofit legal entity to be known as the Hawaii life and disability insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under the plan of operation established and approved under section 431:16-210 and shall exercise its powers through a board of directors established under section 431:16-207. For purposes of administration and assessment the association shall maintain three accounts:

(1) The life insurance account;

(2) The accident and health or sickness insurance account; and

(3) The annuity account.

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association. [L 1987, c 347, pt of §2; am L 2002, c 155, §93; am L 2012, c 250, §6]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

**§431:16-207 Board of directors.** (a) The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services. [L 1987, c 347, pt of §2]

**§431:16-208 Powers and duties of the association.** (a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer;

(2) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate subsection (a)(1) and assure payment of the contractual obligations of the impaired insurer pending action under subsection (a)(1); or

(3) Loan money to the impaired insurer.

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion:

(1) (A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(C) Provide such moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

(A) With respect to life and accident and health or sickness insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred:

(i) With respect to group policies and contracts, not later than the earlier of the next renewal date under the policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies;

(ii) With respect to non-group policies, contracts, and annuities, not later than the earlier of the next renewal date (if any) under the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies or contracts.

(B) Make diligent efforts to provide all known insureds or annuitants (for non-group policies and contracts), or group policy owners with respect to group policies and contracts, thirty days notice of the termination of the benefits provided.

(C) With respect to non-group life and accident and health or sickness insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or

annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with subparagraph (D), if the insureds or annuitants had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

(D) (i) In providing the substitute coverage required under subparagraph (C), the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(ii) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(iii) The association may reinsure any alternative or reissued policy.

(E) (i) Alternative policies adopted by the association shall be subject to the approval of the domiciliary commissioner or the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner or by a court of competent jurisdiction.

(G) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(H) When proceeding under subsection (b)(2) with respect to any policy or contract carrying guaranteed minimum

interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 431:16-203(b)(2)(C).

(c) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this part with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this part.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

(e) The protection provided by this part shall not apply where any guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

(f) In carrying out its duties under subsection (b), the association may, subject to approval by a court in this State:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(2) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of any moratorium or moratorium charge imposed by the receivership court on the payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, except that the association may not defer the payment for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(g) If the association fails to act within a reasonable period of time as provided in subsection (b), the commissioner shall have the powers and duties of the association under this part with respect to the insolvent insurer.

(h) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(i) The association shall have standing to appear or intervene before any court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before

any court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(j)(1) Any person receiving benefits under this part shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this part, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this part upon such person.

(2) The subrogation rights of the association under this section shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this part.

(3) In addition to paragraphs (1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer, or owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts.

(4) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(k) The association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this part;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 431:16-209 and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this part; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this part;

(5) Take such legal action as may be necessary to avoid payment of improper claims or recover payment of improper claims;

(6) Exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or accident and health or sickness insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this part;

(7) Organize itself as a corporation or in other legal form permitted by the laws of the State;

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this part with respect to the person, and the person shall promptly comply with the request; and

(9) Take other necessary or appropriate action to discharge its duties and obligations under this part or to exercise its powers under this part.

(l) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(m) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that the contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association shall pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(n) The board of directors of the association shall have discretion and shall exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(o) Where the association has arranged or offered to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(p) Venue in a suit against the association arising under this part shall be in the circuit court of the first circuit. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

(q) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsection (a) or (b), the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms. [L 1987, c 347, pt of §2; am L 2002, c 155, §94; am L 2012, c 250, §7]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

**§431:16-209 Assessments.** (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at eighteen per cent per annum on and after the due date.

(b) There shall be two assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs, and other expenses and examinations conducted under the authority of section 431:16-212(e). Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 431:16-208 with regard to an impaired or an insolvent insurer.

(c)(1) The amount of any Class A assessment shall be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board of directors may provide that it be credited against future Class B assessments. A non-pro rata assessment shall not exceed $300 per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to the premiums received on business in this State for the calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this part. Classification of assessments under subsection (b) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused the deferral have been removed or rectified, the member shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e)(1) Subject to the provisions of paragraph (2), the total of all assessments authorized by the association with respect to a member insurer for each account shall not in any one calendar year exceed two per cent of the insurer's average premiums received in this State on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(2) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in this section shall be equal and limited to the higher of the

three-year average annual premiums for the applicable account as calculated pursuant to this section.

(3) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this part.

The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses and claims.

(g) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(h) The association shall issue to each insurer paying an assessment under this part, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(i)(1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest, unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of the final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal the final decision to the commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(j) The association may request information of member insurers to aid in the exercise of its powers under this section and member insurers shall promptly comply with any request. [L 1987, c 347, pt of §2; am L

2012, c 250, §8]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

## §431:16-210 Plan of operation.

(a)(1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or if the commissioner has not disapproved it within thirty days.

(2) If the association fails to submit a suitable plan of operation within one hundred twenty days following July 1, 1988, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this part. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under section 431:16-207(c);

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(6) Establish any additional procedures for assessments under section 431:16-209;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(8) Establish procedures to remove a director for cause, including the case in which a director is affiliated with a member insurer that becomes an impaired or insolvent insurer; and

(9) Require the board of directors to establish a policy and procedure for addressing conflicts of interests.

(d) The plan of operation may provide that any or all powers and duties of the association, except those under sections 431:16-208(k)(3) and 431:16-209, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its

performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this part. [L 1987, c 347, pt of §2; am L 2012, c 250, §9]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

**Revision Note**

"July 1, 1988," substituted for "the effective date of this part".

**§431:16-211 Duties and powers of the commissioner.** [(a)] In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this part;

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five per cent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the final action being appealed. If a member insurer is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Any final action or order of the commissioner shall be subject to judicial review in the circuit court of the first judicial circuit.

(d) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this part. [L 1987, c 347, pt of §2; am L 2004, c 122, §75]

**§431:16-212 Prevention of insolvencies.** (a) To aid in the detection and prevention of insurer insolvencies or impairments, it shall

be the duty of the commissioner:

(1) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:

(A) Revocation of license;
(B) Suspension of license; or
(C) Makes any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

The notice shall be mailed to all commissioners within thirty days following the action taken or the date on which the action occurs;

(2) To report to the board of directors when the commissioner has taken any of the actions set forth in paragraph (1) or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner;

(3) To report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer; and

(4) To furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member companies and companies seeking admission to transact insurance business in this State.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this State. The reports and recommendations shall not be considered public documents.

(d) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired insurer or insolvent insurer.

(e) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the commissioner shall begin the examination. The examination may be conducted as a National Association of Insurance Commissioners' examination or may be conducted by such persons as the commissioner designates. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not excuse the commissioner from

complying with subsection (a). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(g) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the board of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations. [L 1987, c 347, pt of §2; gen ch 1993; am L 2004, c 122, §76; am L 2012, c 250, §10]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

**§431:16-213 Credits for assessments paid.** (a) A member insurer may offset against its premium tax liability (or liabilities) to this State an assessment described in section 431:16-209(h) to the extent of twenty per cent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability (or liabilities) for the year it ceases doing business.

(b) Any sums which are acquired by refund, pursuant to section 431:16-209(f), from the association by member insurers, and which have theretofore been offset against premium taxes as provided in subsection (a) shall be paid by the association to the commissioner and by the commissioner deposited with the state director of finance for credit to the general fund of this State. [L 1987, c 347, pt of §2]

**§431:16-214 Miscellaneous provisions.** (a) Nothing in this part shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 431:16-208. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except:

(1) Upon the termination of the impairment or insolvency of the insurer; or

(2) Upon the order of a court of competent jurisdiction.

Nothing in this subsection shall limit the duty of the association to

render a report of its activities under section 431:2-304(b).

(c) For the purpose of carrying out its obligations under this part, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 431:16-208(j). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this part. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in subsection (c) and consistent with section 431:15-324, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this part. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(e)(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 431:16-208 with respect to such insurer have been fully recovered by the association.

(f)(1) If an order for liquidation or rehabilitation of an insurer domiciled in this State has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) to (4).

(2) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, shall be liable up to the amount of distributions the person would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under paragraph (3) is insolvent, all its affiliates that controlled it at the time the

distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate. [L 1987, c 347, pt of §2; am L 1989, c 195, §39; am L 2012, c 250, §11]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

**§431:16-215 Tax exemptions.** The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real property. [L 1987, c 347, pt of §2]

**§431:16-216 Immunity.** There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this part. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees. [L 1987, c 347, pt of §2]

**§431:16-217 Stay of proceedings; reopening default judgments.** All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed one-hundred eighty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits. [L 1987, c 347, pt of §2; am L 2012, c 250, §12]

**Note**

The 2012 amendment shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

**§431:16-218 Prohibited advertisement of association act in insurance sales; notice to policyholders.** (a) No person, including an insurer, and a producer or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses

the existence of the Hawaii life and disability insurance guaranty association of this State for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Hawaii Life and Disability Insurance Guaranty Association Act. This section shall not apply to the Hawaii life and disability insurance guaranty association or any other entity which does not sell or solicit insurance.

(b) Within one hundred eighty days of July 1, 1988, the association shall prepare a summary document describing the general purposes and current limitations of this part and complying with subsection (c). This document shall be submitted to the commissioner for approval. Sixty days after receiving such approval, no insurer may deliver a policy or contract described in section 431:16-203 to a policyholder or contract holder unless the document is delivered to the policyholder or contract holder at the time of delivery of the policy or contract except if subsection (d) applies. The document should also be available upon request by a policyholder. The distribution, delivery or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to this part may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this part.

(c) The document prepared under subsection (b) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the Hawaii life and disability insurance guaranty association and the insurance division;

(2) Prominently warn the policy or contract holder that the Hawaii life and disability insurance guaranty association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and be conditioned on continued residence in this State;

(3) State that the insurer and its producers are prohibited by law from using the existence of the Hawaii life and disability insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(4) Emphasize that the policy or contract holder should not rely on coverage under the Hawaii life and disability insurance guaranty association when selecting an insurer; and

(5) Provide other information as directed by the commissioner.

(d) No insurer or producer may deliver a policy or contract described in section 431:16-203(b)(1) and excluded under section 431:16-203(b)(2)(A) from coverage under this part unless the insurer or producer, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Hawaii life and disability insurance guaranty association. The commissioner shall by rule specify the form and content of the notice. [L 1987, c 347, pt of §2; am L 1990, c 170, §1; am L 2002, c 155, §95; am L 2003, c 212, §114]

**§431:16-219 REPEALED.** L 2012, c 250, §13.

**Note**

The 2012 repeal of this section shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012. L 2012, c 250, §15.

## ARTICLE 17
## INSURANCE INFORMATION PROTECTION ACT--REPEALED

**§§431:17-101 to 106 REPEALED.** L 1993, c 339, §8.

## ARTICLE 18
## [RESERVED]

## ARTICLE 19
## CAPTIVE INSURANCE COMPANIES

### PART I. GENERAL PROVISIONS

**Note**

Part I designation added by L 2008, c 190, §2.

**§431:19-101 Definitions.** As used in this article:

"Administrator" means the captive insurance administrator established in section 431:19-101.5.

"Affiliated entity" means any company, person, or other entity in the same corporate system as a parent or a member organization by virtue of common ownership, control, operation, or management.

"Association" means two or more members who are engaged in business or activities similar or related to the liability to which these members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations; provided that the members of the association shall be individuals, corporations, limited liability companies, partnerships, associations, or other entities, except labor organizations, the member organizations of which or which does itself, whether or not in conjunction with some or all of the member organizations:

(1) Own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer;

(2) Have complete voting control over an association captive insurance company incorporated as a mutual insurer;

(3) Constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer; or

(4) Have complete voting control over an association captive insurance company formed as a limited liability company.

"Association captive insurance company" means a captive insurance company that insures risks of the member organizations of the association, and that may insure the risks of affiliated entities of the member organizations and the risks of the association itself.

"Branch captive insurance company" means an outside captive insurance company licensed under this article by the commissioner to transact the business of insurance in this State through a business unit that has its principal place of business in this State.

"Captive insurance company" or "captive insurer" means a class 1 company, class 2 company, class 3 company, class 4 company, or class 5 company formed or authorized under this article.

"Class 1 company" means a pure captive insurance company that is designated and licensed in this State to write business only as a reinsurer.

"Class 2 company" means a pure captive insurance company that is designated and licensed in this State to write business as a direct insurer or as a direct insurer and reinsurer.

"Class 3 company" means an association captive insurance company or risk retention captive insurance company that is designated and licensed in this State.

"Class 4 company" means a sponsored captive insurance company that is designated and licensed in this State.

"Class 5 company" means a reinsurance or excess insurance company that is a captive insurance company designated and licensed in this State pursuant to section 431:19-111.5.

"Controlled unaffiliated business" means, in the case of a pure captive insurance company, any person:

(1) That is not in the corporate system of a parent and its affiliated entities;

(2) That has an existing contractual relationship with a parent or one of its affiliated entities; and

(3) Whose risks are managed by the pure captive insurance company.

"Governing body" means the board of directors, subscriber's advisory committee, membership, or other entity responsible for the governance of a captive insurance company.

"Leased capital facility". DELETED.

"Member organization" means any individual, corporation, limited liability company, partnership, association, or other entity that belongs to an association.

"Organizational document" means a captive insurance company's articles of association, articles of incorporation, articles of organization, subscribers' agreement, bylaws, operating agreement, or any other document that establishes the captive insurance company as a legal entity or prescribes its existence.

"Outside captive insurance company" means an insurance company licensed under the laws of a jurisdiction other than this State and not otherwise admitted to do business as an insurance company in this State, that insures the risks of its parent or any affiliated entities.

"Parent" means a corporation, limited liability company, partnership, other entity, or individual, that directly or indirectly owns, controls, or holds with power to vote more than fifty per cent of the outstanding voting interests of a pure captive insurance company organized as a stock corporation, nonprofit corporation, or limited liability company.

"Participant" means an entity that meets the requirements of section 431:19-305, and any affiliated entities thereof that are insured by a sponsored captive insurance company where the losses of the participant may be limited through a participant contract to the participant's pro rata share of the assets of one or more protected cells identified in the participant contract.

"Participant contract" means a contract by which a sponsored captive insurance company insures the risks of a participant and may also limit the losses of each participant to its pro rata share of the assets of one or more protected cells identified in such participant contract.

"Protected cell" means a separate account established by a sponsored captive insurance company formed or licensed under this article in which assets are maintained for one or more participants in accordance with the terms of one or more participant contracts to fund the liability of the sponsored captive insurance company assumed on behalf of the participants as set forth in the participant contracts.

"Pure captive insurance company" means a captive insurance company that only insures or reinsures risks of its parent and affiliated entities or of a controlled unaffiliated business. "Pure nonprofit captive insurance company" means a pure captive insurance company formed without capital stock as a nonprofit corporation under chapter 414D, whose voting of membership interest is held by a parent organization formed under a nonprofit law or by such nonprofit parent and its affiliated entities.

"Risk retention captive insurance company" means a captive insurance company that is formed as a "risk retention group" as defined in chapter 431K.

"Sponsor" means any entity that meets the requirements of section 431:19-304 and is approved by the commissioner to provide all or part of the minimum required capital and surplus of a sponsored captive insurance company and to organize and operate a sponsored captive insurance company.

"Sponsored captive insurance company" means a captive insurance company:

(1) In which the minimum required capital and surplus is provided by one or more sponsors;

(2) That is formed or licensed under this article;

(3) That insures the risks only of its participants through separate participant contracts; and

(4) That may fund its liability to each participant through one or more protected cells. A sponsored captive insurance company segregates the assets of each protected cell from the assets of other protected cells and from the assets of the sponsored captive insurance company's general account. [L 1987, c 347, pt of §2; am L 1988, c 187, §8; am L 1989, c 207, §15; am L 1992, c 108, §2; am L 1996, c 248, §1; am L 1998, c 150, §2; am L 1999, c 302, §2; am L 2000, c 36, §2 and c 133, §1; am L 2001, c 194, §3; am L 2002, c 40, §71; am L 2003, c 209, §1; am L 2005, c 31, §1; am L 2007, c 232, §1; am L 2008, c 190, §3; am L 2012, c 253, §2; am L 2014, c 186, §9]

**§431:19-101.2 Confidential treatment.** (a) Except as otherwise provided in this section, all nonpublic information in a captive insurance company's application for licensure, its business plan, or of its parent or the parent's member organizations, and all other nonpublic information disclosed to the commissioner pursuant to this article, shall be given confidential treatment and shall not be made public by the commissioner.

(b) If the commissioner determines that the interest of the policyholders, shareholders, or the public will be served by making the information public, then after giving the captive insurance company and its parent or the parent's member organizations that would be affected thereby, three days written notice of intent, and unless otherwise

contrary to law, the commissioner may make public all or any part of the nonpublic information in a manner that the commissioner deems appropriate; provided that the commissioner may disclose nonpublic information to courts of competent jurisdiction, and insurance departments or regulatory agencies of other competent jurisdictions without prior notification to the person to whom the information pertains.

(c) This section shall not apply to risk retention captive insurance companies. The confidentiality provisions of section 431:2-209 shall apply to risk retention captive insurance companies.

(d) For purposes of this section:

"Equity securities" means:

(1) A share in a corporation, whether or not transferable or denominated a "stock", or similar security evidencing an ownership interest in the person;

(2) The interest of a limited partner in a limited partnership;

(3) The interest of a partner in a partnership, including a joint venture; or

(4) A warrant or right, other than a right to convert, to purchase, sell, or subscribe to a share, security, or interest of a kind specified in paragraph (1), (2), or (3).

"Nonpublic information" means information that, prior to disclosure to the commissioner pursuant to this article is, or was:

(1) Not a public record as defined in rule 1001(5) of section 626-1; or

(2) Not a government record that must be disclosed under section 92F-12;

provided that in the case of a person whose equity securities are collectively owned and held by thirty-six or more persons, "nonpublic information" does not include financial information disclosed to owners and holders of equity securities. [L 2000, c 67, §1; am L 2002, c 157, §1; am L 2012, c 253, §3]

**§431:19-101.3 REPEALED.** L 2012, c 253, §23.

**[§431:19-101.4] Service providers.** The commissioner shall have the authority to approve service providers to captive insurance companies licensed under this article, including but not limited to captive insurance managers, independent certified public accountants, actuaries, and loss reserve specialists. [L 1998, c 150, §1]

**§431:19-101.5 Captive insurance administrator.** There shall be established within the insurance division a captive insurance administrator, who shall be solely responsible for assisting the commissioner in monitoring, regulating, and developing captive insurance companies under this article. The commissioner, with the approval of the director of commerce and consumer affairs, shall appoint the administrator who shall be designated as a deputy commissioner and shall be exempt from chapter 76, notwithstanding section 431:2-105(b) to the contrary. The administrator shall serve at the pleasure of the director of commerce and consumer affairs and shall report directly to the

commissioner. [L 1997, c 261, pt of §2; am L 2000, c 253, §150; am L 2003, c 205, §1; am L 2007, c 232, §2; am L 2012, c 253, §4]

**[§431:19-101.6] Salary.** The salary of the administrator shall be set by the director of commerce and consumer affairs, but shall not be more than ninety-five per cent of the maximum salary of the commissioner. [L 1997, c 261, pt of §2]

**[§431:19-101.7] General powers and duties.** The administrator shall:

(1) Have the authority expressly conferred upon the administrator by, or reasonably implied from, the provisions of this article; and

(2) Assist the commissioner in the enforcement of this article and rules adopted pursuant to this article and related to captive insurance. [L 1997, c 261, pt of §2]

**§431:19-101.8 Captive insurance administrative fund.** (a) The commissioner may establish a separate fund designated as the captive insurance administrative fund to be expended by the commissioner to carry out the commissioner's duties and obligations under this article.

