

SESSION LAWS
OF
HAWAII
PASSED BY THE
FOURTEENTH STATE LEGISLATURE
VOLUME 2

REGULAR SESSION
1987

Convened on Wednesday, January 21
and
Adjourned sine die on Thursday, April 30

INSURANCE

Acts 347, 348, and 349

Effective July 1, 1988

Published by Authority of the
Revisor of Statutes
Honolulu, Hawaii



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A Bill for an Act Relating to Insurance.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapters 294, 431, 431A, 431D, 431F, 431H, 431J, 432, 433, 434 and 435, Hawaii Revised Statutes, are repealed.

SECTION 2. The Hawaii Revised Statutes is amended by adding the following chapters to be appropriately designated and to read as follows:

"CHAPTER 431 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.

§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 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.

§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.

§431:1-103 Headings. The meaning or scope of any provision is not affected by any heading.

§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.

§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.

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;

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- (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 prepaid legal service plan as defined in chapter 488 other than plans in which either the group 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.

§431:1-202 Insurer defined. Insurer means every person engaged in the business of making contracts of insurance and includes reciprocal or interinsurance exchanges.

§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); disability insurance (including group disability insurance); property insurance; marine and transportation insurance; vehicle insurance; general casualty insurance; surety insurance; and such other classes as may be authorized by law.

§431:1-204 Life insurance defined. Life insurance is insurance on human lives and insurance appertaining thereto or connected therewith. For the purposes of this code the transacting of life insurance includes the granting of annuities and endowment benefits; additional benefits in event of death or dismemberment by accident or accidental means; additional benefits in event of total and permanent disability of the insured; and optional modes of settlement of proceeds.

§431:1-205 Disability insurance defined. Disability insurance, also referred to as accident and sickness 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.

§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.

§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.

§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.

§431:1-209 General casualty insurance defined. General casualty insurance includes vehicle insurance as defined in section 431:1-208, disability insurance defined in section 431:1-205 and in addition 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.

The making of a contract covering only defects in material and work in exchange for a separately stated charge where it is incidental to the business of selling or leasing motor vehicles, shall not be deemed insurance; provided the maker of the contract has an insurance policy, with an insurer as defined in section 431:1-202, providing coverage for the making of those contracts. The policy shall assume the legal liability created by each contract or, alternatively, the ultimate legal liability of all contracts made by the issuer. If the maker of the contract is unable to perform the duties imposed by the contract, the purchaser of the contract then shall be considered a policyholder of the insurer. The policy shall include a loss payee endorsement that provides coverage to any lending institution as its interest may appear. In addition, the contract conspicuously shall state the name and address of the licensed underwriting insurer and contain a statement that the policyholder shall be entitled to make a direct claim against the insurer upon the failure of the issuer to pay any claim within sixty days after proof of loss has been filed with the issuer. The requirement that the maker of the contract have an insurance policy with an insurer shall not apply if the maker is a manufacturer, distributor or importer of automobiles.

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.

- (15) Against any other kind of loss, damage or liability properly the subject of insurance and not within any other class or classes of insurance as defined in section 431:1-204 to section 431:1-211, if such insurance is not contrary to law or public policy.

§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.

§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.

§431:1-212 Person defined. Person means any individual, company, insurer, association, organization, group, reciprocal or interinsurance exchanges, partnership, business, trust, or corporation.

§431:1-213 State defined. State means any state of the United States, the government of Puerto Rico and the District of Columbia.

§431:1-214 United States defined. United States, when used to signify place, means the states of the United States, the government of Puerto Rico and the District of Columbia.

§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.

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.

§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 chapters 76 and 77. 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.

§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.

§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.

§431:2-105 Deputies, employees. (a) There shall be a chief deputy commissioner, who shall be subject to the provisions of chapters 76 and 77. The chief deputy commissioner shall have power to perform any act or duty conferred upon the commissioner, and shall take and subscribe the same oath of office as the commissioner, which oath shall be endorsed upon the certificate of the chief deputy commissioner's appointment and 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 chapters 76 and 77.

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

(d) The commissioner may require any employee to be bonded as the commissioner deems proper. The cost of any such bond shall be borne by the State.

§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.

§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 chapters 76 and 77.

§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.

§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.

§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.

PART II. POWERS AND DUTIES OF COMMISSIONER

§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, subject to chapter 91, reasonable rules and regulations for effectuating any provision of this code, except those relating to the commissioner's appointment, qualifications, or compensation.
- (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 such provision.
- (3) Require, upon reasonable notice, that insurers report such claims information as the commissioner may deem necessary to protect the public interest.

§431:2-202 Orders and notices. (a) Orders and notices of the commissioner shall not be effective unless in writing signed by the commissioner or the commissioner's authority.

(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.

§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 stated in this code or 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 certify the facts of the violation to the public prosecutor of the jurisdiction of which the offense was committed.
- (3) Violation of any provision of this code is punishable by a fine of not less than \$10 nor more than \$1,000, 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 have the meanings given in sections 702-206(1) and 702-206(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 bring an action in any court of competent jurisdiction to enjoin the person from continuing the violation or doing any act in furtherance thereof.

(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, shall on behalf of the commissioner, 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 person 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 person still does not comply with the order, the commissioner may commence a new action or forfeiture, and may continue commencing actions in forfeiture until the person complies.

All proceeds from actions of forfeiture will be paid to the director of finance and paid into the general fund.

(g) A monetary penalty may be imposed in addition to any applicable suspension, revocation, or denial of a license or certificate of authority.

§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.

§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.

§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 \$7.50, 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.

§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.

§431:2-208 Access to records. (a) Every person subject to investigation or examination by the commissioner, its officers, employees and representatives 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 or improperly kept or posted, the commissioner may employ experts to rewrite, post or balance them 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.

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

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hearings, investigations, and examinations, and shall file such 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) Five years after conclusion of transactions to which they relate, the commissioner may destroy any correspondence, claim files, working papers of examinations of insurers, reports of examination by insurance supervisory officials of other states, void or obsolete filings relating to license applications, cards, expired bonds, records of hearings, investigations, and any similar records, documents, or memoranda now or hereafter in the commissioner's possession.

(d) Five years after the year to which they relate, the commissioner may destroy any foreign or alien insurer's tax reports, or similar records or reports now or hereafter in the commissioner's possession.

(e) The commissioner shall concurrently execute and file in a separate, permanent office file a certificate listing and giving a summary description of the records, files, documents and memoranda as they are destroyed.

(f) Complaints and investigation reports on file with the commissioner shall be protected from discovery, production and disclosure for so long as the commissioner deems prudent.

§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.

§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.

§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 items (2) and (3) 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.

PART III. INVESTIGATIONS, EXAMINATIONS, HEARINGS AND APPEALS

§431:2-301 Purpose and scope of examination. The commissioner shall determine the nature and scope of each examination and in doing so shall take into account all available relevant factors concerning the financial and business affairs, practices, and conditions of the examinee.

§431:2-302 Examination of insurers. (a) The commissioner may examine the affairs, transactions, accounts, records, documents, and assets of each authorized insurer as often as the commissioner deems prudent. The commissioner shall examine each domestic insurer at least once in every three years. Examination of an alien insurer may be limited to its insurance transactions in the United States.

(b) The commissioner shall examine fully each insurer applying for authority to do business in this State.

(c) In lieu of making the commissioner's examination, the commissioner may accept a full report of the last recent examination of a foreign or alien insurer certified to by the insurance supervisory official of the state, province, or country of domicile or the state of entry into the United States. A certified copy of the annual report of the directors and statement of accounts approved by the British Assurance Companies' Act may be acceptable to the commissioner in absence of other British insurance supervisory officials' examination.

§431:2-303 Examination of agents, managers, promoters. 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 general agent, subagent, solicitor, or adjuster, 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.

§431:2-304 Examination of the 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.

§431:2-305 Examination reports. (a) The commissioner shall make a full written report of each examination made by the commissioner.

(b) The report shall include:

- (1) A statement of findings of fact ascertained from the books, records, documents and other evidence obtained by investigation and examination, or ascertained from the sworn testimony of its officers, agents, or other persons examined concerning the financial condition of the examinee, its assets, obligations, ability to fulfill obligations, and compliance with all the provisions of this code; and
- (2) A summary of important points noted in the report, conclusions, recommendations and suggestions as may reasonably be warranted from the facts so ascertained in the examination.