(b) All moneys collected pursuant to this article, including premium taxes from captive insurance companies licensed in this State under this article, all captive insurance company application fees, annual license fees, and examination fees, shall be credited to the captive insurance administrative fund.

(c) Up to ten per cent of the total moneys credited to the fund in the prior fiscal year may be used for purposes of promoting Hawaii as a captive insurance domicile. Disbursements for promotional activities from the fund shall be subject to the approval of the director of commerce and consumer affairs.

(d) Sums from the fund expended by the commissioner shall be used to defray any administrative costs, including personnel costs associated with the captive programs of the insurance division, and costs incurred by supporting offices, branches, divisions, and departments. Notwithstanding any law to the contrary, the commissioner may use the moneys in the fund to employ or retain, by contract or otherwise and without regard to chapter 76, hearings officers, attorneys, investigators, accountants, examiners, and other necessary professional, technical, and support personnel to implement and carry out the purposes of this article; provided that any position, except any attorney position, that is subject to chapter 76 prior to July 1, 1999, shall remain subject to chapter 76.

(e) Moneys deposited by the commissioner in the fund shall not revert to the general fund. [L 1997, c 261, pt of §2; am L 1999, c 163, §12; am L 2000, c 131, §1; am L 2002, c 39, §17 and c 206, §1; am L Sp 2005, c 1, §2; am L 2012, c 253, §5]

**§431:19-102 Certificate of authority.** (a) When permitted by an applicant captive insurance company's organizational documents, the applicant captive insurance company may apply to the commissioner for a

certificate of authority to do any and all insurance set forth in subsection (h); provided that:

(1) No pure captive insurance company may insure or reinsure any risks other than those of its parent, affiliated entities, and controlled unaffiliated businesses, which shall be approved on a case by case basis;

(2) No association captive insurance company may insure any risks other than those of its association, those of the member organizations of its association, and those of a member organization's affiliated entities;

(3) Unless otherwise allowed under section 431:19-102.2, no captive insurance company may provide personal motor vehicle or homeowner's insurance coverage or any component thereof, other than as:

(A) Employee benefits for the employees of a parent, association, or its members, and their respective affiliated entities; or
(B) Reinsurance as may be allowed under this article; and

(4) No captive insurance company may accept or cede insurance except as provided in section 431:19-111.

(b) No captive insurance company shall do any insurance business in this State unless:

(1) It first obtains from the commissioner a certificate of authority authorizing it to do insurance business in this State;

(2) Its governing body holds at least one meeting each year in this State;

(3) It maintains its principal place of business and registered office in this State, except that a branch captive insurance company need only maintain the principal place of a business unit in this State; and

(4) It designates a registered resident agent in accordance with chapter 414, 414D, or 428, as applicable, to accept service of process and to otherwise act on its behalf in this State. Whenever the registered resident agent cannot, with reasonable diligence, be found at the registered office of the captive insurance company, the commissioner shall be an agent of the captive insurance company upon whom any process, notice, or demand may be served in accordance with section 431:2-206.

(c) Before an applicant captive insurance company receives a certificate of authority, the applicant captive insurance company shall file with the commissioner:

(1) A certified copy of its organizational documents;

(2) A statement under oath of:

(A) Any two of its principal officers;
(B) Its attorney-in-fact in the case of a captive insurance company formed as a reciprocal insurer; or
(C) The duly authorized representative of its governing body,

showing its financial condition; and

(3) Any other statements or documents required by the commissioner.

(d) In addition to the information required by subsection (c), each applicant captive insurance company shall file with the commissioner evidence of the following:

(1) The amount and liquidity of its assets relative to the risks to be assumed;

(2) The adequacy of the expertise, experience, and character of the person or persons who will manage it;

(3) The overall soundness of its plan of operation, including the net retained risk on any one subject of insurance;

(4) The adequacy of the loss prevention programs of its parent or member organizations as applicable; and

(5) Any other factors deemed relevant by the commissioner in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations.

(e) Each applicant captive insurance company shall pay to the commissioner a nonrefundable application fee for examining, investigating, and processing its application for the certificate of authority. Upon approval of the application for the certificate of authority, the applicant captive insurance company shall pay to the commissioner a license fee for the certificate of authority. Thereafter, the captive insurance company shall pay to the commissioner an annual renewal fee. The amount of the nonrefundable application fee, license fee, and renewal fee shall be set forth in rules adopted by the commissioner. In addition, the commissioner may adopt rules with respect to fees for the issuance of other documents as may be deemed necessary or requested by captive insurance companies.

(f) The commissioner may use independent advisors and consultants to assist in the review and analysis of a specific application or business plan amendment. The independent advisory and consulting fee, to be paid by the applicant captive insurance company, shall be a reasonable fee authorized by the commissioner pursuant to section 431:19-114.

(g) If the commissioner is satisfied that the documents and statements filed by the captive insurance company comply with this article, the commissioner may issue a certificate of authority authorizing it to do insurance business in this State until April 1 thereafter, which certificate of authority may be renewed.

(h) A captive insurance company may engage in the business of any of the following types of insurance:

(1) All casualty insurance;

(2) Marine and transportation insurance;

(3) Marine protection and indemnity insurance, which includes insurance against, or against legal liability of the insured for loss, damage, or expense arising out of or incident to, the ownership, operation, chartering, maintenance, use, repair, or construction of a vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, death, or for loss of or damage to the property of another person;

(4) Wet marine and transportation insurance, which is that part of marine and transportation insurance that includes only:

(A) Insurance upon vessels, crafts, hulls, and of interests therein or with relation thereto;
(B) Insurance of marine builder's risks, marine war risks and contracts, or marine protection and indemnity insurance;
(C) Insurance of freights and disbursements pertaining to a subject of insurance; and
(D) Insurance of personal property and interests therein, in the course of exportation from or importation into any country, and in the course of transportation coastwise or

on inland waters, including transportation by land, water, or air from point of origin to final destination, with respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit, or transportation, and while being prepared for and while awaiting shipment, and during delays, storage, transshipment, or reshipment incident thereto;

(5) Property insurance;

(6) Surety insurance;

(7) Title insurance;

(8) Credit life insurance and credit disability insurance offered as part of, or relating directly to the business or operations of its parent or affiliated entities; and

(9) Other lines of insurance that the commissioner may allow.

(i) No risk retention captive insurance company may insure any risks other than those allowed under chapter 431K. [L 1987, c 347, pt of §2; am L 1988, c 187, §9; am L 1989, c 195, §40; am L 1990, c 254, §1; am L 1997, c 16, §2; am L 1998, c 150, §3; am L 1999, c 174, §1; am L 2000, c 133, §2; am L 2003, c 209, §2; am L 2004, c 122, §77; am L 2005, c 31, §3; am L 2007, c 232, §3; am L 2012, c 253, §6]

**§431:19-102.2 Personal lines insurance.** (a) A captive insurance company may be licensed to provide personal lines coverage for unrelated risks if the commissioner deems that extraordinary circumstances exist whereby coverage would be appropriate and in the best interest of the public. In determining whether extraordinary circumstances exist, the commissioner shall consider the following factors:

(1) The extent to which the particular coverage is available in the voluntary market;

(2) The existence of a relationship between the parent of the captive insurance company and the proposed policyholders other than that of insurer to insured;

(3) Whether the captive insurance company has sufficient capitalization to insure the proposed risks; and

(4) Any other factors that the commissioner deems appropriate.

(b) Any captive insurance company formed pursuant to this section shall be subject to articles 5, 10, 10A, 10B, 10C, 10D, 10E, 10F, 10G, 12, and 15 of this chapter in addition to all other applicable law. [L 1993, c 339, §4; am L 2005, c 22, §28; am L 2012, c 253, §7]

**§431:19-102.3 Redomestication; approval as a domestic captive insurer.** (a) Any foreign or alien captive insurance company may become a domestic captive insurance company by meeting the following requirements:

(1) Complying with all of the requirements relating to the organization and licensing of a domestic captive insurance company of the same type, and any requirements that the commissioner may adopt by rule;

(2) Amending and restating its organizational documents in compliance with the laws of this State, and submitting the amended and restated organizational documents for the commissioner's review; and

(3) Petitioning the commissioner to issue a certificate of general good, which sets forth the commissioner's finding that the redomestication and maintenance of the company will promote the general good of the State. In arriving at the finding, the commissioner shall consider the factors set forth in section 431:19-106(b). The petition shall include a nonrefundable application fee.

(b) Upon issuance of the certificate of general good by the commissioner pursuant to subsection (a)(3), the foreign or alien captive insurance company shall file the following with the department of commerce and consumer affairs:

(1) Articles of redomestication, which shall include:

(A) Name of the company;
(B) Date and location of incorporation or organization;
(C) Street address of the principal office in this State;
(D) Names and titles of the:
(i) Officers and directors of the company; or
(ii) Members of the governing body;
(E) A statement that the company is moving its domicile to this State;
(F) A statement that redomestication will occur upon filing the articles of redomestication and that the company shall be subject to the laws of this State; and
(G) A statement that copies of the articles of incorporation or other organizational document and any amendments certified by the proper officer of the jurisdiction under the laws of which the company is incorporated or organized are attached; provided that if any of these documents are in a foreign language, a translation under oath of the translator shall accompany these documents;

(2) Certificate of general good issued pursuant to subsection (a)(3);

(3) Certificate of good standing or comparable documentation certified by the proper officer of the jurisdiction under which the foreign or alien captive insurance company is incorporated or organized; provided that:

(A) The certificate or documentation shall be dated not earlier than thirty days prior to the date of the certificate of general good; and
(B) If the certificate of good standing or documentation is in a foreign language, a translation under oath of the translator shall accompany the certificate or documentation; and

(4) The company's organizational documents, which shall be amended and restated in compliance with the laws of this State.

(c) Upon payment of the license fee and annual renewal fees, the domestic captive insurance company shall be entitled to the necessary or appropriate certificates and licenses to do business in this State and shall be subject to the authority and jurisdiction of this State. No captive insurance company redomesticating into this State need merge, consolidate, transfer assets, or otherwise engage in any other reorganization, other than as specified in this section.

(d) Upon redomestication in accordance with this section, the foreign or alien captive insurance company shall become a domestic captive insurance company organized under the laws of this State and shall have all the rights, privileges, immunities, and powers and be subject to all applicable laws, duties, and liabilities of a domestic captive insurance company of the same type. The domestic captive insurance company shall possess all rights that it had prior to the redomestication to the extent permitted by the laws of this State and shall be responsible and liable for all the liabilities and obligations that it was subject to prior to the redomestication. All outstanding policies of the captive insurance company shall remain in full force and effect. [L 1993, c 205, pt of §1; am L 1994, c 128, §7; am L 2007, c 232, §4; am L 2012, c 253, §8; am L 2013, c 190, §4]

**§431:19-102.4 Redomestication; conversion to foreign insurer.** (a) Any domestic captive insurance company, upon approval by the commissioner, may transfer its domicile to any other jurisdiction in accordance with the laws of that jurisdiction.

(b) Before transferring its domicile to any other jurisdiction and before the notice of change in domicile is transmitted to the department of commerce and consumer affairs, the domestic captive insurance company shall submit a written request to the commissioner to redomesticate to another jurisdiction and a transfer fee of $300.

(c) Upon approval of the written request to redomesticate pursuant to subsection (b), the commissioner shall issue a certificate of transfer. The domestic captive insurance company shall submit the certificate of transfer, a notice of change of domicile, and the filing fee to the department of commerce and consumer affairs. The notice of change in domicile shall set forth the following:

(1) Name of the company;

(2) Dates that notice of the company's intent to transfer domicile from this State was published pursuant to the publication requirements of section 1-28.5;

(3) Date of the transfer of its domicile; and

(4) Jurisdiction to which its domicile will be transferred.

(d) Upon meeting the requirements of subsection (c) and upon the issuance of a certificate of discontinuance by the department of commerce and consumer affairs, the captive insurance company shall cease to be domiciled in this State, and its corporate or other legal existence in this State shall cease. The captive insurance company shall pay a certificate fee at the time that the certificate of discontinuance is issued in accordance with chapter 414. [L 1993, c 205, pt of §1; am L 1994, c 128, §8; am L 2002, c 40, §72; am L 2007, c 232, §5; am L 2012, c 253, §9]

**§431:19-102.5 REPEALED.** L 2000, c 67, §3.

**§431:19-103 Names of companies.** No captive insurance company shall adopt a name that is the same, deceptively similar, or likely to be

confused with or mistaken for any other existing business name registered in the State, except that the commissioner may allow a branch captive insurance company to be licensed in this State under a different trade name if the normal name of the branch captive insurance company is not available for use in this State. [L 1987, c 347, pt of §2; am L 2000, c 133, §3]

**§431:19-104 Minimum capital and surplus.** (a) Each captive insurance company licensed pursuant to this article shall possess and thereafter maintain unimpaired capital and surplus in the amount established by the commissioner; provided that:

(1) The commissioner shall take into account the nature and volume of business transacted by each captive insurance company, and any other factors deemed appropriate by the commissioner;

(2) Class 3 companies shall be subject to other applicable provisions of this chapter that may require capital and surplus in excess of those established by the commissioner; and

(3) Minimum capital and surplus established by the commissioner shall be no less than the following amounts:

(A) Class 1 company: $100,000;
(B) Class 2 company: $250,000;
(C) Class 3 company: $500,000;
(D) Class 4 company: $500,000; and
(E) Class 5 company: An amount as determined by the commissioner on a case by case basis.

(b) Minimum required capital and surplus established by the commissioner pursuant to subsection (a) shall be in any one or combination of the following forms: cash, irrevocable letter of credit issued by a bank chartered by this State or a member bank of the Federal Reserve System, public obligations as defined in section 431:6-301, or other form approved by the commissioner; provided that minimum required capital and surplus in excess of the amounts listed in subsection (a)(3) shall be allowed to be invested in accordance with a strategic investment policy adopted and monitored by the captive insurance company's governing body, and approved by the commissioner.

(c) In the case of a branch captive insurance company, and in lieu of minimum capital and surplus under this section, the commissioner shall determine the amount and form of security to be maintained by the branch captive insurance company in this State after taking into consideration:

(1) The amount and nature of risk written through and retained by the branch captive insurance company in this State;

(2) The financial condition of the outside captive insurance company whose branch office is located in this State;

(3) Trusts or other security posted for ceding insurers; and

(4) Any other factors the commissioner deems appropriate.

The security required by the commissioner may be in the form of cash, an irrevocable letter of credit issued by a bank chartered in this State or a member bank of the Federal Reserve System, a trust, public obligations as defined in section 431:6-301, or any other forms of security deemed appropriate by the commissioner. [L 1987, c 347, pt of §2; am L 1998, c

150, §4; am L 1999, c 302, §3; am L 2000, c 36, §4 and c 133, §4; am L 2003, c 209, §3; am L 2007, c 232, §6; am L 2008, c 190, §5; am L 2012, c 253, §10]

**§431:19-105 REPEALED.** L 2007, c 232, §10.

**§431:19-106 Formation of captive insurance companies in this State.** (a) A captive insurance company shall be:

(1) Incorporated pursuant to chapter 414 as a stock insurer with its capital divided into shares and held by the stockholders;

(2) Incorporated pursuant to chapter 414D as a nonprofit insurer;

(3) Incorporated pursuant to chapter 414 as a mutual insurer without capital stock, the governing body of which is elected by the member organization of its association;

(4) Organized in the State as a reciprocal insurer in accordance with sections 431:3-107, 431:3-108, 431:4-404, 431:4-405 (provided that the principal office of the attorney-in-fact for the domestic reciprocal insurer shall not be required to be maintained in this State), 431:4-406 (excluding 431:4-406(b)(3)), 431:4-407, and 431:4-415(a); or

(5) Organized pursuant to chapter 428 as a member-managed or manager-managed limited liability company.

(b) Before the required organizational documents are transmitted to the department of commerce and consumer affairs, the incorporators or organizers shall petition the commissioner to issue a certificate setting forth the commissioner's finding that the establishment and maintenance of the proposed company will promote the general good of the State. In arriving at such a finding, the commissioner shall consider:

(1) The character, reputation, financial standing, and objectives of the organizers;

(2) The character, reputation, financial responsibility, insurance experience, and business qualifications of the captive insurance company's officers and directors, or members of its governing body, and its service providers; and

(3) Other aspects as the commissioner deems advisable.

(c) The required organizational documents and fees shall be transmitted to the department of commerce and consumer affairs for filing and recordation, as may be necessary.

(d) The capital stock of a captive insurance company incorporated as a stock insurer shall be issued at not less than par value.

(e) Captive insurance companies formed under this article shall have the privileges and be subject to the general corporation law, nonprofit corporation law, or limited liability company law of this State as may be applicable, as well as this article. In the event of conflict between any of the foregoing applicable laws of this State and this article, this article shall control. [L 1987, c 347, pt of §2; am L 1992, c 108, §3; am L 1993, c 205, §36; am L 1997, c 15, §1; am L 1999, c 302, §5; am L 2003, c 209, §5; am L 2005, c 31, §4; am L 2007, c 232, §7; am L 2012, c 253, §11]

**§431:19-106.3 REPEALED.** L 2008, c 190, §7.

**§431:19-106.5 Conversion or merger of captive insurers.** (a) Subject to this section, a captive insurance company domiciled in the State may be converted into, or merged with, a different form of captive insurer under this article.

(b) A plan of conversion or merger shall be submitted to and be approved by the commissioner in advance of the proposed conversion or merger. The commissioner shall not approve the plan unless:

(1) The commissioner finds that it is fair, equitable, and consistent with law;

(2) The plan has been approved by at least two-thirds of the voting interest or unanimous written consent of the voting interest of the captive insurance company;

(3) The plan provides for:

(A) The conversion of existing stockholder, member, or subscriber interests into equal or proportionate interests in the new converted or merged insurer, or such other method and basis for the conversion of the stockholder, member, or subscriber interests that is fair and equitable;

(B) The purchase or other disposition of the shares of any nonconsenting shareholder of a stock insurer, policyholder interest of any nonconsenting member of a mutual insurer, membership interest of a limited liability company, or subscriber surplus account interest, if any, of a subscriber of a reciprocal insurer, in accordance with either an agreement with any nonconsenting stockholder, member, or subscriber or with the existing organizational documents of the insurer relating to the buyback buyout, or the termination of the stockholder, member, or subscriber interests, if any, or if no such provisions exist, then in accordance with the laws of this State relating to the rights of dissenting shareholders; and

(C) The novation, assignment, transfer, run-off, or other disposition of in-force policies insuring any nonconsenting shareholder, member, or subscriber;

(4) The conversion or merger will leave the resulting converted insurer or surviving insurer of the merger with capital or surplus funds reasonably adequate to preserve the security of its policyholders and an ability to continue to transact business in the classes of insurance in which it is then authorized to transact; and

(5) The commissioner finds that the conversion or merger will promote the general good of the State.

(c) After approval of the plan of conversion or merger by the commissioner, the converting or merging insurer shall file with the director of commerce and consumer affairs, appropriate organizational documents to commence the existence of the company in its converted or merged form. Documents filed with the director of commerce and consumer affairs pursuant to this subsection shall comply with all applicable requirements for such documents as may be contained in this article and chapter 414, 414D, or 428, as to the extent that these laws are applicable to the conversion or merger.

(d) Where a stock or mutual insurer converts to a reciprocal insurer or merges with a reciprocal insurer in which the reciprocal

insurer will be the surviving company, the stock or mutual insurer shall include in its articles of amendment the fact of the conversion to, or merger with, a reciprocal insurer and that the resulting or surviving entity shall be a reciprocal insurer under the continued jurisdiction of the commissioner, the effective date of the conversion or merger, and the name of the agent for service of process of the converted or surviving reciprocal insurer.

(e) In the case of the merger of two reciprocal insurers, no articles of amendment, merger, or incorporation shall be required to be filed with the director of commerce and consumer affairs, and the merger shall be effective upon the effective date approved by the commissioner pursuant to the plan of merger filed with and approved by the commissioner.

(f) Notwithstanding that the corporate existence of a stock or mutual insurer which converts to, or merges with, a reciprocal insurer may cease, in all cases of a conversion or merger pursuant to this section, and unless otherwise provided in the approved plan of conversion or merger, the converted insurer or the surviving company of the merger shall assume and succeed to all of the obligations and liabilities of the pre-conversion insurer or the respective merging insurers and shall be held liable to pay and discharge all such debts and liabilities and perform such obligations in the same manner as if they had been incurred or contracted by the converted or surviving merged insurer.

(g) An alien or foreign insurer may be a party to a merger under this section provided that the surviving company shall otherwise qualify and be approved by the commissioner as a captive insurance company under this article. For purposes of chapters 414 and 414D, an alien stock or mutual insurer subject to this section shall be considered a foreign corporation.

(h) This section shall not supersede section 431:19-102, and shall not apply to redomestications or conversions of captive insurers under section 431:19-102.4. [L 2000, c 68, §2; am L 2001, c 55, §21; am L 2002, c 40, §73; am L 2003, c 212, §115; am L 2007, c 232, §8; am L 2012, c 253, §12]

**§431:19-107 Financial statements and other reports.** (a) Each captive insurance company other than a risk retention captive insurance company shall submit to the commissioner financial statements reporting the financial condition and the results of operations of the insurer written according to generally accepted accounting principles, or other comprehensive basis of accounting as may be deemed appropriate by the commissioner, and audited by an independent certified public accountant, or other qualified professional as deemed appropriate by the commissioner, on or before the last day of the sixth month following the end of the company's fiscal year.

(b) Each risk retention captive insurance company shall annually file with the commissioner the following:

(1) Annual statement and audit:

(A) On or before March 1, or such day subsequent thereto as the commissioner upon request and for cause may specify, an annual statement using the National Association of Insurance Commissioners' annual statement blank plus any additional information required by the commissioner, which shall be a true statement of its financial condition,

transactions, and affairs as of the immediately preceding December 31. The reported information shall be verified by oaths of at least two of the captive's principal officers;

(B) On or before June 1, or any day subsequent thereto as the commissioner upon request and for cause may specify, an audit by a designated independent certified public accountant or accounting firm of the financial statements reporting the financial condition and results of the operation of the captive; and

(C) The annual statement and audit shall be prepared in accordance with the National Association of Insurance Commissioners' annual statement instructions, accounting practices and procedures manual, and rules adopted by the commissioner following the practices and procedures prescribed by the National Association of Insurance Commissioners; and

(2) On or before each March 1, or any day subsequent thereto as the commissioner upon request and for cause may specify, a risk-based capital report in accordance with section 431:3-402.

(c) The statements required to be filed in subsections (a) and (b) shall include but not be limited to actuarially appropriate reserves for the business underwritten. An actuarial opinion regarding reserves for the business underwritten by the company shall be included in the audited statements, except that the actuarial opinion for class 3 companies shall be filed with the annual statement required under subsection (b), on or before March 1 each year. The actuarial opinion shall be given by a member of the American Academy of Actuaries or other qualified loss reserve specialist as defined in the annual statement adopted by the National Association of Insurance Commissioners; provided that all captive insurance companies, other than a class 3 company, may, alternatively, utilize an actuarial opinion prepared by a loss reserve specialist deemed appropriate by the commissioner.

(d) The commissioner may prescribe the format and frequency of other reports which may include, but shall not be limited to, summary loss reports and quarterly financial statements.

(e) The commissioner may suspend or revoke the certificate of authority or fine any captive insurer that fails to file any of the documents or reports required by this section. The fine shall be not more than $500 per day past the due date.

(f) Each branch captive insurance company shall file with the commissioner copies of all reports and financial statements required to be filed by the outside captive insurance company of the branch captive insurance company under the laws of the jurisdiction in which the outside captive insurance company is domiciled. The copies of the reports and financial statements shall be certified under oath by two officers of the outside captive insurance company and shall be filed with the commissioner no later than thirty days after the reports and financial statements are filed with the insurance regulator of the domicile of the outside captive insurance company. In addition to, and at the same time as the foregoing filings with the commissioner, the outside captive insurance company shall file a statement signed by two of its executive officers, one of which must be the president or chief financial officer, setting forth the gross premiums written, reinsurance ceded and accepted, and reserves and other liabilities associated with the insurance business written through the branch captive insurance company in this State.

If the commissioner is not satisfied that the reports, financial statements, and statement required to be filed under this subsection fairly and adequately describe the financial condition of the outside captive insurance company and the business underwritten through the branch captive insurance company in this State, the commissioner may require the branch captive insurance company to file an annual statement pursuant to subsection (a) within a reasonable time after notification of such requirement. [L 1987, c 347, pt of §2; am L 1988, c 187, §10; am L 1994, c 190, §§4, 10; am L 1995, c 61, §2 as superseded by c 232, §§2, 4; am L 1997, c 368, §7; am L 1998, c 72, §1; am L 1999, c 128, §2 and c 302, §§6, 9; am L 2000, c 36, §5, c 67, §2, and c 133, §5; am L 2003, c 209, §6 and c 212, §116; am L 2005, c 31, §5; am L 2010, c 116, §1(25); am L 2012, c 253, §13]

**§431:19-108 Examinations, investigations, and financial surveillance.** (a) The commissioner or any authorized examiner may conduct an examination, investigation, or financial surveillance of any captive insurance company as often as the commissioner deems appropriate; provided that, unless the commissioner requires otherwise:

(1) An examination shall be conducted at least once every five years for all captive insurance companies, except as provided in paragraph (2); and

(2) An examination of a risk retention captive insurance company shall be conducted no later than three years after its formation and at least once every five years thereafter.

The commissioner or any authorized examiner shall thoroughly inspect and examine the captive insurance company's affairs to ascertain its financial condition, its ability to fulfill its obligations, and whether it has complied with this article.

(b) The powers, authorities, and duties relating to examinations vested in and imposed upon the commissioner under section 431:2-301 through section 431:2-307.5 of the code are extended to and imposed upon the commissioner in respect to examinations of captive insurance companies.

(c) All examination reports, preliminary examination reports or results, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any person in the course of an examination made under this section are confidential and are not subject to subpoena and may not be made public by the commissioner or an employee or agent of the commissioner without the written consent of the company, except to the extent provided in this subsection. Nothing in this subsection shall prevent the commissioner from using information in furtherance of the commissioner's regulatory authority under this title. The commissioner may grant access to the information to public officers having jurisdiction over the regulation of insurance in any other state or country, or to law enforcement officers of this State or any other state or agency of the federal government at any time, so long as the officers receiving the information agree in writing to hold it in a manner consistent with this section.

(d) Each branch captive insurance company shall file annually with the commissioner a certificate of compliance issued by the insurance regulatory authority of the jurisdiction in which the outside captive insurance company of the branch captive insurance company is domiciled along with certified copies of any examination reports conducted of the

outside captive insurance company by its domiciliary insurance regulator during the preceding calendar year. These filings shall be made with the commissioner by March 1 of each year. So long as the branch captive insurance company complies with the requirements of this subsection, and unless otherwise deemed necessary by the commissioner, any examination of the branch captive insurance company under this subsection shall be only with respect to the business underwritten by the branch captive insurance company in this State. If necessary, however, the commissioner may examine the outside captive insurance company of any branch captive insurance company licensed under this article. [L 1987, c 347, pt of §2; am L 1989, c 195, §41; am L 1996, c 248, §2; am L 1999, c 7, §1 and c 163, §13; am L 2000, c 133, §6; am L 2005, c 31, §6; am L 2008, c 190, §6; am L 2010, c 7, §1; am L 2012, c 253, §14]

**§431:19-109 Grounds and procedures for suspension and revocation of certificate of authority; fines.** (a) The commissioner may suspend or revoke the certificate of authority of a captive insurance company to do business in this State or impose a fine of not less than $100 nor more than $10,000 per violation, or any combination of these actions, for any of the following reasons:

(1) Insolvency or impairment of capital or surplus;

Failure to meet the requirements of section 431:19-104;

(3) Refusal or failure to submit an annual report, as required by section 431:19-107 or any other report or statement required by law or by lawful order of the commissioner;

(4) Failure to comply with the provisions of its own organizational documents;

(5) Failure to submit to examination or any legal obligation relative thereto, as required by section 431:19-108;

(6) Refusal or failure to pay the cost of examination pursuant to section 431:19-108;

(7) Use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or to its policyholders;

(8) Failure to maintain actuarially appropriate loss reserves as determined by the commissioner; provided that the commissioner shall issue at least one warning to the captive insurance company to correct the problem prior to suspending or revoking the certificate of authority; and

(9) Failure otherwise to comply with the laws of this State.

(b) If the commissioner takes action pursuant to subsection (a), the commissioner shall notify the captive insurance company in writing of the reason for that action. The captive insurance company may make written demand upon the commissioner within ten days of the date of receipt of the notice for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within thirty days of receipt of the written demand and shall be held pursuant to chapter 91. [L 1987, c 347, pt of §2; am L 2003, c 209, §7; am L 2010, c 7, §2; am L 2012, c 253, §15]

**§431:19-110 Investments.** (a) Except for risk retention captive

insurance companies, captive insurance companies licensed under this article shall be allowed to maintain investments in accordance with a strategic investment policy adopted and monitored by the captive insurance company's governing body, and approved by the commissioner; provided that in addition to the minimum capital and surplus requirements prescribed in section 431:19-104(b), each captive insurance company with an approved strategic investment policy shall maintain investments in one or more of the following forms, which aggregate not less than one hundred per cent of reserves as required by this chapter or the commissioner:

(1) Cash;

(2) Irrevocable letter of credit issued by a bank chartered by this State or a member bank of the Federal Reserve System;

(3) Investments in accordance with a strategic investment policy adopted and monitored by the captive insurance company's governing body, and approved by the commissioner;

(4) Premiums in the course of collection; or

(5) Other forms approved by the commissioner.

(b) Each captive insurance company that does not maintain a strategic investment policy as described in subsection (a) and risk retention captive insurance companies shall be subject to the restrictions on allowable investments provided under sections 431:6-101 to 431:6-501; provided that the commissioner may approve other assets, investments, and investment provisions as the commissioner deems appropriate.

(c) The commissioner may require a captive insurance company to file a complete disclosure of the identity, background, and experience of the key individuals or staff that are involved with its investment activities and administration, if deemed necessary.

(d) Each captive insurance company shall maintain in its principal office in this State a written record documenting its investment transactions, as well as documents evidencing the authorization or approval of the investments by the captive insurance company's governing body or its designated representative.

(e) The commissioner may prohibit or limit any investments or investible assets if the captive insurance company is not in compliance with this article or applicable rules. [L 1987, c 347, pt of §2; am L 1988, c 187, §11; am L 2003, c 208, §1; am L 2007, c 232, §9; am L 2012, c 253, §16]

**§431:19-111 Reinsurance.** (a) Any captive insurance company may provide reinsurance on risks ceded by any other insurer only upon approval of the reinsurance agreement by the commissioner.

(b) Any captive insurance company may take credit for reserves on risks ceded to a reinsurer; provided that no captive insurance company shall cede risks without the approval of the commissioner.

(c) In the case of a risk retention captive insurance company, a risk retention captive insurance company:

(1) Shall qualify for credit for reinsurance on risks ceded to a reinsurer if the reinsurer is in compliance with article 4A; or

(2) May qualify for credit for reinsurance on risks ceded to a reinsurer, if the reinsurer meets the reinsurance guidelines for risk retention captive insurance companies as adopted by the commissioner pursuant to chapter 91. [L 1987, c 347, pt of §2; am L 1988, c 187, §12; am L 2013, c 193, §1]

**§431:19-111.5 Class 5 companies.** (a) A class 5 company under this article is one that is not a class 1 company, class 2 company, class 3 company, or class 4 company, and acts only as a reinsurer or excess insurer, or both. Notwithstanding any other provision of this article, a class 5 company authorized under this article may reinsure or provide excess insurance, or both, for the risks and lines of insurance approved by the commissioner.

(b) Notwithstanding section 431:19-107(a), reserves for risks located outside of the United States reinsured or insured by a class 5 company, upon approval of the commissioner, may be determined in accordance with the required or approved reserve standards of the country in which the ceding insurer is domiciled or the excess insurance risks are located.

(c) Notwithstanding article 6 of this chapter and section 431:19-110, where the risks reinsured or insured by a class 5 company are located outside of the United States, the class 5 company, upon approval of the commissioner, may invest its funds in accordance with the laws and regulations applicable to insurers or reinsurers domiciled in the jurisdictions in which the risks are located, in proportion to the reserves held for the risks. [L 2000, c 36, §1; am L 2003, c 209, §8; am L 2012, c 253, §17]

**§431:19-112 Rating organizations; memberships.** No captive insurance company shall be required to join a rating organization. [L 1987, c 347, pt of §2]

**§431:19-113 Exemption from compulsory associations.** No captive insurance company shall be permitted to join or contribute financially to any plan, pool, association, or guaranty or insolvency fund in this State, except as provided under chapter 386, nor shall any captive insurance company, its insured, or its parent or any affiliated entity, or any member organization of its association, receive any benefit from any plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of the captive insurance company. [L 1987, c 347, pt of §2; am L 1991, c 79, §2; am L 2012, c 253, §18]

**§431:19-114 Rules.** The commissioner may adopt rules pursuant to chapter 91 to implement this article. [L 1987, c 347, pt of §2]

**§431:19-115 Laws applicable.** (a) No insurance laws of this State other than those contained in this article, or contained in specific references contained in this section or article, shall apply to captive insurance companies.

(b) Sections 431:3-302 to 431:3-304.5, 431:3-307, 431:3-401 to 431:3-409, 431:3-411, 431:3-412, and 431:3-414; articles 1, 2, 4A, 5, 6,

9A, 9B, 9C, 11, 11A, and 15; and chapter 431K shall apply to risk retention captive insurance companies.

(c) Articles 1, 2, 6, and 15 shall apply to class 5 companies.

(d) If any of the laws specified in this section are inconsistent with this article, this article shall apply unless the commissioner by rule or order determines otherwise on a case-by-case basis.

(e) The application of the foregoing provisions shall not diminish the commissioner's authority for exemption as may be contained therein or as may be deemed appropriate under the circumstances. [L 1987, c 347, pt of §2; am L 1994, c 190, §§5, 10; am L 1997, c 358, §§1, 2; am L 1998, c 150, §6; am L 1999, c 302, §7; am L 2000, c 36, §6 and c 133, §7; am L 2003, c 209, §9; am L 2012, c 253, §19; am L 2013, c 190, §5; am L 2016, c 140, §2]

**§431:19-115.5 Applicability of other laws to captive insurance companies writing motor vehicle insurance policies in this State.** Captive insurance companies writing motor vehicle insurance policies in this State shall be subject to sections 431:10C-102, 431:10C-103, 431:10C-107, 431:10C-108, 431:10C-109, 431:10C-112, 431:10C-115, 431:10C-119, 431:10C-120, 431:10C-207, 431:10C-211, 431:10C-212, 431:10C-213, 431:10C-215, 431:10C-301, and 431:10C-303 through 431:10C-315. Captive insurance companies shall also be subject to the rules adopted by the commissioner to implement these sections. [L 1993, c 205, pt of §1; am L 1997, c 251, §56; am L 1999, c 163, §14]

**[§431:19-115.6] Applicability of other laws to captive insurance companies writing credit life or other credit disability insurance policies.** Captive insurance companies writing credit life or credit disability policies in this State shall be subject to sections 431:10B-101 through 431:10B-114. Captive insurance companies shall also be subject to the rules adopted, pursuant to chapter 91, by the commissioner to implement these sections. [L 1997, c 16, §1]

**§431:19-115.7 Applicability of other laws to captive insurance companies writing direct workers' compensation insurance policies.** Captive insurance companies writing direct workers' compensation insurance policies pursuant to chapter 386 may be subject to article 15 if the captive insurance company is deemed insolvent. [L 2012, c 253, §1]

**§431:19-116 Taxation.** (a) Each captive insurance company licensed to do business in this State shall pay to the director of finance through the commissioner a tax on gross premiums on or before March 1 of each year, as follows:

(1) .25 per cent on $0 to $25,000,000 of gross premiums for insurance written on all risks or property resident, situated, or located within this State, and on risks and property situated elsewhere upon which no premium tax is otherwise paid during the year ending on the preceding December 31, less return premiums and less any reinsurance accepted;

(2) .15 per cent on more than $25,000,000, to $50,000,000 of gross premiums for insurance written on all risks or property resident, situated, or located within this State, and on risks and property situated elsewhere upon which no premium tax is otherwise paid during the year ending on the preceding December 31, less

return premiums and less any reinsurance accepted;

(3) .05 per cent on more than $50,000,000, to $250,000,000 of gross premiums for insurance written on all risks or property resident, situated, or located within this State, and on risks and property situated elsewhere upon which no premium tax is otherwise paid during the year ending on the preceding December 31, less return premiums and less any reinsurance accepted; and

(4) 0.00 per cent on more than $250,000,000 of gross premiums for insurance written on all risks or property resident, situated, or located within this State, and on risks and property situated elsewhere upon which no premium tax is otherwise paid during the year ending on the preceding December 31, less return premiums and less any reinsurance accepted;

provided that the annual maximum aggregate tax on gross premiums to be paid by a captive insurance company shall not exceed $200,000.