(c) The commissioner shall furnish to the person examined a copy of the examination report by the examiner not less than sixty days prior to the filing of the report for public inspection in the division. If the person so requests in writing within the sixty day period, the commissioner shall hold a hearing to consider the person'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.

(d) The report, when filed for public inspection, shall be admissible evidence in action or proceeding brought by the commissioner against the person examined, or its officers or agents; 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, whether or not a written report of the examination has at that time been either made, served, or filed in the division.

(e) If the commissioner or the commissioner's examiners find that any of the information ascertained is flawed, the person examined shall be subject to the penalties provided for in section 710-1060 to section 710-1062.

§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 of this code;

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 the general fund of the State, or to the insurance examiner's revolving fund if independent contractor examiners were employed for the examination. The commissioner or the

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

§431:2-307 Insurance examiners' revolving fund. (a) The commissioner may establish a separate fund designated as the insurance examiners' revolving fund.

(b) The funds shall be used to compensate independent contractor examiners. Independent contractor examiners may be reimbursed or compensated for:

- (1) Actual travel expenses in amounts customary for such expenses and approved by the commissioner;
- (2) A reasonable living expense allowance at a rate customary for such expenses and approved by the commissioner; and
- (3) Per diem compensation at a rate customary for such compensation as approved by the commissioner.

(c) All persons receiving any reimbursement or compensation from the insurance examiners' revolving fund shall submit to the commissioner for approval a detailed account of all expenses and compensation necessarily incurred on account of an examination. Persons shall not receive or accept any additional emolument on account of an examination. Any reimbursement or compensation made by the fund and approved by the commissioner shall be charged to the person being examined by the commissioner and all receipts shall be credited to the fund.

(d) Moneys in the insurance examiners' revolving fund shall not revert to the general fund.

(e) Each authorized insurer shall deposit at a time determined by the commissioner the sum of \$200 with the commissioner to be credited to the insurance examiners' revolving fund.

§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. The commissioner shall hold the hearing applied for within thirty days after the commissioner's receipt of the application unless postponed by mutual consent.

(e) The person aggrieved may waive this initial hearing and proceed to a contested case hearing pursuant to chapter 91.

(f) Any appeal made from a decision by the commissioner shall be made pursuant to chapter 91.

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.

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§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.

§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.

§431:3-104 Domestic insurer. A domestic insurer is one formed under the laws of this State.

§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.

§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.

§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.

§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.

§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.

PART II. CERTIFICATE OF AUTHORITY

§431:3-201 Authority required. (a) No person shall act as an insurer and no insurer shall transact insurance 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. Chapter 418 shall not be applicable to any insurer authorized to do business in this State pursuant to 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 specify:

- (1) The name of the insurer, the location of its principal office, 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.

§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.

§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:

- (1) Have appointed a general agent who is qualified according to the standards set forth in article 9; and
- (2) 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.

§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 section 431:1-204 to section 431:1-211; provided that:

- (1) A life insurer shall not transact any insurance in addition to life insurance except disability, provided that nothing herein shall limit a life insurer existing and authorized on the effective date of this code from writing any authorized insurance stated in its charter; and
- (2) A reciprocal insurer shall not transact life or disability insurance.

§431:3-205 Funds required of new insurers. To qualify for authority to transact any one class of insurance and subject to section 431:3-203(a)(2), an insurer, not existing and authorized in this State on December 31, 1955, shall possess and maintain paid-up capital stock, if a stock insurer, or surplus, if a reciprocal insurer or if a domestic mutual insurer which does not seek to qualify upon the basis of applications and premiums collected as provided in section 431:4-303 to section 431:4-307, in amount not less than as shown by the applicable portion of the following Schedule "A":

SCHEDULE "A"

Class of Insurance	Amount Required
Life	\$200,000
Disability	100,000
Life and Disability	250,000
Property	200,000
Marine and Transportation	250,000
Vehicle	200,000
General Casualty	300,000
Surety	300,000

§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 December 31, 1987, or domestic mutual insurers not existing and authorized in this State on December 31, 1987, 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 percent 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, bona fide additional surplus in an amount not less than fifty percent 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.