(b) The tax imposed by this section shall be in settlement of and in lieu of all demands for taxes of every character imposed by the laws of this State, the ordinances or other laws, or rules of any county of this State, except taxes on real property and taxes on the purchase, use, or ownership of tangible personal property. [L 1988, c 187, §2; am L 1993, c 205, §37; am L 1995, c 232, §3; am L 1999, c 302, §8; am L 2002, c 206, §2; am L 2007, c 224, §1]

## PART II. SPECIAL PURPOSE FINANCIAL CAPTIVE INSURANCE COMPANIES

**[§431:19-201] Purpose.** This part provides for the creation of special purpose financial captive insurance companies for the exclusive purpose of facilitating the securitization of one or more risks as a means of accessing alternative sources of capital and achieving the benefits of securitization. This part intends to allow the organizers of special purpose financial captive insurance companies to achieve greater efficiencies in structuring and executing insurance securitization, to diversify and broaden access to sources of capital, to facilitate access to insurance securitization and capital markets financing technology, and to further the economic development opportunities of the State. [L 2008, c 190, pt of §1]

**[§431:19-202] Applicable law.** (a) A special purpose financial captive insurance company shall be subject to the provisions of this part and to part I. If there is any conflict between this part and part I, this part shall control.

(b) A special purpose financial captive insurance company shall be subject to all applicable rules adopted pursuant to section 431:19-114 that are in effect as of July 1, 2008 and that are adopted after July 1, 2008.

(c) The commissioner, by order, may exempt a special purpose financial captive insurance company from any provision of this article or from any rule adopted pursuant to section 431:19-114 if the commissioner determines the provision to be inappropriate, given the nature of risks to be insured by the special purpose financial captive insurance company or its approved plan of operation, and that the public interest is being served or protected, and that reasonable expectations of the policyholders and consumers will be maintained.

(d) Nothing in this part shall be construed to affect chapter 485A in any manner. [L 2008, c 190, pt of §1]

**Revision Note**

"July 1, 2008" substituted for "the effective date of this part".

**§431:19-203 Definitions.** For purposes of this part:

"Counterparty" means the insurer that cedes risk to a special purpose financial captive insurance company which, unless otherwise approved by the commissioner, shall be the parent or an affiliated entity of the special purpose financial captive insurance company.

"Insolvency" or "insolvent", for the purpose of applying the provisions of article 15 to a special purpose financial captive insurance company, means:

(1) That the special purpose financial captive insurance company is unable to pay its obligations when due, unless those obligations are the subject of a bona fide dispute; or

(2) That the special purpose financial captive insurance company has failed to meet all the criteria and conditions for solvency of the special purpose financial captive insurance company established by the commissioner by rule or order.

"Insurance securitization" and "securitization" mean a transaction or a group of related transactions, which may include capital market offerings, that are effected through related risk transfer instruments and facilitating administrative agreements, where all or part of the result of the transactions is used to fund the special purpose financial captive insurance company's obligations to the counterparty under the special purpose financial captive insurance company contract in accordance with the terms of the transaction, and by which:

(1) Proceeds are obtained by a special purpose financial captive insurance company, directly or indirectly, through the issuance of securities by the special purpose financial captive insurance company or any person; or

(2) A person provides one or more letters of credit or other assets for the benefit of the special purpose financial captive insurance company that the commissioner authorizes the special purpose financial captive insurance company to treat as admitted assets for the purposes of the special purpose financial captive insurance company's annual report and where all or any part of the proceeds, letters of credit, or assets, as applicable, are used to fund the special purpose financial captive insurance company's obligations under the special purpose financial captive insurance company contract with a counterparty.

The terms "insurance securitization" and "securitization" do not include the issuance of a letter of credit for the benefit of the commissioner to satisfy all or part of the special purpose financial captive insurance company's capital and surplus requirements under section 431:19-104.

"Management" means the board of directors, managing board, or other individual or individuals vested with overall responsibility for the management of the affairs of the special purpose financial captive insurance company, including but not limited to officers or agents elected or appointed to act on behalf of the special purpose financial captive insurance company.

"Special purpose financial captive insurance company" means a captive insurance company that has received a certificate of authority from the commissioner to operate as a special purpose financial captive insurance company pursuant to this part.

"Special purpose financial captive insurance company contract" means a contract between the special purpose financial captive insurance company and the counterparty pursuant to which the special purpose

financial captive insurance company agrees to provide insurance or reinsurance protection to the counterparty for risks associated with the counterparty's insurance or reinsurance business.

"Special purpose financial captive insurance company security" means a security defined in section 485A-102, and shall also include any other form of debt obligation, equity, surplus certificate, surplus note, funding agreement, derivative, or other financial instrument that the commissioner designates, by rule or order, as a security, and that is issued by a special purpose financial captive insurance company, or a third party, where the proceeds from the security are obtained directly or indirectly by a special purpose financial captive insurance company.

"Surplus note" means an unsecured subordinated debt obligation possessing characteristics consistent with paragraph 3 of the National Association of Insurance Commissioners Statement of Statutory Accounting Principles No. 41, as amended from time to time by the National Association of Insurance Commissioners, and as modified or supplemented by rule or order of the commissioner. [L 2008, c 190, pt of §1; am L 2012, c 253, §20]

**§431:19-204 Certificate of authority.** (a) Any special purpose financial captive insurance company, when permitted by its organizational documents, may apply to the commissioner for a certificate of authority to transact insurance or reinsurance business as authorized in this part. A special purpose financial captive insurance company may only insure or reinsure the risks of its counterparty. Notwithstanding any other provision of this part, a special purpose financial captive insurance company may purchase reinsurance to cede the risks assumed under the special purpose financial captive insurance contracts, subject to the prior approval of the commissioner.

(b) In conjunction with the issuance of a certificate of authority to a special purpose financial captive insurance company, the commissioner may issue an order that includes any provisions, terms, and conditions regarding the organization, licensing, and operation of the special purpose financial captive insurance company that are deemed appropriate by the commissioner and that are not inconsistent with this part. Except as provided in sections 431:19-212 and 431:19-213, a certificate of authority issued to a special purpose financial captive insurance company pursuant to this part shall not be revoked, suspended, amended, or modified other than as follows:

(1) The special purpose financial captive insurance company consents to the revocation, suspension, amendment, or modification; or

(2) The commissioner makes a showing of clear and convincing evidence demonstrating that the revocation, suspension, amendment, or modification is necessary to avoid irreparable harm to the special purpose financial captive insurance company, investors who hold special purpose financial captive insurance company securities, the public, or a counterparty, if applicable.

(c) To qualify for a certificate of authority, a special purpose financial captive insurance company shall be subject, in addition to the requirements of section 431:19-102, to the following:

(1) The special purpose financial captive insurance company shall submit its plan of operation to the commissioner for approval. The plan of operation shall include:

(A) Draft documentation or, at the discretion of the

commissioner, a written summary, of all agreements and material transactions, including but not limited to the name of the counterparty, the nature of risk being assumed, and the nature and purpose of the interrelationships between the various transactions that are entered into to effectuate the special purpose financial captive insurance company contract and the insurance securitization;

(B) The source and form of the special purpose financial captive insurance company's initial and ongoing capital and surplus;

(C) The proposed strategic investment policy of the special purpose financial captive insurance company;

(D) A description of the underwriting, reporting, and claims reserving and payment methods by which losses covered by the special purpose financial captive insurance company are reported, accounted for, and settled; and

(E) Projected financial statements of the special purpose financial captive insurance company using an expected and at least one adverse case scenario applied to the special purpose financial captive insurance company contract;

(2) The special purpose financial captive insurance company shall submit an affidavit of or a declaration by its president, a vice president, the treasurer, or the chief financial officer, that includes the following statements, to the best of that person's knowledge and belief after reasonable inquiry:

(A) That the proposed organization and operation of the special purpose financial captive insurance company complies with all applicable provisions of this part;

(B) That the special purpose financial captive insurance company's strategic investment policy reflects and takes into account the liquidity of assets and the reasonable preservation, administration, and management of the assets with respect to the risks associated with the special purpose financial captive insurance company contract and the insurance securitization transaction; and

(C) That the special purpose financial captive insurance company contract and any arrangement for securing the special purpose financial captive insurance company's obligations under the special purpose financial captive insurance company contract, including but not limited to any agreement or other documentation to implement the arrangement, comply with the provisions of this part;

(3) The special purpose financial captive insurance company shall submit other documents or statements of the special purpose financial captive insurance company's officer as may be required by the commissioner to evaluate the special purpose financial captive insurance company's application for licensure; and

(4) The application shall include an opinion of qualified legal counsel, in a form acceptable to the commissioner, that the offer and sale of any special purpose financial captive insurance company securities comply with all applicable registration requirements, or applicable exemptions from or exceptions to the requirements of the federal securities laws and that the offer and sale of securities by the special purpose financial captive insurance company itself comply with all registration requirements or applicable exemptions from or exceptions to the requirements of the security laws of this State. The legal opinions shall not be required as part of the application if the special purpose financial captive insurance company includes a specific statement in its plan of operation that the opinions shall be provided to the commissioner prior to the offer or sale of any special purpose financial captive insurance company securities.

(d) The commissioner may issue a certificate of authority to transact insurance and reinsurance business as a special purpose financial captive insurance company in this State that shall be valid through the term of the insurance securitization and automatically renewed each April 1 following the date of initial issuance, except as provided for in section 431:19-212, and upon the commissioner's finding that:

(1) The proposed plan of operation provides for a reasonable and expected successful operation;

(2) The terms of the special purpose financial captive insurance company contract and related transactions comply with this part; and

(3) The insurance regulator of the home domicile of each counterparty has notified the commissioner in writing or otherwise provided assurance satisfactory to the commissioner that it has approved or has not disapproved the transaction; provided that the commissioner shall not be precluded from issuing or renewing a certificate of authority in the event that the insurance regulator of the home domicile of a counterparty has not responded with respect to all or any part of the transaction.

(e) Section 431:19-101.2 shall apply to all information submitted pursuant to subsection (c) and to any order issued to the special purpose financial captive insurance company pursuant to subsection (b). [L 2008, c 190, pt of §1; am L 2009, c 11, §6]

**[§431:19-205] Changes in plan of operation; voluntary dissolution or cessation of business.** (a) Any change in the special purpose financial captive insurance company's plan of operation shall require the prior approval of the commissioner.

(b) Any transaction or series of transactions shall be subject to the prior approval of the commissioner if the transaction or series of transactions:

(1) Is undertaken to dissolve a special purpose financial captive insurance company; or

(2) Results in the termination of all or any part of a special purpose financial captive insurance company's business; provided that no prior approval of the commissioner shall be required for any transaction or series of transactions performed in accordance with a document, contract, or agreement described in the special purpose financial captive insurance company's plan of operation and if the commissioner is notified in advance of the transaction or series of transactions.

(c) A special purpose financial captive insurance company shall notify the commissioner in advance of any change in the legal ownership of any security issued by the special purpose financial captive insurance company. [L 2008, c 190, pt of §1]

**[§431:19-206] Formation.** (a) A special purpose financial captive insurance company may be incorporated as a stock corporation, limited liability company, mutual association, partnership, or other form of organization approved by the commissioner.

(b) A special purpose financial captive insurance company's organizational documents shall limit the special purpose financial captive insurance company's authority to transact the business of insurance or reinsurance to those activities that the special purpose financial captive insurance company conducts to accomplish its purposes as expressed in this part. [L 2008, c 190, pt of §1]

**[§431:19-207] Minimum capital and surplus.** A special purpose financial captive insurance company shall not be issued a license unless it possesses and thereafter maintains unimpaired capital and surplus of not less than $250,000 in the form of cash or other assets approved by the commissioner. [L 2008, c 190, pt of §1]

**[§431:19-208] Issuance of securities.** (a) A special purpose financial captive insurance company may issue securities, as defined in section 485A-102, subject to and in accordance with its approved plan of operation and its organizational documents.

(b) A special purpose financial captive insurance company, in connection with the issuance of securities, may enter into and perform all of its obligations under any required contracts to facilitate the issuance of these securities.

(c) A special purpose financial captive insurance company may:

(1) Subject to the approval of the commissioner, account for the proceeds of surplus notes as surplus; and

(2) Submit for prior approval of the commissioner, periodic written requests for payments of interest on and repayment of principal surplus notes, and any other debt obligations issued by the special purpose financial captive insurance company; provided that the commissioner may, in lieu of the approval of periodic written requests, approve a formula or plan that provides for the payment of interest, principal, or both.

(d) Securities issued by a special purpose financial captive insurance company pursuant to an insurance securitization shall not be considered to be insurance or reinsurance contracts. An investor in these securities or a holder of these securities, by sole means of this investment or holding, shall not be considered to be transacting the business of insurance in this State. The underwriter's placement or selling agents and their partners, directors, officers, members, managers, employees, agents, representatives, and advisors involved in an insurance securitization pursuant to this part shall not be considered to be insurance producers or brokers or conducting business as an insurance or reinsurance company or agency, brokerage, intermediary, advisory, or consulting business only by virtue of their activities in conjunction with the insurance securitization. [L 2008, c 190, pt of §1]

**§431:19-209 Authorized contracts and agreements.** (a) A special purpose financial captive insurance company shall insure only the risks of a counterparty and shall not issue a contract for assumption of risk or indemnification of loss other than a special purpose financial captive insurance company contract; provided that the special purpose financial captive insurance company may cede risks assumed through a special purpose financial captive insurance company to third party reinsurers through the purchase of reinsurance or retrocession protection on terms approved by the commissioner.

(b) A special purpose financial captive insurance company may enter into contracts and agreements with affiliated entities and third parties to conduct other activities related or incidental to and necessary to fulfill the purposes of the special purpose financial captive insurance company contract, the insurance securitization, and this part; provided that the contracts and activities are included in the special purpose financial captive insurance company's plan of operation or are otherwise approved in advance by the commissioner. Those contracts, agreements,

and activities may include but are not limited to:

(1) Entering into special purpose financial captive insurance company contracts;

(2) Issuing of special purpose financial captive insurance company securities;

(3) Complying with the terms of the special purpose financial captive insurance company contracts or securities;

(4) Entering into trust, tax, administration, reimbursement, or fiscal agent transactions; or

(5) Complying with trust indenture, reinsurance or retrocession and other contracts, agreements, and activities necessary or incidental to effectuate an insurance securitization in compliance with the special purpose financial captive insurance company's plan of operation approved by the commissioner or as authorized by this part.

(c) A special purpose financial captive insurance company may enter into swap agreements, or other forms of asset management agreements, including guaranteed investment contracts, or other transactions that have the objective of leveling timing differences in funding of up-front or ongoing transaction expenses or managing asset, credit, or interest rate risk of the investments in the trust to ensure that the investments are sufficient to assure payment or repayment of the securities, and related interest or principal payments issued pursuant to a special purpose financial captive insurance company insurance securitization transaction or the obligations of a special purpose financial captive insurance company under a special purpose financial captive insurance company contract.

(d) A special purpose financial captive insurance company shall immediately notify the commissioner of any threatened or pending action by a counterparty or any other person to foreclose or otherwise take possession of or control over or encumber the collateral provided by the special purpose financial captive insurance company and part of the insurance securitization.

(e) Unless otherwise approved in advance by the commissioner, a special purpose financial captive insurance company shall not:

(1) Issue or otherwise administer primary insurance contracts;

(2) Enter into a special purpose financial captive insurance company contract with a counterparty that is not licensed or otherwise authorized to transact the business of insurance or reinsurance in at least its state or country of domicile;

(3) Enter into a special purpose financial captive insurance contract that contains any provision for payment by the special purpose financial captive insurance company in discharge of its obligations under the contract to any person other than the counterparty or receiver;

(4) Have any direct obligation to the policyholders or reinsured of the counterparty; or

(5) Lend or otherwise invest, or place in custody, trust, or under management any of its assets with, or to borrow money or receive a loan from anyone convicted of a felony, anyone convicted of a criminal offense involving the conversion or misappropriation of funds, including fiduciary funds or insurance amounts, or theft, deceit, fraud, misrepresentation, embezzlement, or corruption, or anyone whom the commissioner has cause to believe has violated, is violating, or is about to violate any provision of this code, any order of the commissioner, or undertakes or plans to undertake any action that may cause the special purpose financial captive insurance company to be in a condition as to render the continuance of the special purpose financial captive insurance company's business hazardous to the public or to the holders of the special purpose financial captive insurance company contracts or special purpose financial captive insurance company

securities. [L 2008, c 190, pt of §1; am L 2009, c 11, §7]

**[§431:19-210] Disposition of assets; investments.** (a) The assets of a special purpose financial captive insurance company shall be preserved and administered by or on behalf of the special purpose financial captive insurance company to satisfy the liabilities and obligations of the special purpose financial captive insurance company, the insurance securitization, and other related contracts and agreements.

(b) Unless waived by the commissioner, any security offering memorandum or other document issued to prospective investors regarding the offer and sale of a surplus note or other special purpose financial captive insurance company securities shall include a disclosure that all or part of the proceeds of the insurance securitization will be used to fund the special purpose financial captive insurance company's obligations to the counterparty.

(c) A special purpose financial captive insurance company shall not be subject to any restriction on investments; provided that the special purpose financial captive insurance company:

(1) Maintains compliance with the strategic investment policy adopted by the special purpose financial captive insurance company; and

(2) Shall not make a loan to any person other than as permitted under its plan of operation or as otherwise approved in advance by the commissioner;

provided further that the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of the special purpose financial captive insurance company unless the investment is otherwise approved in its plan of operation or in an order issued to the special purpose financial captive insurance company pursuant to section 431:19-202(c). [L 2008, c 190, pt of §1]

**[§431:19-211] Annual reporting; books and records.** (a) For purposes of section 431:19-107(a), the commissioner may require any appropriate or necessary modification or supplemental or additional information to be filed with the required financial statements.

(b) Unless otherwise approved in advance by the commissioner, a special purpose financial captive insurance company shall maintain its books, records, documents, accounts, vouchers, and agreements in this State. A special purpose financial captive insurance company shall make its books, records, documents, accounts, vouchers, and agreements available for inspection by the commissioner at any time. A special purpose financial captive insurance company shall keep its books and records in a manner that its financial condition, affairs, and operations can be readily ascertained and so that the commissioner may readily verify its financial statements and determine its compliance with this part.

(c) Unless otherwise approved in advance by the commissioner, all original books, records, documents, accounts, vouchers, and agreements shall be preserved and kept available in this State for the purpose of examination and inspection and until a time as the commissioner approves the destruction or other disposition of the books, records, documents, accounts, vouchers, and agreements. If the commissioner approves the keeping of the items listed in this subsection outside this State, then

the special purpose financial captive insurance company shall maintain in this State a complete and true copy of each original. Books, records, documents, accounts, vouchers, and agreements may be photographed, reproduced on film, or stored and reproduced electronically. [L 2008, c 190, pt of §1]

**[§431:19-212] Suspension and revocation of certificate of authority.** (a) The commissioner shall notify a special purpose financial captive insurance company not less than thirty days before suspending or revoking its certificate of authority pursuant to section 431:19-109, which notice shall state the basis for the suspension or revocation. The special purpose financial captive insurance company shall be afforded the opportunity for a hearing pursuant to chapter 91.

(b) Notwithstanding subsection (a) and section 91-9.5, the commissioner may cause the immediate suspension or restriction of the special purpose financial captive insurance company's certificate of authority, subject to timely subsequent notice and opportunity for a hearing, upon the commissioner's determination that the failure to take an action may result in the material deterioration of the financial condition or soundness of the special purpose financial captive insurance company, and that for the protection of the public from the possible consequences of practices, the special purpose financial captive insurance company's certificate of authority should be immediately suspended or restricted.

The commissioner may order the summary suspension of the certificate of authority for a period not to exceed the later of thirty days or, if a hearing is requested by the special purpose financial captive insurance company pursuant to chapter 91, the conclusion of the hearing. Any attempt by the special purpose financial captive insurance company to continue its operations while its certificate of authority has been summarily suspended shall be sufficient to warrant a permanent revocation of the certificate of authority and shall subject the special purpose financial captive insurance company to all penalties prescribed by this article, or any rule or order issued by the commissioner.

(c) For purposes of this section, any reference to section 431:19-104 in section 431:19-109(a)(2) shall be construed to also reference section 431:19-207. [L 2008, c 190, pt of §1]

**[§431:19-213] Supervision, rehabilitation, liquidation.** (a) Except as otherwise provided in this part, article 15 shall apply in full to a special purpose financial captive insurance company.

(b) Upon any order of supervision, rehabilitation, or liquidation of a special purpose financial captive insurance company, the receiver shall manage the assets and liabilities of the special purpose financial captive insurance company pursuant to this part.

(c) Amounts recoverable by the receiver of a special purpose financial captive insurance company under a special purpose financial captive insurance company contract shall not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to a counterparty, notwithstanding any provision in the contracts or other documentations governing the special purpose financial captive insurance company securitization.

(d) Notwithstanding article 15 or any other law of this State:

(1) An application or petition for a temporary restraining order or injunction issued pursuant to article 15 with respect to a counterparty does not prohibit the transaction of business by a special purpose financial

captive insurance company, including any payment by a special purpose financial captive insurance company made with respect to a special purpose financial captive insurance company security, or any action or proceeding against a special purpose financial captive insurance company or its assets;

(2) The commencement of a summary proceeding with respect to a special purpose financial captive insurance company and any order issued by the court in the summary proceeding, unless otherwise specifically addressed in the summary proceeding or order issued by the court, shall not prohibit payments by a special purpose financial captive insurance company and shall not prohibit the special purpose financial captive insurance company from taking any action required to make payments; provided that payments are made:

(A) Pursuant to a special purpose financial captive insurance company security or special purpose financial captive insurance company contract; and
(B) Consistent with the special purpose financial captive insurance company's plan of operation and any order issued to the special purpose financial captive insurance company pursuant to section 431:19-204(b), as either is amended from time to time;

(3) A receiver of a counterparty may not void a nonfraudulent transfer by a counterparty to a special purpose financial captive insurance company of money or other property made pursuant to a special purpose financial captive insurance company contract; and

(4) A receiver of a special purpose financial captive insurance company may not void a nonfraudulent transfer by the special purpose financial captive insurance company of money or other property:

(A) Made to a counterparty pursuant to a special purpose financial captive insurance company contract or made to or for the benefit of any holder of a special purpose financial captive insurance company security with respect to the special purpose financial captive insurance company security; and
(B) Made consistent with the special purpose financial captive insurance company's plan of operation and any order issued to the special purpose financial captive insurance company pursuant to section 431:19-204(b), as either is amended from time to time.

(e) With the exception of the fulfillment of the obligations under a special purpose financial captive insurance contract and notwithstanding any other provision of this part or other laws of this State, the assets of a special purpose financial captive insurance company, including assets held in trust, on a funds-withheld basis, or in any other arrangement to secure the special purpose financial captive insurance company's obligations under a special purpose financial captive insurance company contract, shall not be consolidated with or included in the estate of a counterparty in any delinquency proceeding against the counterparty pursuant to this part for any purpose including, without limitation, distribution to creditors of the counterparty. [L 2008, c 190, pt of §1]

**[§431:19-214] Existing licenses.** Except as otherwise determined by the commissioner, a captive insurance company, that has been issued a certificate of authority by the commissioner pursuant to section 431:19-102 as of July 1, 2008, and is engaged in or will be engaged in an insurance securitization, need not obtain a certificate of authority

pursuant to section 431:19-204, but shall otherwise be subject to this part as a special purpose financial captive insurance company; provided that the commissioner may require the captive insurance company to take any action that the commissioner determines is reasonably necessary to bring the captive insurance company into compliance with this part; provided further that the commissioner may issue an order described in section 431:19-204(b) with respect to the captive insurance company. [L 2008, c 190, pt of §1]

## PART III. SPONSORED CAPTIVE INSURANCE COMPANIES

**[§431:19-301] Formation.** (a) One or more sponsors may form a sponsored captive insurance company under this part. In addition to the general provisions of this article, the provisions of this part shall apply to sponsored captive insurance companies.

(b) A sponsored captive insurance company shall be incorporated as a stock insurer with its capital divided into shares and held by the stockholders, as a nonprofit corporation with one or more members, or as a member-managed or manager-managed limited liability company. [L 2008, c 190, pt of §1]

**[§431:19-302] Supplemental application materials.** In addition to the information required in section 431:19-102(c) and (d), each sponsored captive insurance company applicant that segregates the risks of its participants through one or more protected cells shall file with the commissioner the following:

(1) All contracts or draft contracts between the sponsored captive insurance company and its participants;

(2) A description of the means by which the assets, liabilities, income, and expenses of each protected cell shall be segregated from those of other protected cells in the sponsored captive insurance company, and reported to the commissioner; and

(3) A fair and equitable plan for allocating direct and indirect expenses to each protected cell. [L 2008, c 190, pt of §1]

**§431:19-303 Protected cells.** A sponsored captive insurance company formed and licensed under this article may establish and maintain one or more protected cells to insure risks of one or more participants, subject to the following:

(1) The shareholders or members of a sponsored captive insurance company shall be limited to its participants and sponsors; provided that a sponsored captive insurance company may issue nonvoting securities to other persons on terms approved by the commissioner;

(2) A protected cell shall be organized and operated in only those forms of business organization authorized by the commissioner, including an association, corporation, limited liability company, partnership, or trust;

(3) Each protected cell shall be accounted for separately on the books and records of the sponsored captive insurance company to reflect the financial condition and results of operations of the protected cell, net income or loss, dividends or other distributions to participants, and other factors as may be provided in the participant contract or required by the commissioner;

(4) The assets of a protected cell shall not be chargeable with liabilities arising out of any other insurance

business the sponsored captive insurance company may conduct;

(5) No sale, exchange, or other transfer of assets may be made by a sponsored captive insurance company between or among any of its protected cells without the consent of the protected cells;

(6) No sale, exchange, transfer of assets, dividend, or distribution may be made from a protected cell to a sponsor or participant without the commissioner's approval, and in no event shall the approval be given if the sale, exchange, transfer, dividend, or distribution would result in insolvency or impairment with respect to a protected cell;

(7) Each sponsored captive insurance company shall annually file with the commissioner, financial reports as the commissioner shall require, that shall include, without limitation, accounting statements detailing the financial experience of each protected cell;

(8) Each sponsored captive insurance company shall notify the commissioner in writing within ten business days of any protected cell that is insolvent or otherwise unable to meet its claim or expense obligations; and

(9) No participant contract shall take effect without the commissioner's prior written approval, and the addition of each new protected cell and withdrawal of any participant or termination of any existing protected cell shall constitute a change in business plan requiring the commissioner's prior written approval. [L 2008, c 190, pt of §1; am L 2010, c 7, §3]

**§431:19-304 Qualification of sponsors.** A sponsor of a sponsored captive insurance company shall be an insurer licensed under laws of any state, a reinsurer authorized or approved under the laws of any state, a captive insurance company formed or licensed under this article, or any other person, company, or organization approved by the commissioner in the exercise of the commissioner's discretion, after finding that the approval of that person, company, or organization as a sponsor is not inconsistent with the purposes of this article. A risk retention group shall not be a sponsor of a sponsored captive insurance company. [L 2008, c 190, pt of §1; am L 2016, c 141, §10]

**§431:19-305 Participants in sponsored captive insurance companies.** (a) Associations, corporations, limited liability companies, partnerships, trusts, risk retention groups, and other business entities may be participants in any sponsored captive insurance company formed or licensed under this chapter.

(b) A sponsor of a sponsored captive insurance company may be a participant.

(c) A participant need not be a shareholder or member of the sponsored captive insurance company or any affiliate thereof.

(d) A participant shall insure only its own risks through a sponsored captive insurance company. [L 2008, c 190, pt of §1; am L 2016, c 141, §11]

**[§431:19-306] Investments by sponsored captive insurance companies.** Notwithstanding section 431:19-303, the assets of two or more protected cells may be combined for purposes of investments, and the combination shall not be construed as defeating the segregation of the

assets for accounting or other purposes. Sponsored captive insurance companies shall comply with the investment requirements under section 431:19-110. [L 2008, c 190, pt of §1]

**[§431:19-307] Delinquency of sponsored captive insurance companies.** In the case of a sponsored captive insurance company, article 15 shall apply; provided that:

(1) The assets of a protected cell may not be used to pay any expenses or claims other than those attributable to the protected cells; and

(2) Its capital and surplus shall at all times be available to pay any expenses of or claims against the sponsored captive insurance company. [L 2008, c 190, pt of §1]

**§431:19-308 Applicable laws.** A sponsored captive insurance company shall be subject to this part and to part I. If there is any conflict between this part and part I, this part shall control. [L 2008, c 190, pt of §1; am L 2012, c 253, §21]

**§431:19-309 Existing licenses.** Except as otherwise determined by the commissioner, a captive insurance company that has been issued a certificate of authority by the commissioner pursuant to section 431:19-102 as of July 1, 2008, and is licensed as a class 4 company shall not be required to re-apply for a certificate of authority under this part, but shall otherwise be subject to this part as a sponsored captive insurance company; provided that the commissioner may by order require the captive insurance company to take any action that the commissioner determines is reasonably necessary to bring the captive insurance company into compliance with this part. [L 2008, c 190, pt of §1; am L 2012, c 253, §22]

## ARTICLE 20
## TITLE INSURANCE AND TITLE INSURERS

### Case Notes

Mentioned: 74 H. 85, 839 P.2d 10.

**§431:20-101 Scope.** This article relates only to title insurers and title insurance policies. [L 1987, c 347, pt of §2]

**§431:20-102 Definitions.** For the purposes of this article:

(1) Controlled escrow company means each person engaged in the business of handling escrows of real property transactions in connection with which title policies are issued by a title insurer, which person:

(A) If an artificial person, directly or indirectly, is controlled by or controls, or is under common control with a title insurer, or is controlled by or controls, or is under common control with an underwritten title company; or

(B) If a natural person, is employed by or controlled by a title insurer, or by an underwritten title company.

(2) Title insurance business or business of title insurance means:

(A) Issuing as insurer or offering to issue as insurer a title insurance policy; or

(B) Transacting or proposing to transact by a title insurer any of the following activities when conducted or performed in contemplation of the issuance of a title insurance policy:

(i) Soliciting or negotiating the issuance of a title insurance policy;

(ii) Guaranteeing, warranting or otherwise insuring the correctness of title searches;

(iii) Handling of escrows, settlements or closings;

(iv) Execution of title insurance policies;

(v) Effecting contracts of reinsurance;

(vi) Abstracting, searching or examining titles; or

(vii) Doing or proposing to do any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this article.

(3) Title insurance policy or policy means a contract issuing or indemnifying against loss or damage arising from any or all of the following existing on or before the policy date:

(A) Defects in, liens against, or encumbrances on the insured title;

(B) Unmarketability of the insured title; or

(C) Invalidity or unenforceability of liens or encumbrances on the stated property. Title insurance policy does not include a preliminary report, binder, commitment, or abstract.

(4) Title insurer or insurer means a company organized under laws of this State for the purpose of transacting as insurer the business of title insurance, and any foreign or alien title insurer engaged in this State in the business of title insurance as insurer.

(5) Underwritten title company means each person engaged in the business of preparing lien or title searches, title examinations, certificates of searches of title, or abstracts of title upon the basis of which a title insurer regularly writes title policies. [L 1987, c 347, pt of §2]

**§431:20-103 General insurance law applicable.** The following provisions shall apply to title insurance and to title insurers:

(1) Sections 431:1-103 and 431:1-105;

(2) Sections 431:1-212, 431:1-213, and 431:1-214;

(3) Sections 431:2-101 to 431:2-106, and sections 431:2-108 to 431:2-110;

(4) Sections 431:2-201 to 431:2-204, sections 431:2-207 to 431:2-212, and section 431:2-215;

(5) Sections 431:2-302, 431:2-303, 431:2-305, and 431:2-306;

(6) Sections 431:3-101 to 431:3-105;

(7) Sections 431:3-201 to 431:3-203, 431:3-205, and 431:3-206, and sections 431:3-209 to 431:3-220;

(8) Sections 431:3-301, 431:3-305, 431:3-307, and 431:3-308;

(9) Sections 431:4-102 to 431:4-127;

(10) Sections 431:4-202 to 431:4-207;

(11) Section 431:5-101;

(12) Sections 431:5-201 to 431:5-203;

(13) Sections 431:5-305 and 431:5-306, and sections 431:5-308 to 431:5-311;

(14) Article 6;

(15) Article 7;

(16) Article 9A;

(17) Sections 431:10-211, 431:10-216 to 431:10-218, and 431:10-220, 431:10-221, and 431:10-224, 431:10-225, and sections 431:10-235 to 431:10-238;

(18) Article 13; and

(19) Article 15. [L 1987, c 347, pt of §2; am L 1988, c 363, §2(4); am L 2002, c 155, §96; am L 2003, c 212, §117; am L 2006, c 154, §41]

**§431:20-104 Particular provisions prevail.** If any provision of this code as incorporated in this article by section 431:20-103 is in conflict with any provision of this article, the provision contained in this article shall prevail. [L 1987, c 347, pt of §2]

**§431:20-105 Authorized business.** (a) Each title insurer may engage in the title insurance business in this State if licensed to do so by the commissioner.

(b) Each domestic title insurer may issue policies and may also insure:

(1) The identity, due execution, and validity of any note or bond secured by mortgage;

(2) The identity, due execution, validity, recording of any such mortgage; and

(3) The identity, due execution, and validity of evidences of indebtedness issued by this State, by any political subdivision or district therein, or by any private or public corporation. [L 1987, c 347, pt of §2]

**§431:20-106 Restrictions on business.** Any insurer which anywhere in the United States transacts any class of insurance other than title insurance is not eligible for the issuance of a certificate of authority to transact title insurance in this State nor for the renewal thereof, nor shall title insurance be transacted, underwritten or issued by any insurer transacting or licensed to transact any other kind of insurance. [L 1987, c 347, pt of §2]

**[§431:20-106.5] Escrow depositories.** Any title insurer or insurer which operates as an escrow depository as defined in chapter 449 shall be licensed in accordance with chapter 449. [L 1996, c 27, §1]

**§431:20-107 Capital requirements.** A title insurer shall have a minimum capital, which shall be paid in and maintained, of not less than $400,000. [L 1987, c 347, pt of §2 as superseded by c 348, §21]

**§431:20-108 Guarantee fund.** (a) A title insurer, before issuing any title insurance policy covering property located in this State, shall deposit $400,000 with the commissioner, which deposit shall be known as a guarantee fund and shall be held for the security and protection of the holders or beneficiaries under its title insurance policies.

(b) The deposit required under subsection (a) may be made in lawful money of the United States or in the securities authorized for investment by domestic incorporated insurers under article 6 of this code.

(c) Assets deposited pursuant to subsection (a), with the commissioner's approval, may be exchanged from time to time for other assets that qualify under subsection (b).

(d) The depositing title insurer shall receive the income, interests, and dividends on any assets deposited.

(e) A title insurer that has deposited assets pursuant to this section, with the approval of the commissioner, may withdraw any part of the assets so deposited. If a title insurer continues to engage in the business of title insurance, it shall not be permitted to withdraw assets that would reduce the amount of its deposits below the amount required by subsection (a).

(f) In the event of the insolvency or dissolution of a title insurer, the deposit made pursuant to this section shall be retained by the commissioner until the time all outstanding liabilities created by the title insurance policies issued or reinsurance assumed by the title insurer have been discharged by reinsurance or otherwise. As much of the deposit as shall be necessary may be used by or with the written approval of the commissioner in the payment of claims arising under the title insurance policies or reinsurance assumed or to purchase reinsurance thereon. Any amounts then remaining shall be applied first to the payment of other obligations of the title insurer, and second, shall be distributed to the stockholders of the title insurer.

(g) In lieu of a deposit maintained in this State, the commissioner shall accept the certificate in proper form of the public officer having general supervision of insurers in any other state to the effect that a deposit, in a like amount, by the insurer is being maintained for like purposes in public custody or control pursuant to the laws of that state. [L 1987, c 347, pt of §2 as superseded by c 348, §22]

**§431:20-109 Limitations on compliance with section 431:20-107 and section 431:20-108.** If section 431:20-107 or section 431:20-108 requires a greater amount of capital and surplus or deposits than that required of a title insurer prior to July 1, 1988, such title insurer shall have three years after July 1, 1988, to comply with any such increase requirement. [L 1987, c 347, pt of §2]

**Revision Note**

"July 1, 1988" substituted for "the effective date of this code".