§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.

§431:3-208 Funds required of existing and new insurers for transacting additional classes of insurance. (a) An insurer otherwise qualified therefor may be authorized to transact combinations of classes of insurance while possessing and maintaining additional paid-up capital stock, if a stock insurer, or additional surplus, if a mutual or reciprocal insurer, subject to subsection (b) as to domestic mutual or reciprocal insurers, and subject to section 431:3-203(a)(2), in amount not less than as determined under the following Schedule "B".

SCHEDULE "B"

If Authorized to Transact: (Basic Stock Insurer Capital Shown in Parentheses)	Additional Amount Required for Authority to Transact Additional Classes of Insurance:					
	Disability	Property	Marine and Transportation	Vehicle	General Casualty	Surety
Life (\$200,000)	50,000	xxx	xxx	xxx	Qualify for general casualty	xxx
Disability (\$100,000)	xxx	150,000	225,000	Qualify for general casualty	Qualify for general casualty	275,000
Marine & Transportation (\$250,000)	75,000	150,000	xxx	150,000	200,000	200,000
Vehicle (\$200,000)	75,000	150,000	200,000	xxx	Qualify for general casualty	250,000
General Casualty (\$300,000)	No Additional funds required	150,000	150,000	No Additional funds required	xxx	200,000
Surety (\$300,000)	75,000	150,000	150,000	150,000	200,000	xxx
Property (\$200,000)	75,000	xxx	200,000	150,000	250,000	250,000

An insurer while possessing \$500,000 of capital, if a stock insurer, or of surplus, if a reciprocal or mutual insurer, may be authorized to transact all classes of insurance, subject to section 431:3-204 to section 431:3-206.

(b) To qualify for authority to transact a combination of classes of insurance, domestic mutual or reciprocal insurer shall possess surplus in amount equal to the paid-up capital stock required of stock insurers for authority to transact a like combination of classes of insurance.

§431:3-209 Deposits of alien and foreign insurers. (a) An alien insurer is not permitted to be authorized to transact a business of insurance in this State unless it deposits and maintains on deposit assets equal in amount to either the amount of paid-up capital stock, if a stock insurer, or surplus, if 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 \$200,000, whichever amount is the greater.

(b) The deposit shall be for the security of all policyholder or 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 insurance commissioner. In lieu of such 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, are being maintained by the insurer in the state for the benefit of all of the insurer's policyholders in the United States or all 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 amount not less than the amount required pursuant to subsection (a).

§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.

§431:3-211 Alien reinsurers. No credit shall be allowed to any insurer, as an asset or as a deduction from liability, for reinsurance ceded to an alien insurer, other than under a contract of ocean marine insurance, covering a

subject of insurance resident, located, or to be performed in this State unless the alien reinsurer:

- (1) Is authorized to transact insurance in a state of the United States; and
- (2) Maintains an adequate guaranty deposit in a state of the United States for the protection of its insurance obligees in the United States; and
- (3) Has an attorney-in-fact resident in the United States upon whom service of legal process may be made.

§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.
 - (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. 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.
 - (E) A copy of the appointment and authority of its United States manager, certified by its proper officer, if an alien insurer.
 - (F) 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.
 - (G) The declaration required by section 431:4-409 if a domestic reciprocal insurer.
 - (H) Certificate of the proper public official as to any deposit made or held in compliance with this code.
 - (I) 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.
 - (J) Certificate of appointment of general agent.
 - (K) Other documents or stipulations as the commissioner may reasonably require to evidence compliance with this code.
- (3) Deposit with the commissioner the appropriate fees required by this code.

§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.

§431:3-214 Extension; amendment. (a) No certificate of authority shall contain an expiration date, but all certificates of authority must be extended 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.

(b) The commissioner shall amend a certificate of authority at any time in accordance with changes in the insurer's charter or insuring powers.

§431:3-215 Reinsurance and return of certificate of authority upon withdrawal. (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) An insurer desiring to withdraw from this State must first 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 must 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 must 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 general agents issued by the commissioner.