**§431:20-110 Purchase of materials and plant; valuation.** Any domestic title insurer, after having its required capital paid in and depositing its required guarantee fund with the commissioner, may invest its funds in the preparation and purchase of materials and plant necessary to enable it to engage in the title insurance business. In all statements and proceedings required by law for the ascertainment and determination of the condition of such insurer, the materials and plant shall be treated in one of the following ways:

(1) They may be treated as an asset, valued at actual cost to the insurer not to exceed fifty per cent of the aggregate par value of the shares of the insurer's capital stock then issued, outstanding, and apportioned to its title insurance department, including treasury shares.

(2) They may be treated as an asset, at such lesser value than that permitted by item (1) as the insurer estimates.

(3) They may be omitted entirely from the statement or proceeding. [L 1987, c 347, pt of §2]

**§431:20-110.5 Dividends.** A title insurer shall not pay any dividends except from profits remaining on hand after retaining unimpaired assets aggregating in value an amount equal to the sum of the following:

(1) The aggregate par value of the shares of its capital stock, issued and outstanding, including treasury shares;

(2) The amount set apart as the title insurance reinsurance reserve; and

(3) A sum sufficient to pay all liabilities for expenses and taxes, all losses reported or in course of settlement, and all other indebtedness, without impairment of the amount required to be set apart as the title insurance reinsurance reserve. [L 1989, c 195, §8]

**§431:20-111 Loans to officers, etc.** A title insurer shall not directly or indirectly make a loan from its assets to any of its officers, employees, or directors, or to any member of the family of any officer or director. Any officer, director, agent, or employee of any such insurer who knowingly consents to any violation of this section is guilty of a misdemeanor. [L 1987, c 347, pt of §2]

**§431:20-112 Limit of risk.** No insurer transacting title insurance in this State shall expose itself to any one risk in an amount exceeding fifty per cent of the aggregate amount of its total capital and surplus and its reserves other than its loss or claim reserves. As used in this section, the words "any one risk" mean the risk or hazard attaching to or arising in connection with any one piece or parcel of property, whether or not the policy insures other property. Any risk or portion of any risk which has been reinsured as authorized in this part shall be deducted in determining the limitation of risk prescribed in this section. [L 1987, c 347, pt of §2]

**§431:20-113 Underwriting standards and record retention.** (a) No

title insurance policy may be written unless and until the title insurer has caused to be conducted a reasonable search and examination of the title, and has caused to be made a determination of insurability of title in accordance with sound underwriting practices. Evidence of the examination of title and determination of insurability shall be preserved and retained in the files of the title insurer for a period of not less than fifteen years after the title insurance policy has been issued. Instead of retaining the original evidence, the title insurer may, in the regular course of business, establish a system whereby all or part of the evidence is recorded, copied or reproduced by any process that accurately and legibly reproduces or forms a durable medium for reproducing the contents of the original. This subsection shall not apply to:

(1) A title insurer assuming liability through a contract of reinsurance; or

(2) A title insurer acting as co-insurer if one of the other co-insuring title insurers has complied with this section.

(b) Except as allowed by regulations promulgated by the commissioner, no title insurer shall knowingly issue any title insurance policy or commitment to insure without showing all outstanding, enforceable recorded liens or other interests against the property title to which is to be insured. [L 1987, c 347, pt of §2]

**Case Notes**

Section mandates that title policies be issued based on title search results, not on indemnification of title insurer. 74 H. 85, 839 P.2d 10.

**§431:20-114 Reinsurance reserve.** (a) A domestic title insurer shall establish and maintain a reinsurance reserve computed in accordance with this section, and all sums attributed to the reserve shall at all times and for all purposes be considered and constitute unearned portions of the original premiums. This reserve shall be reported as a liability of the title insurer in its financial statements.

(b) The reinsurance reserve shall be maintained by the title insurer for the protection of holders of title insurance policies. Except as provided in this section, assets equal in value to the reinsurance reserve are not subject to distribution among creditors or stockholders of the title insurer until all claims of policyholders or claims under reinsurance contracts have been paid in full, and all liability on the policies or reinsurance contracts has been paid in full and discharged or lawfully reinsured.

(c) A foreign or alien title insurance company licensed to transact title insurance business in this State shall maintain at least the same reserves on title insurance policies issued on properties located in this State as are required of domestic title insurance companies, unless the laws of jurisdiction of domicile of the foreign or alien title insurance company require a higher amount.

(d) The reinsurance reserve shall consist of:

(1) The amount of this surplus fund on July 1, 1988; and

(2) A sum equal to twenty cents for each $1,000 of net retained liability under each title insurance policy on a single risk written on properties located in this State written after July 1, 1988.

(e) Amounts placed in the reinsurance reserve in any year in

accordance with subsection (d)(2) shall be deducted in determining the net profit of the title insurer for that year.

(f) A title insurer shall release from the reinsurance reserve a sum equal to ten per cent of the amount added to the reserve during a calendar year on July 1 of each of the five years following the year in which the sum was added, and shall release from the reinsurance reserve a sum equal to three and one-third per cent of the amount added to the reserve during that year on each succeeding July 1 until the entire amount for that year has been released. The amount of the reinsurance reserve or similar unearned premium reserve maintained before July 1, 1988, shall be released in accordance with the law in effect before July 1, 1988. [L 1987, c 347, pt of §2 as superseded by c 348, §23]

**Revision Note**

"July 1, 1988" substituted for "the effective date of this code" or "Act".

**§431:20-115 Use of reinsurance reserve on liquidation, dissolution or insolvency.** (a) If a domestic title insurer becomes insolvent, is in the process of liquidation or dissolution, or is in the possession of the commissioner:

(1) The amount of the reinsurance reserve then remaining may be used by or with the written approval of the commissioner to pay for reinsurance of the liability of the title insurer upon all outstanding title insurance policies or reinsurance agreements to the extent for which claims for losses by the holders thereof are not then pending. The balance of the assets, if any, equal to the reinsurance reserve may be transferred to the general assets of the title insurer; and

(2) The assets net of the reinsurance reserve shall be available to pay claims for losses sustained by holders of title insurance policies then pending or arising up to the time reinsurance is effected. If claims for losses exceed any other assets of the title insurer, the claims, when established, shall be paid pro rata out of the surplus assets attributable to the reinsurance reserve, to the extent of the surplus, if any.

(b) If reinsurance is not obtained, assets equal to the reinsurance reserve and assets constituting minimum capital, or so much as remains thereof after outstanding claims have been paid, shall constitute a trust fund to be held and invested by the commissioner for twenty years, out of which claims of policyholders shall be paid as they arise. The balance, if any, of the trust fund, at the expiration of twenty years, shall revert to the general assets of the title insurer. [L 1987, c 347, pt of §2 as superseded by c 349, §13]

**§431:20-116 Loss and loss expense reserve.** (a) All title insurers licensed in this State shall establish and maintain reserves against unpaid losses and loss expenses.

(b) Upon receiving notice from or on behalf of the insured of a title defect in, or lien or adverse claim against, the title of the insured that may result in a loss or cause expense to be incurred in the proper disposition of the claim, the title insurer shall determine the amount to be added to the reserve, which amount shall reflect a careful estimate of the loss or loss expense likely to result by reason of the claim.

(c) Reserves required under this section may be revised from time to time and shall be redetermined at least once each year. [L 1987, c 348, §24]

**§431:20-117 Reinsurance.** (a) A title insurer may obtain reinsurance for all or any part of its liability under one or more of its title insurance policies or reinsurance agreements, and may also reinsure title insurance policies issued by other title insurers on risks located in this State or elsewhere. Reinsurance on policies issued on properties located in this State must be obtained from title insurers authorized to transact title insurance business in this State.

(b) Upon application by a title insurer, the commissioner may permit the insurer to obtain reinsurance from an unauthorized title insurer upon the following conditions:

(1) The title insurer is unable to obtain reinsurance from a title insurer authorized to transact title insurance business in this State; and

(2) The capital and surplus of the unauthorized title insurer meets the requirements for authorized companies under section 431:20-107. [L 1987, c 347, pt of §2]

**§431:20-118 Prohibition on rebates and inducements.** (a) No title insurer, controlled escrow company, or underwritten title company shall:

(1) Pay to the insured or to any other person any commission, any part of its premiums, fees or other charges; or any other consideration as inducement or compensation for the referral of title business, for performance of any escrow, or other service in connection with which a title policy is issued;

(2) Make any rebate of any portion of the fee or charge shown by the schedule required in section 431:20-120. For purposes of this article, the amount by which any fee or charge is less than that called for by the then currently effective schedule of fees and charges of the title insurer is an unlawful rebate; or

(3) Quote any fee or make any charge for a title policy to any person that is less than that currently available to others for the same type of title policy in a like amount covering property in the same county and involving the same factors as set forth in its then currently effective schedule of fees and charges. Nothing in this article shall prohibit bulk rates or special rates for customers of prescribed classes if the bulk or special rates are provided for in the schedule.

(b) No title insurer shall issue any title policy in any transaction in connection with which it or any person, who is a controlled escrow company or underwritten title company by reason of its relationship with such title insurer, has paid or contemplates paying any commission in violation of subsection (a)(1) or, in connection with which it or any such controlled escrow company or underwritten title company, has made or contemplates making any unlawful rebate in violation of subsection (a)(2).

(c) No insured named in a title insurance policy nor any other person may knowingly receive or accept, directly or indirectly, any commission, rebate or inducement referred to in subsection (a).

(d) Nothing in this section shall be construed as prohibiting reasonable payments, other than for the referral of title insurance business, for services actually rendered to a title insurer in connection with title insurance business. [L 1987, c 347, pt of §2; am L 2004, c 122, §78]

**§431:20-119 Division of fees.** Nothing in this article shall prohibit the division of fees or charges between two or more title

insurers or between one or more title insurers and one or more underwritten title companies, if such division does not constitute an unlawful rebate or inducement, or payment of a finder's fee; provided that a title insurer shall specify on any title policy issued by it, either in a single amount or by itemization, the entire charge made to obtain such title policy, including the charges made by any underwritten title company for the title search, title examination, certificate, or abstract of title upon the basis of which the title policy is issued. If so specified in a single amount, the charge shall be clearly described as the total charge for both the title insurance fee and the search, certificate, chain or abstract title, lien search, or any continuation of any of the above, as the case may be, of any underwritten title company. [L 1987, c 347, pt of §2]

**§431:20-120 Schedules of premiums and charges.** (a) Every title insurer shall adopt, print, and make available to the public schedules of its currently effective premiums and charges.

(b) The schedules shall:

(1) Be printed in type not smaller than ten point;

(2) Be dated to show the date the premiums and charges become effective;

(3) Be kept available to the public and prominently displayed in a public place in each of the offices of the insurer, the controlled escrow company, and the underwritten title company in the particular county to which they relate;

(4) Set forth the total premium and charge for each type of title insurance policy or service issued or provided by the title insurer in the given amount of coverage, by a statement of the charge per unit of the amount of coverage, or a combination of the two; and

(5) Include the charge made by any underwritten title company for the search, certificate, chain or abstract of title, lien search, or any continuation of any of the above, upon the basis of which such title policy is issued.

(c) The schedule may:

(1) Include a statement that additional charges are made when unusual conditions of title are encountered or when special or unusual risks are insured against and that additional charges are made for special services rendered in connection with the issuance of a title policy; and

(2) Provide different fees or charges for title policies covering property in different counties or separate schedules may be adopted for title policies covering property in different counties.

(d) All or any part of any schedule may be changed or amended at any time or from time to time. Each change or amendment shall be printed and dated to show the effective date of the change or amendment. No change or amendment shall become effective until at least five days after it has been displayed in the offices of the title insurer in the same manner as provided for the display of schedules. No change or amendment increasing fees or charges shall apply to title policies ordered prior to the effective date of such change or amendment.

(e) Each title insurer, controlled escrow company, and underwritten title company shall keep a complete file of its schedules of premiums and charges and of all changes and amendments thereto until at least five years after they shall have ceased to be in effect, and such file shall be available for inspection by the commissioner. [L 1987, c 347, pt of

§2]

**§431:20-121 Contract forms, filing, disapproval.** (a) Every title insurer shall at least thirty days before use, file with the commissioner every form of insurance contract which it proposes to issue as to risks located in this State, together with the forms of all printed endorsements or other modifications of such contracts proposed to be used. Each filing shall be accompanied by a $20 fee payable to the commissioner, which fee shall be deposited in the commissioner's education and training fund.

(b) The commissioner may disapprove any such form if it:

(1) Is in violation of law;

(2) Contains inconsistent, ambiguous or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract;

(3) Has any title, heading or other indication of its provisions which is misleading; or

(4) Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

(c) The commissioner shall not disapprove any such form after expiration of the initial thirty-day advance filing period except after a hearing thereon held in accordance with chapter 91.

(d) A title insurer shall not use in this State any form while it is so disapproved by the commissioner. [L 1987, c 347, pt of §2; am L 1988, c 363, §2(5)]

**Cross References**

Commissioner's education and training fund, see §431:2-214.

**§431:20-122 Annual statement.** Every title insurer shall include in its annual statement furnished to the commissioner pursuant to section 431:20-103(4), the name of each person in this State which is a controlled escrow company or underwritten title company by reason of its relationship with such title insurer. [L 1987, c 347, pt of §2]

**§431:20-123 Remedies.** In enforcing this article, the commissioner shall be entitled to the remedies provided for in section 431:20-103(2), (3), and (4). [L 1987, c 347, pt of §2; am L 2004, c 122, §79]

**§431:20-124 Additional penalty.** Every title insurer, controlled escrow company, and underwritten title company who pays any commission or who makes any unlawful rebate in violation of this article shall be liable to this State for five times the amount of any such commission or unlawful rebate, the amount thereof to be recovered by the commissioner as a general realization of this State, in addition to any other penalty imposed by law. [L 1987, c 347, pt of §2]

**§431:20-125 Revocation or suspension of title insurer's certificate of authority.** (a) The commissioner may after a hearing suspend or revoke the certificate of authority of any title insurer which:

(1) After ten days' written notice from the commissioner requiring it so to do, fails to print, display, and make available to the public its schedule of fees and charges in the manner provided in section 431:20-120.

(2) After ten days' written notice from the commissioner requiring it to cease and desist, continues to pay any commission or to make any rebate in wilful violation of section 431:20-118.

(b) The hearings shall be conducted in accordance with section 431:20-103(3) and the commissioner shall have all the powers granted therein. [L 1987, c 347, pt of §2]

## ARTICLE 21
## HAWAII PROPERTY INSURANCE ASSOCIATION

### Cross References

Hawaii hurricane relief fund, see chapter 431P.

**[§431:21-101] Purpose.** The purpose of this article is to establish the Hawaii Property Insurance Association to:

(1) Assure stability in the property insurance market for property located in the State;

(2) Assure the availability of basic property insurance as defined by this article; and

(3) Provide for the equitable distribution among member insurers of the responsibility for insuring qualified property for which basic property insurance cannot be obtained through the authorized insurers. [L 1991, c 284, pt of §2]

**[§431:21-102] Definitions.** As used in the article:

"Association" means the Hawaii Property Insurance Association created under section 431:21-103.

"Basic property insurance" means insurance against direct loss to real or tangible personal property from perils insured under the standard fire policy and extended coverage endorsement.

"Member insurer" means any person who is authorized to transact property or casualty insurance in this State and is not engaged only in writing motor vehicle insurance under section 431:10C-106.

"Net direct written premiums" means the premiums taxable pursuant to section 431:7-202(a) for policies of property and casualty insurance. [L 1991, c 284, pt of §2]

**§431:21-103 Creation of association.** (a) There is created a nonprofit unincorporated legal entity to be known as the Hawaii Property Insurance Association. All insurers included in the definition of member insurer in section 431:21-102 shall be and remain members of the association as a condition of their authority to transact the business of insurance in this State. The association shall perform its functions under a plan of operation established and approved under section 431:21-106 and shall exercise its powers through a board of directors established under section 431:21-104.

(b) Each member insurer shall participate in the writings, expenses, profits, and losses of the association in the proportion that its net direct written premiums during the preceding calendar year bear

to the net direct written premiums for all member insurers for the preceding calendar year. [L 1991, c 284, pt of §2; am L 1992, c 143, §2]

**§431:21-104 Board of directors.** (a) The board of directors shall have responsibility and control over the organization, management, policies, and activities of the association. The board of directors of the association shall consist of twelve persons serving terms as established in the plan of operation. The board shall be composed of:

(1) Eight voting members selected by the member insurers;

(2) One voting member appointed by the commissioner to represent insurance producers; and

(3) Three voting members appointed by the commissioner to represent the public.

(b) The commissioner shall appoint the initial members of the board of directors. All member insurers shall be fairly represented on the board.

(c) Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors. [L 1991, c 284, pt of §2; am L 1992, c 143, §3; am L 1994, c 128, §9; am L 1996, c 99, §2; am L 2003, c 212, §118]

**§431:21-105 Powers and duties of the association.** (a) In addition to any other requirements imposed by law, the association shall:

(1) Formulate and administer a plan of operation to insure persons having an insurable interest in real or tangible personal property in the area designated by the commissioner;

(2) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while processing applications and servicing policies on behalf of the association; and

(3) Collect and maintain statistical information and other information required by the commissioner.

(b) In addition to any other powers allowed by law, the association may:

(1) Add additional insurance coverages with the approval of the commissioner, including coverage for commercial risks up to the limits of coverage for residential risks as set forth in the plan of operation;

(2) Employ or retain persons as are necessary to perform the duties of the association;

(3) Contract with a member insurer to perform the duties of the association;

(4) Sue or be sued;

(5) Borrow funds necessary to effectuate the purposes of this article in accord with the plan of operation;

(6) If approved by the commissioner, assess member insurers amounts necessary to cover extraordinary losses incurred by the association. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year an amount greater than two per cent of that member insurer's net direct written premiums for the preceding calendar year. The association may exempt or defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact business;

(7) Devise a method to give credit to member insurers for homeowners and fire insurance policies individually underwritten on risks located in the area designated for coverage by the association;

(8) Negotiate and become a party to contracts as are necessary to carry out the purposes of this article; and

(9) Perform all other acts as are necessary or proper to effectuate the purpose of this article. [L 1991, c 284, pt of §2; am L 1992, c 143, §4]

**[§431:21-105.5] Default in payment of assessments.** In the event any member insurer fails to pay any assessment by the association when due, the association shall report the default in writing to the commissioner no later than five days after the default and may bring a civil action in circuit court to enforce payment. [L 1992, c 143, §1]

**§431:21-106 Plan of operation.** (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendment shall become effective upon approval in writing by the commissioner. If the association fails to submit a suitable plan of operation or if at any time the association fails to submit suitable amendments to the plan, the commissioner shall adopt the rules necessary to carry out this article. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved in writing by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall:

(1) Establish procedures for performance of all the powers and duties of the association under section 431:21-105;

(2) Establish maximum limits of liability to be placed through the association;

(3) Establish reasonable underwriting standards for determining insurability of a risk which are comparable to the standards used to determine insurability of a risk located outside the area designated by the commissioner as eligible for association coverage;

(4) Establish a schedule of deductibles, if appropriate;

(5) Establish the commission to be paid to licensed producers;

(6) Establish the rates to be charged for the insurance coverages, so that the total premium income from all association policies, when combined with the investment income, shall annually fund the administration of the association. The administration of the association shall include the expenses incurred in processing applications, conducting inspections, issuing and servicing policies, paying commissions, and paying claims, but shall not include assessments approved by the commissioner;

(7) Establish the manner and scope of the inspection and the form of the inspection report. The inspection guidelines may include setting minimum conditions the property must meet before an inspection is required;

(8) Establish procedures whereby selections for the board of directors will be submitted to the commissioner for the commissioner's information;

(9) Establish procedures for records to be kept of all financial transactions of the association, its

producers, and its board of directors;

(10) Establish procedures by which applications will be received and serviced by the association;

(11) Establish guidelines for the investigation and payment of claims; and

(12) Establish procedures whereby the association may assume and cede reinsurance on risks written through the association. [L 1991, c 284, pt of §2; am L 1992, c 143, §5; am L 2002, c 155, §97; am L 2003, c 212, §119]

**[§431:21-107] Designation of area.** After consultation with representatives of the United States Geological Survey, the state department of defense, and the county in which the area is located, the commissioner shall designate the geographical area eligible for coverage through the association. Those properties in the designated area that meet the standards set forth in the plan of operation shall be provided insurance through the association. [L 1991, c 284, pt of §2]

**[§431:21-108] Renewals of existing policies.** Member insurers shall renew policies in existence on June 18, 1991, on property situated in the area designated by the commissioner under section 431:21-107. A member insurer may choose not to renew such a policy if the insured property does not meet the member insurer's underwriting criteria. [L 1991, c 284, pt of §2]

**Revision Note**

"June 18, 1991" substituted for "the effective date of this article".

**§431:21-109 Insurance coverages available under plan.** (a) All properties qualifying for coverage under the plan of operation shall be eligible for the standard fire policy and extended coverage endorsement. The association shall provide additional coverages when directed by the commissioner or when approved by the commissioner.

(b) At the written request of any person who is, or is attempting to become, a mortgagor on real property that qualifies for coverage under the plan of operation, the association shall provide coverage for an amount not less than the amount of the mortgage obligation, but no greater than the value of the property being insured; provided that it does not exceed the limits of the plan. The policy shall name the intended mortgagee as the beneficiary for the amount equal to the outstanding balance on the mortgage.

(c) In the application of subsection (b), the amount covered under the policy shall comply with article 10E. [L 1991, c 284, pt of §2; am L 1997, c 14, §1]

**[§431:21-110] Application; inspection.** (a) Any person having an insurable interest in real or tangible personal property who has been unable to obtain basic property insurance from a licensed insurer may apply to the association for coverage.

(b) Within ten days of receiving an application, the association may conduct an inspection of the property to determine the condition of the property and decide if the property qualifies for coverage under the

standards set forth in the plan of operation.

(c) The inspection of the property shall include, but need not be limited to, inspection of pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. A representative photograph may be taken as part of the inspection.

(d) Within ten days of the inspection, an inspection report shall be filed with the member insurer designated by the association. A copy of the completed inspection report shall be sent to the applicant upon request. [L 1991, c 284, pt of §2]

**[§431:21-111] Duties and powers of the commissioner.** (a) The commissioner shall provide the association with a statement of the net direct written premiums of each member insurer.

(b) The commissioner shall approve an assessment of member insurers by the association when the association is insolvent as defined in section [431:15-103(a)].

(c) The commissioner may suspend or revoke after a hearing the certificate of authority of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. The fine shall not exceed five per cent of the unpaid assessment per month and shall not be less than $100 per month. [L 1991, c 284, pt of §2]

**[§431:21-112] Reports.** (a) The association shall submit to the commissioner each year not later than one hundred twenty days after the association's fiscal year, a financial report in a form approved by the commissioner.

(b) The commissioner may require other reports from insurers concerning risks insured under the plan. [L 1991, c 284, pt of §2]

**§431:21-113 Appeals.** Any applicant or member insurer affected by a decision of the association shall have the right to appeal to the board of directors within thirty days after the decision. The application for appeal shall specify in what respects the person making the appeal was aggrieved and the grounds to be relied upon as a basis for the relief demanded. The board of directors shall hold the hearing within thirty days after the board of directors' receipt of the application for appeal unless postponed by mutual consent.

Any final action or order of the board of directors shall be subject to judicial review by the circuit court of the first judicial circuit. [L 1991, c 284, pt of §2; am L 1992, c 143, §6]

**[§431:21-114] Tax exemptions.** The association shall be exempt from payment of all fees and all taxes levied by this State. [L 1991, c 284, pt of §2]

**[§431:21-115] Credits for assessments paid.** A member insurer may offset against its premium tax liability to this State an assessment made with the commissioner's approval to the extent of twenty per cent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. In the event a member insurer

should cease doing business in this State, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business. [L 1991, c 284, pt of §2]

**[§431:21-116] Examination.** For the purpose of ascertaining its condition, or compliance with this article, the commissioner, as often as the commissioner deems advisable, may examine the accounts, records, documents, and transactions of the association. The association shall pay the expenses of the examination in accordance with section 431:2-306(b). [L 1991, c 284, pt of §2]

**§431:21-117 Immunity and limitation on liability.** There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors, the commissioner, or the commissioner's representatives for any action taken by them in the performance of their powers and duties under this article. Chapters 661 and 662 or any other law to the contrary notwithstanding, nothing in this article shall create an obligation, debt, claim, cause of action, claim for relief, charge, or any other liability of any kind whatsoever in favor of any person or entity, without regard to whether that person or entity receives any benefits under this article, against the State, or its officers and employees. The State and its officers and employees shall not be liable for the results of any application, denial of application, claim, loss, or other benefits provided by the association pursuant to this article. Nothing in this article shall be construed as authorizing any claim against the State whatsoever, nor shall this article be construed as authorizing any claim against the association in excess of any note, loan, liability, or other obligation incurred by the association. [L 1991, c 284, pt of §2; am L 1992, c 143, §7]

**[§431:21-118] Status of association policies.** All financial institutions shall consider a policy issued by the association to be the same as a similar policy issued by an insurer authorized to transact insurance in this State. [L 1991, c 284, pt of §2]

**§431:21-119 Issuance of new policies; removal of moratorium.** If residential property insurance is unavailable, as determined by the commissioner, due to a moratorium on the issuance of policies on property situated in lava zones where the mayor of the county of Hawaii has issued a proclamation declaring a state of emergency exists due to the threat of imminent disaster from a lava flow, the association shall remove its moratorium. Upon the moratorium's removal, the association shall offer new policies and may provide a waiting period of no longer than six months for the policy coverage to take effect; provided that the residential property in the lava zone does not have current insurance. [L 2015, c 32, §3; am L 2016, c 6, §1]

**Cross References**

Insurance for properties in lava zones in the county of Hawaii, see §§431:10E-141 and 431:10E-142.

## [ARTICLE 22]
## LOSS MITIGATION GRANT PROGRAM

**§431:22-101 Definitions.** As used in this article:

"Commissioner" means the insurance commissioner.

"Loss mitigation" means actions undertaken to reduce losses that may result from a hazard.

"Wind resistive devices" means devices, techniques, and residential safe rooms, as identified and determined in accordance with section 431:22-104(b), that increase a building's or structure's resistance to damage from wind forces. [L 2002, c 179, pt of §3; am L Sp 2005, c 5, §9; am L 2007, c 80, §2]

**§431:22-102 REPEALED.** L 2011, c 124, §55.

**§431:22-103 Establishment of loss mitigation grant program.** The commissioner shall develop and implement a pilot grant program to encourage the installation of wind resistive devices. The commissioner may spend up to $6,000,000 over three years for the grant program, which amounts shall include the costs of administering, operating, and marketing the grant program.

For the first year of the grant program, the commissioner may make grants only to former policyholders of the Hawaii hurricane relief fund. From the second year onward, the commissioner may also make grants to all single or multi-family residential owners, which may include owners of townhouse units or condominium apartments under section 431:22-104(c)(3). [L 2002, c 179, pt of §3; am L 2011, c 124, §46]

**§431:22-104 Standards for the award of grants.** (a) Subject to the availability of funds and the standards in this article, grants for wind resistive devices shall be awarded by the commissioner:

(1) That reimburse thirty-five per cent of costs incurred for the wind resistive devices and their installation, up to a maximum total reimbursement of $2,100 per dwelling;

(2) On a first-come, first-served basis, as determined by the commissioner; and

(3) For a wind resistive device or devices installed only in a single or multi-family residential dwelling.

(b) Grants shall be awarded for the installation of the following:

(1) Uplift restraint ties at roof ridges and roof framing members to wall or beam supports;

(2) Additional fastening of roof sheathing and roof decking for high wind uplift;

(3) Impact and pressure resistant exterior opening protective devices;

(4) Wall to foundation uplift restraint connections strengthening for wood foundation posts on footings; and

(5) Residential safe rooms.

The description, specifications, guidelines, and requirements for these wind resistive devices shall be further developed and determined by the

commissioner in the commissioner's sole discretion. The commissioner, in the commissioner's sole discretion, may amend, narrow, or expand the definitions, description, specifications, and requirements of the wind resistive devices.

(c) In addition, a grant may be made to an applicant only if the applicant:

(1) Has met the descriptions, specifications, guidelines, and requirements established by the commissioner for the grant program;

(2) Has filed a completed application form, as determined solely by the commissioner, together with all supporting documentation required by the commissioner;

(3) Has, in the case of a building with multiple dwellings, filed together completed grant applications for all dwellings in the building, for installation of wind resistive devices indicated in section 431:22-104(b)(1), (2), and (4); provided that this requirement does not apply to section 431:22-104(b)(3);

(4) Has installed a wind resistive device or devices including residential safe room designs that meet the standards established by the state department of defense and that have been designated and approved by the commissioner;

(5) Has fully paid, prior to applying for the grant, the cost of the wind resistive device or devices, as well as the installation costs for which the grant is sought. The grant shall be used to reimburse only these costs or a portion thereof;

(6) Has hired an inspector, determined by the commissioner to be qualified in accordance with the requirements of the commissioner, who has verified in writing that the installation of the wind resistive device or devices is complete and is in compliance with the grant program specifications, guidelines, and requirements, as determined by the commissioner;

(7) Has installed the wind resistive device or devices after July 1, 2002;

(8) Has provided any other information deemed necessary by the commissioner; and

(9) Has met all additional requirements needed to implement the grant program as determined by the commissioner.

(d) Moneys appropriated for the grant program may be used to pay for the costs of administering, operating, and marketing the grant program, as determined by the commissioner. [L 2002, c 179, pt of §3; am L Sp 2005, c 5, §§10, 11; am L 2007, c 80, §3]

**[§431:22-105] Technical advisory committee.** The commissioner shall appoint an advisory committee of persons having expertise and familiarity relevant to the mitigation grant program and feasibility study report. [L 2002, c 179, pt of §3]

## [ARTICLE 30]
## INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

**[§431:30-101] Scope.** (a) The interstate insurance product regulation compact is intended to help states join together to establish an interstate compact to regulate designated insurance products. Pursuant to the terms and conditions of this article, the State seeks to join with other states by enacting the interstate insurance product regulation compact, and thus become a member of the interstate insurance

product regulation commission.

(b) The purposes of this compact are, through means of joint and cooperative action among the compacting states:

(1) To promote and protect the interest of consumers of individual and group annuity, life insurance, long-term care, and disability income products;

(2) To develop uniform standards for insurance products covered under the compact;

(3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states;

(4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

(5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;

(6) To create the interstate insurance product regulation commission; and

(7) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance. [L 2004, c 104, pt of §2]

**§431:30-102 Definitions.** As used in this article, the following definitions apply:

"Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the rules and operating procedures of the commission.

"Bylaws" means those bylaws established by the commission for its governance, or for directing or controlling the commission's actions or conduct.

"Commission" means the interstate insurance product regulation commission established by this compact.

"Commissioner" means the chief insurance regulatory official of a state.

"Compacting state" means any state that has enacted this compact legislation and that has not withdrawn pursuant to section 431:30-119, or been terminated pursuant to section 431:30-120.

"Insurer" means any entity licensed by a state to issue contracts of insurance for those lines of insurance covered by this article.

"Member" means the commissioner of a compacting state, as its representative to the commission, or the commissioner's designee.

"Noncompacting state" means any state that is not at the time a compacting state.

"Operating procedures" means procedures adopted by the commission implementing a rule, uniform standard, or a provision of this compact.

"Product" means the form of a policy or contract, including any application, endorsement, or related form that is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an insurer is authorized to issue.

"Rule" means a statement of general or particular applicability and future effect adopted by the commission, including a uniform standard developed pursuant to section 431:30-112 of this compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the commission, which shall have the force and effect of law in the compacting states.

"State" means any state, district, or territory of the United States of America.

"Third-party filer" means an entity that submits a product filing to the commission on behalf of an insurer.

"Uniform standard" means a standard adopted by the commission for a product line, pursuant to section 431:30-112 of this compact, and shall include all of the product requirements in aggregate; provided that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable, or against public policy as determined by the commission. [L 2004, c 104, pt of §2; am L 2010, c 116, §1(26)]

**[§431:30-103] Establishment of the commission and venue.** (a) The compacting states hereby create and establish a joint public entity known as the interstate insurance product regulation commission. Pursuant to section 431:30-112, the commission may develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards; provided it is not intended that the commission be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance, and any such filing shall be subject to the laws of the state where filed.

(b) The commission is a body corporate and politic and an instrumentality of the compacting states.

(c) The commission is solely responsible for its liabilities except as otherwise specifically provided in this compact.

(d) Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. [L 2004, c 104, pt of §2]

**[§431:30-104] Powers of the commission.** The commission may:

(1) Adopt rules pursuant to section 431:30-112, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this article;

(2) Exercise its rulemaking authority and establish reasonable uniform standards for products covered under the compact, and advertisements related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for such products filed with the commission; provided that a compacting state may opt out of such uniform standard pursuant to section 431:30-112, to the extent and in the manner provided in this article; provided further that any uniform standard established by the commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners long-term care insurance model act and long-term care insurance model regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the National Association of

Insurance Commissioners long-term care insurance model act or the long-term care insurance model regulation adopted by the National Association of Insurance Commissioners require amending of the uniform standards established by the commission for long-term care insurance products;

(3) Receive and review in an expeditious manner products filed with the commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the compact;

(4) Receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the commission, and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long-term care insurance products, the commission may require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the commission as provided in this section shall have the force and effect of law and shall be binding on the compacting states to the extent and in the manner provided in the compact;

(5) Exercise its rulemaking authority and designate products and advertisements that may be subject to a self-certification process without the need for prior approval by the commission;

(6) Adopt operating procedures pursuant to section 431:30-112, which shall be binding on the compacting states to the extent and in the manner provided in this article;

(7) Bring and prosecute legal proceedings or actions in its name as the commission; provided that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

(8) Issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(9) Establish and maintain offices;

(10) Purchase and maintain insurance and bonds;

(11) Borrow, accept, or contract for services of personnel, including but not limited to employees of a compacting state;

(12) Hire employees, professionals, or specialists, and elect or appoint officers, determine their qualifications, fix their compensation, define their duties, and give them appropriate authority to carry out the purposes of the compact, and establish the commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel;

(13) Accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and receive, use, and dispose of the same; provided that at all times the commission shall strive to avoid any appearance of impropriety;

(14) Lease, purchase, and accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed; provided that at all times the commission shall strive to avoid any appearance of impropriety;

(15) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(16) Remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures;

(17) Enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws;

(18) Provide for dispute resolution among compacting states;

(19) Advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this compact;

(20) Provide advice and training to those personnel in state insurance departments responsible for product review, and be a resource for state insurance departments;

(21) Establish a budget and make expenditures;

(22) Borrow money;

(23) Appoint committees, including advisory committees comprised of members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws;

(24) Provide and receive information from, and cooperate with law enforcement agencies;

(25) Adopt and use a corporate seal; and

(26) Perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with state regulation of the business of insurance. [L 2004, c 104, pt of §2]

**§431:30-105 REPEALED.** L 2010, c 116, §4.

**[§431:30-106] Membership; voting; bylaws.** (a) Each compacting state shall have and be limited to one member. Each member shall be qualified to serve in such capacity under or pursuant to the applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which the member is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state wherein such vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

(b) Each member shall be entitled to one vote and shall have an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the commission with respect to the adoption of a uniform standard shall be effective unless two-thirds of the members vote in favor thereof.

(c) The commission, by a majority of the members, shall prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including but not limited to:

(1) Establishing the fiscal year of the commission;

(2) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee;

(3) Providing reasonable standards and procedures for the establishment and meetings of other committees, and governing any general or specific delegation of any authority or function of the commission;

(4) Providing reasonable procedures for calling and conducting meetings of the commission that consist of a majority of commission members, ensuring reasonable advance notice of each such meeting, and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting in toto or in part. As soon as practicable, the commission shall make public a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed, and votes taken during such meeting;

(5) Establishing the titles, duties, and authority, and reasonable procedures for the election, of the officers of the commission;

(6) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the commission;

(7) Adopting a code of ethics to address permissible and prohibited activities of commission members and employees; and

(8) Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment or reserving of all of its debts and obligations.

(d) The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compacting states. [L 2004, c 104, pt of §2]

**§431:30-107 Management committee; officers and personnel.** (a) A management committee comprising no more than fourteen members shall be established as follows:

(1) One member from each of the six compacting states with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the National Association of Insurance Commissioners for the prior year;

(2) Four members from compacting states with at least two per cent of the market based on the premium volume described above, other than the six compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

(3) Four members from those compacting states with less than two per cent of the market, based on the premium volume described above, with one selected from each of the four zone regions of the National Association of Insurance Commissioners as provided in the bylaws.

(b) The management committee shall have the authority and duties set forth in the bylaws, including but not limited to:

(1) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission;

(2) Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard; provided that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds of the members of the management committee;

(3) Overseeing the offices of the commission; and

(4) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations to advance the goals of the commission.

(c) The commission shall annually elect officers from the management committee with each having such authority and duties as may be specified in the bylaws.