(e) An insurer desiring to withdraw from this State will, in addition to other requirements, publish in this State a notice of withdrawal once each week in four successive weeks, the last publication to be not less than twenty-one days after the first publication, in a newspaper of daily circulation. The notice of withdrawal as published must have the prior approval of the commissioner.

§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.

§431:3-217 Discretionary refusal, suspension or revocation provisions.

The commissioner may after a hearing 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 such 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) Usually 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.
- (9) Fails to file its annual statement when due or within any extension of time which the commissioner may for good cause have granted.

§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 less than ten days in advance of the effective date of the revocation or suspension.

- (2) Likewise revoke or suspend all agents' authority to represent the insurer in this State and give notice thereof to the agents.
- (3) Give notice thereof to the insurance supervisory official of each other state in which the insurer is authorized to transact insurance.

§431:3-219 Suspension period. 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 will be effective.

§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.

§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 may, after hearing, levy a fine upon the insurer in 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, and which period shall not be less than thirty nor more than forty-five days from the date of the order. Upon failure to pay any such 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 general fund.

PART III. ANNUAL REQUIREMENTS AND LIMITING PROVISIONS

§431:3-301 Annual filings with commissioner. (a) Annually before March 16, or such day subsequent thereto as the commissioner upon request and for cause may specify, the following documents are required to be filed with the commissioner:

- (1) By each insurer:
 - (A) A true statement of its financial condition, transactions, and affairs as of the immediately preceding December 31, in general form and context as approved by the National Association of Insurance Commissioners plus any additional information required by the commissioner, 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 is required to relate only to its transactions and affairs in the United States. The commissioner shall annually during November furnish each domestic insurer duplicate copies of annual statement forms required to be filed.
 - (B) The tax statement provided for by section 431:7-201.
 - (C) In the event of a change in any of the other information which section 431:3-212 requires an insurer to file with the commissioner at the time of its application for a certificate

- of authority, the current information in the form stated in section 431:3-212.
- (2) By each insurer, the certificate of valuation provided for by section 431:5-307 and documentation of the liabilities provided for by section 431:5-203(2) and (3).
 - (3) By each foreign or alien insurer, a certificate from the proper public official of its state or country of domicile showing that it is duly authorized to transact the classes of insurance which it is transacting.
 - (4) By each alien insurer, a certificate of the proper public official as to any deposit made or held as compliance with this code.
- (b) The commissioner may suspend or revoke the certificate of authority of any insurer which fails to file any of the documents to which subsection (a) relates.

§431:3-302 Annual filings with the National Association of Insurance Commissioners. (a) Each domestic, foreign and alien insurer which is authorized to transact insurance in this State shall annually on or before March 1 of each year file with the National Association of Insurance Commissioners (NAIC) a copy of its annual statement convention blank along with such additional filings as prescribed by the commissioner for the preceding year. The information filed with the NAIC 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 addendums to the statement filing subsequently filed with the commissioner shall also be filed with the NAIC.

(b) Foreign insurers that are domiciled in a state which has a law substantially similar to subsection (a) shall be deemed in compliance with this section.

§431:3-303 Immunity. In the absence of actual malice, members of the NAIC, their duly authorized committees, subcommittees, and task forces, their delegates, NAIC 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.

§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.

§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.

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

- (1) Domestic mutual insurers may insure up to the applicable limits provided by section 431:4-303 to section 431:4-305, if greater; or
- (2) In the case of fire risks adequately protected by automatic sprinklers or fire risks principally of noncombustible construction and occupancy, an insurer may retain fire risks as to any one subject in an amount not exceeding twenty-five percent of the sum of:
 - (A) Its unearned premium reserve, and
 - (B) 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 an alien reinsurer not qualified under section 431:3-211 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.

§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.

§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.

§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.

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.

§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.

§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.

§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 415-54:

- (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.

§431:4-105 Affidavit. (a) Before applying to the commissioner for an initial certificate of authority, an 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.

§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.

§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.

§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.

§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.

§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 \$20,000, 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 such bond, the person may deposit with the director of finance through the commissioner \$20,000 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.

§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 percent 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.

§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.

§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 485.

§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.

§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.

§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.

§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.

§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.

§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.

§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 percent of such funds as and when actually received.