(d) The management committee, subject to the approval of the commission, may appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the commission may deem appropriate. The executive director shall serve as secretary to the commission, but shall not be a member of the commission. The executive director shall hire and supervise such other staff as may be authorized by the commission. [L 2004, c 104, pt of §2; am L 2005, c 132, §7]

**[§431:30-108] Legislative and advisory committees.** (a) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the commission including the management committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget, or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

(b) The commission shall establish two advisory committees, one of which shall be comprised of consumer representatives independent of the insurance industry, and the other, of insurance industry representatives.

(c) The commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions. [L 2004, c 104, pt of §2]

**[§431:30-109] Corporate records of the commission.** The commission shall maintain its corporate books and records in accordance with the bylaws. [L 2004, c 104, pt of §2]

**[§431:30-110] Qualified immunity; defense; indemnification.** (a) The members, officers, executive director, employees, and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused or arising out of any actual or alleged act, error, or omission that occurred or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that nothing in this subsection shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or wilful and wanton misconduct of any such person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil

action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit such person from retaining counsel; provided further that the actual or alleged act, error, or omission did not result from the intentional or wilful and wanton misconduct of any such person.

(c) The commission shall indemnify and hold harmless the member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against such persons arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that the actual or alleged act, error, or omission did not result from the intentional or wilful and wanton misconduct of any such person. [L 2004, c 104, pt of §2]

**[§431:30-111] Meetings and acts of the commission.** (a) The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

(b) Each member of the commission may cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(c) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws. [L 2004, c 104, pt of §2]

**§431:30-112 Rules and operating procedures; rulemaking functions of the commission and rejection of uniform standards.** (a) The commission shall adopt reasonable rules, including uniform standards, and operating procedures to effectively and efficiently achieve the purposes of this compact. Notwithstanding the foregoing, in the event the commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this article or the powers granted hereunder, such action by the commission shall be invalid and have no force and effect.

(b) Rules and operating procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981, as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committees in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. In adopting a uniform standard, the commission shall consider fully all submitted materials and issue a concise explanation of its decision.

(c) A uniform standard shall become effective ninety days after its adoption by the commission or such later date as the commission may determine; provided that a compacting state may "opt out" of a uniform

standard as provided in this article. "Opt out" shall be defined as any action by a compacting state to decline to adopt or participate in an adopted uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure, or amendment.

(d) A compacting state may opt out of a uniform standard, either by legislation or by rule adopted by the insurance commissioner. If a compacting state elects to opt out of a uniform standard by rule, it shall:

(1) Give written notice to the commission no later than ten business days after the later of the adoption of the uniform standard or the state becoming a compacting state;

(2) Find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state that warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner shall consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh:

(A) The intent of the legislature to participate in, and reap the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this article; and
(B) The presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this compact. An opt out pursuant to this section shall be effective at the time of enactment of this compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently adopted; and

(3) In accordance with the provisions of paragraph (2), this State does prospectively opt out of all uniform standards involving long-term care insurance products promulgated by the commission, as this State has previously enacted article 10H providing additional standards for federal conformity and universal availability for reciprocal beneficiary and multi-generation populace which facilitates flexibility and innovation in the development of long-term care insurance coverage.

(e) If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time the opt out legislation is enacted into law or the opt out regulation becomes effective.

Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under section 431:30-119 for withdrawals.

(f) If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the commission, at

least fifteen days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension thereof may postpone the effective date by up to ninety days, unless affirmatively extended by the commission; provided that a stay may not be permitted to remain in effect for more than one year unless the compacting state can show extraordinary circumstances that warrant a continuance of the stay, including but not limited to the existence of a legal challenge that prevents the compacting state from opting out. A stay may be terminated by the commission upon notice that the rulemaking process has been terminated.

(g) Not later than thirty days after a rule or operating procedure is adopted, any person may file a petition for judicial review of the rule or operating procedure; provided that the filing of such petition shall not stay or otherwise prevent such rule or operating procedure from becoming effective unless there is a finding that there is a substantial likelihood of success on behalf of the party filing such petition. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if such rule or operating procedure represents a reasonable exercise of the commission's authority. [L 2004, c 104, pt of §2; am L 2010, c 116, §1(27)]

**[§431:30-113] Commission records and enforcement.** (a) The commission shall adopt rules establishing conditions and procedures for public inspection and copying of its information and official records, except information and records involving the privacy of individuals and insurers' trade secrets. The commission may adopt additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(b) Except as to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data, or information to the commission; provided that disclosure to the commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and provided further that, except as otherwise expressly provided in this article, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the commission shall remain confidential after such information is provided to any commissioner.

(c) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify such noncomplying compacting state in writing of its noncompliance with commission bylaws, rules, or operating procedures. If the noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in section 431:30-120.

(d) The commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise the commissioner's authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following provisions:

(1) With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards, or requirements of the compact, except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission; and

(2) Before a commissioner may bring an action for violation of any provision, standard, or requirement of the compact relating to the content of an advertisement not approved or certified to the commission, the commission, or an authorized commission officer or employee, shall authorize the action; provided that authorization pursuant to this paragraph does not require notice to the insurer, opportunity for hearing, or disclosure of requests for authorization or records of the commission's action on such requests. [L 2004, c 104, pt of §2]

**[§431:30-114] Dispute resolution.** The commission, upon the request of a member, shall attempt to resolve any disputes or other issues that are subject to this compact and that may arise between two or more compacting states, or between compacting states and noncompacting states, and shall adopt an operating procedure providing for resolution of such disputes. [L 2004, c 104, pt of §2]

**[§431:30-115] Product filing and approval.** (a) Insurers and third-party filers seeking to have a product approved by the commission shall file such product with, and pay applicable filing fees to, the commission. Nothing in this article shall be construed to restrict or otherwise prevent an insurer from filing its product in any state wherein such insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the state where filed.

(b) The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the commission shall adopt rules to establish conditions and procedures under which the commission will provide public access to product filing information. In establishing such rules, the commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets that may be contained in a product filing or supporting information.

(c) Any product approved by the commission may be sold or otherwise issued in compacting states for which the insurer is legally authorized to do business. [L 2004, c 104, pt of §2]

**[§431:30-116] Review of commission decisions regarding product filings.** (a) Not later than thirty days after the commission has given notice that it has disapproved a product or advertisement filed with the

commission, the insurer or third party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall adopt rules to establish procedures for appointing the review panel and provide for notice and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, shall be subject to judicial review in accordance with section 431:30-103.

(b) The commission may monitor, review, and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product or advertisement does not meet the relevant uniform standard. Where appropriate, the commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in this section. [L 2004, c 104, pt of §2]

**[§431:30-117] Finance.** (a) The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, compacting states, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of its duties shall not be compromised.

(b) The commission shall collect a filing fee from each insurer and third party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

(c) The commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in rules adopted in accordance with section 431:30-112.

(d) The commission shall be exempt from all taxation in and by the compacting states.

(e) The commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(f) The commission shall keep complete and accurate accounts of all its internal receipts (including grants and donations) and disbursements of all funds under its control. The internal financial accounts of the commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports, including the system of internal controls and procedures of the commission shall be audited annually by an independent certified public accountant. Upon the determination of the commission, but no less frequently than every three years, the review of such independent auditor shall include a management and performance audit of the commission. The commission shall make an annual report to the governor and legislature of the compacting states, which shall include a report of such independent audit. The commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state upon request; provided that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(g) No compacting state shall have any claim to or ownership of any

property held by or vested in the commission or to any commission funds held pursuant to the provisions of this compact. [L 2004, c 104, pt of §2]

**[§431:30-118] Compacting states; effective date; amendment.** (a) Any state is eligible to become a compacting state.

(b) The compact shall become effective and binding upon legislative enactment of the compact into law by two compacting states; provided the commission shall become effective for purposes of adopting uniform standards for reviewing and giving approval or disapproval of products filed with the commission that satisfy the applicable uniform standards only after twenty-six states are compacting states or, alternatively, the compact is enacted by states representing greater than forty per cent of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the National Association of Insurance Commissioners for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state.

(c) Amendments to the compact may be proposed by the commission for enactment by the compacting states. No amendment shall become effective and binding upon the commission and the compacting states unless and until all compacting states enact such amendment into law. [L 2004, c 104, pt of §2]

**§431:30-119 Withdrawal.** (a) Once effective, the compact shall continue in force and remain binding upon each and every compacting state; provided that a compacting state may withdraw from the compact ("withdrawing state") by enacting a statute specifically repealing the statute that enacted the compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state, unless the approval is rescinded by the withdrawing state as provided in subsection (e).

(c) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state.

(d) The commission shall notify the other compacting states of the introduction of legislation repealing the compact within ten days of its receipt of notice thereof.

(e) The withdrawing state shall be responsible for its share of obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved

under state law.

(f) Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state's reenactment of the compact. [L 2004, c 104, pt of §2; am L 2005, c 132, §8]

**[§431:30-120] Default.** (a) If the commission determines that any compacting state has at any time defaulted ("defaulting state") in the performance of any of its obligations or responsibilities under this compact, the bylaws or duly adopted rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by this compact on such defaulting party shall be suspended from the effective date of default as fixed by the commission. The grounds for default include but are not limited to failure of a compacting state to perform such obligations or responsibilities, and any other grounds designated in commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state shall be terminated from the compact and all rights, privileges, and benefits conferred by this compact shall be terminated from the effective date of termination.

(b) Product approvals by the commission or product self-certifications, or any other advertisement in connection with the product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to section 431:30-119(a).

(c) Reinstatement following termination of any compacting state requires a reenactment of the compact by the state seeking reinstatement. [L 2004, c 104, pt of §2]

**[§431:30-121] Dissolution of compact.** (a) The compact dissolves effective upon the date of the withdrawal or default of the compacting state that reduces membership in the compact to one compacting state.

(b) Upon the dissolution of this compact, the compact shall be void and shall be of no further effect, the business and affairs of the commission shall be wound up, and any surplus funds shall be distributed in accordance with the bylaws. [L 2004, c 104, pt of §2]

**[§431:30-122] Severability and construction.** (a) The provisions of this compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of this compact shall be liberally construed to effectuate its purposes. [L 2004, c 104, pt of §2]

**[§431:30-123] Other laws.** (a) Nothing herein prevents the

enforcement of any other law of a compacting state except as provided in subsection (b).

(b) For any product approved by or certified to the commission, the rules, uniform standards, and any other requirements of the commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such products. For advertisement that is subject to the commission's authority, any rule, uniform standard, or other requirement of the commission that governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the commission shall abrogate or restrict:

(1) The access of any person to state courts;

(2) Remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product;

(3) State law relating to the construction of insurance contracts; or

(4) The authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings as authorized by law.

(c) All insurance products filed with individual states shall be subject to the laws of those states. [L 2004, c 104, pt of §2]

**[§431:30-124] Binding effect of the compact.** (a) All lawful actions of the commission, including all rules and operating procedures adopted by the commission, are binding upon the compacting states.

(b) All agreements between the commission and the compacting states are binding in accordance with their terms.

(c) Upon the request of a party to a conflict over the meaning or interpretation of commission actions, and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding such meaning or interpretation.

(d) If any provision of this compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by such provision upon the commission shall be ineffective as to such compacting state, and such obligations, duties, powers, or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which such obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this compact becomes effective. [L 2004, c 104, pt of §2]

## [ARTICLE 31]
## PORTABLE ELECTRONICS INSURANCE

**[§431:31-101] Definitions.** For purposes of this article:

"Customer" means a person who purchases portable electronics or services.

"Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

"Location" means any physical location in the State or any website,

call-center site, or similar location directed to residents of the State.

"Portable electronics" means electronic devices that are portable in nature, and the accessories and services related to the use of the device.

"Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics, which may provide coverage for portable electronics against any one or more of the following: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes. The term does not include:

(1) A service contract, as defined by section 481X-2;

(2) A policy of insurance covering a seller's or manufacturer's obligations under a warranty; or

(3) A homeowner's, renter's, private passenger automobile, commercial multi-peril, or similar insurance policy.

"Portable electronics transaction" means:

(1) The sale or lease of portable electronics by a vendor to a customer; or

(2) The sale of a service related to the use of portable electronics by a vendor to a customer.

"Supervising entity" means a business entity that is a licensed insurer or insurance producer that is appointed or authorized by an insurer to supervise the administration of a portable electronics insurance program.

"Vendor" means a person in the business of directly or indirectly engaging in portable electronics transactions. [L 2012, c 321, pt of §1]

**[§431:31-102] Licensure of vendors.** (a) A vendor shall hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(b) A limited lines license issued under this section shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(c) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in the State. Upon request by the commissioner and with ten days' notice to the supervising entity, the registry shall be open to inspection and examination by the commissioner during regular business hours of the supervising entity.

(d) Notwithstanding any law to the contrary, a license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in the activities that are permitted in this section. [L 2012, c 321, pt of §1]

**[§431:31-103] Requirements for sale of portable electronics insurance.** (a) At every location at which portable electronics insurance is offered to customers, brochures or other written materials shall be made available to prospective customers. The brochures or other written materials shall:

(1) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

(2) State that enrollment by the customer in a portable electronics insurance program is not required to purchase or lease portable electronics or services;

(3) Summarize the material terms of the insurance coverage, including:

(A) The identity of the insurer;
(B) The identity of the supervising entity;
(C) The amount of any applicable deductible and how it is to be paid;
(D) The benefits of the coverage; and
(E) The key terms and conditions of coverage, such as whether portable electronics may be repaired or replaced with a similar make and model reconditioned, or with non-original manufacturer parts or equipment;

(4) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable if the customer fails to comply with any equipment-return requirements; and

(5) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(b) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor for its enrolled customers.

(c) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program. [L 2012, c 321, pt of §1]

**[§431:31-104] Authority of vendors.** (a) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this chapter, provided that:

(1) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to this section;

(2) The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of a portable electronics insurance program, including development of a training program for employees and authorized representatives of the vendors. The training shall comply with the following:

(A) The training shall be delivered to employees and authorized representatives of a vendor who are directly engaged in the activity of selling or offering portable electronics insurance;
(B) The training may be provided in electronic form; provided that, if the training is conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by a licensed employee of the supervising entity; and
(C) Each employee and authorized representative shall receive

basic instruction about the portable electronics insurance offered to customers and the disclosures required under section 431:31-103; and

(3) No employee or authorized representative of a vendor shall advertise, represent, or otherwise portray the employee or representative as a non-limited lines licensed insurance producer.

(b) The charges for portable electronics insurance coverage may be billed and collected by the vendor. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services. Vendors billing and collecting the charges shall not be required to maintain the funds in a segregated account; provided that the vendor is authorized by the insurer to hold the funds in an alternative manner and remits the amounts to the supervising entity within sixty days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services. [L 2012, c 321, pt of §1]

**[§431:31-105] Sanctions for violations.** The vendor or its employee or authorized representative shall be subject to sanctions pursuant to this chapter for the violation of any provision of this chapter. [L 2012, c 321, pt of §1]

**[§431:31-106] Termination or modification of portable electronics insurance.** (a) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance. The vendor and enrolled customers shall be provided at least sixty days' notice before the change becomes effective.

(b) If the insurer changes the terms and conditions of a policy of portable electronics insurance, the insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating that a change in the terms and conditions has occurred, and a summary of material changes.

(c) Notwithstanding subsection (a), an insurer may terminate an enrolled customer's enrollment under a policy of portable electronics insurance upon fifteen days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(d) Notwithstanding subsection (a), an insurer may immediately terminate an enrolled customer's enrollment under a policy of portable electronics insurance:

(1) For nonpayment of an insurance policy premium;

(2) If the enrolled customer ceases to have an active service with the vendor; or

(3) If an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the policy of portable electronics insurance and the insurer sends notice of termination to the enrolled customer within thirty calendar days after exhaustion of the limit; provided that, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability, until the insurer sends notice of termination to the enrolled customer.

(e) If a policy of portable electronics insurance is terminated by a vendor, the vendor shall mail or deliver written notice to the enrolled customer informing the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty days prior to the termination.

(f) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this section, or is otherwise required by law, the notice or correspondence shall be in writing and sent within the notice period, if any, specified within the law requiring the notice or correspondence. Notwithstanding any law to the contrary, notice and correspondence may be sent either by mail or by electronic means as set forth in this subsection. If the notice or correspondence is mailed, it shall be sent to the vendor at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor, as applicable, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor at the vendor's electronic-mail address specified for such purpose and to its affected enrolled customers' last known electronic-mail addresses as provided by each enrolled customer to the insurer or vendor, as applicable.

For purposes of this subsection, an enrolled customer's provision of an electronic-mail address to the insurer or vendor, as applicable, shall be deemed consent to receive notices and correspondence by electronic means. The insurer or vendor, as applicable, shall maintain proof that the notice or correspondence was sent.

(g) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor, as applicable, by the supervising entity appointed by the insurer. [L 2012, c 321, pt of §1]

**§431:31-107 Application for license and fees.** (a) A sworn application for a license under this article shall be filed with the commissioner on forms prescribed and furnished by the commissioner.

(b) The application for a license shall provide the:

(1) Name, residence address, electronic-mail address, and other information required by the commissioner for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this article; provided that, if the vendor derives more than fifty per cent of its revenue from the sale of portable electronics insurance, the information in this paragraph shall be provided for all officers, directors, and shareholders of record having beneficial ownership of ten per cent or more of any class of securities registered under the federal securities law; and

(2) Location of the applicant's home office.

(c) Any vendor engaging in portable electronics insurance

transactions on or before [January 1, 2013,] shall apply for licensure within ninety days of the application's being made available by the commissioner. Any applicant commencing operations after [January 1, 2013,] shall obtain a license prior to offering portable electronics insurance.

(d) Initial licenses issued pursuant to this article shall be valid for a period of not less than twenty-four months. Renewed licenses shall be valid for a period of twenty-four months.

(e) Each vendor licensed under this article shall pay to the commissioner a fee of $5,000 for the issuance of the initial portable electronics limited lines license, plus a license fee of $2,500 per year for the initial or renewal term. A pro rata portion of the license fee may be applied for a partial year of the initial term. [L 2012, c 321, pt of §1; am L 2013, c 194, §2]

**[§431:31-108] Portable electronics insurance claims.** No licensed independent adjuster or licensed vendor shall supervise more than twenty-five employees; provided that a licensed vendor who supervises employees or adjusts claims shall not be required to be licensed as an adjuster.

For purposes of this section:

"Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of portable electronics insurance claims, which:

(1) Shall be used only by a licensed independent adjuster, a licensed vendor, or supervised employees; and

(2) Shall comply with all claims-payment requirements of the insurance code.

"Employee" means an individual who collects claim information for portable electronics insurance claims from, or furnishes claim information to, insureds or claimants, and who conducts data entry, including entering data into an automated claims adjudication system. [L 2012, c 321, pt of §1]