§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.

§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.

§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.

§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.

§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, by regulations from time to time, 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.

§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.

§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.

PART II. DOMESTIC STOCK INSURERS

§431:4-201 Other articles applicable. The provisions in chapters 416, 417, and 417E relating to organization, powers, capital stock, meetings, bylaws, rights, duties and liabilities of directors, managers and stockholders, dissolution, consolidation and merger of private corporations shall apply except where inconsistent with the express provisions of this article.

§431:4-202 Increase of capital. (a) A domestic stock insurer may increase its capital stock by:

- (1) Complying with section 416-64, except that the increase in capital is effective upon the payment of the increased capital in full; and
- (2) Filing a certificate with the commissioner that the increased capital has been paid in full in cash, upon which filing the increase in capital is effective. Such certification shall be filed:
 - (A) After filing of a certificate required by section 416-64; and
 - (B) Within a period prescribed by the commissioner.

(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.

§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 percent of the holders of the shares of stock outstanding and entitled to vote; and
- (2) Filing a certificate that such vote occurred, executed in the same manner as the section 416-65 certificate, and 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.

§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.

§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.

§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.

§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.

§431:4-208 Statement by beneficial owner, director, officer. Every person who is directly or indirectly the beneficial owner of more than ten percent 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.

§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.

§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.

§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.

§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.

§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).

§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.

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.

§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.

§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 promulgated 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 \$100,000.

(b) The maximum of any single risk proposed to be assumed by the insurer shall not exceed ten percent 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 such applications, premiums, and surplus, it is required to have a surplus amounting to not less than \$200,000 over all liabilities.

§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 such 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 insurance 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 \$150,000.

(b) In lieu of such applications, premiums and surplus, it is required to have a surplus amounting to not less than \$300,000 over all liabilities.

§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 \$10,000 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 insurance 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 \$100,000.

(b) In lieu of such applications, premiums and surplus, it is required to have a surplus amounting to not less than \$200,000 over all liabilities.

§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 term 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 \$2,000,000; 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 \$50,000; and
- (3) Have surplus over all liabilities, as at completion of issuance of the insurance contracts so applied for, amounting to not less than \$100,000.

(b) In lieu of such applications, premiums and surplus, it is required to have a surplus amounting to not less than \$200,000 over all liabilities.

§431:4-307 Mutual disability insurer. (a) When applying for a certificate of authority a domestic mutual disability insurer must:

- (1) Have at least five hundred applications from at least five hundred persons for individual disability insurance providing not more than \$1,000 of accidental death benefit and not more than \$25 of weekly indemnity for each applicant; and
- (2) Have collected from each applicant the proper premium for one year and have so received from all applicants premiums aggregating at least \$10,000; 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 \$50,000.

(b) In lieu of such applications, premiums and surplus, it is required to have a surplus amounting to not less than \$100,000 over all liabilities.

§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.

§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.

§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.

§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.

§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.

§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.

§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, disability, 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 percent 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.

§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.

§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.

§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.

§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 percent 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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

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.

§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.

§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 disability 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.

§431:4-404 Suits. A reciprocal insurer shall sue and be sued in its own name.

§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 whose principal office shall be maintained within this State.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§431:4-420 Time limit for assessment. (a) 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.

§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.

§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.

§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.

§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.

§431:4-425 Merger or conversion. (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 the 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 such 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 in the same manner as if they had been incurred or contracted by it, but the subscribers of such 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 obligations incurred by them, or on their behalf as such 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 any plan for a merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, 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.

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.

§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.

§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.

§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) 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.

(c) 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.

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.

§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.

§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.

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 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 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) Agents 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 regulations prescribed 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 regulation prescribed 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.

§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) Goodwill, trade names, agency plants, other like intangible assets, and any receivable without adequate documentation.
- (2) 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.
- (3) Advances to officers, employees, agents, and other persons on personal security only.
- (4) 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.
- (5) 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(d)(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.

- (6) 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.

§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 disability 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 disability 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 practice formulated or approved by the National Association of Insurance Commissioners, on account of such insurances;
- (4) With reference to insurance other than those specified in item (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.

§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.

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) Disability 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) Such reserve shall be computed according to the following table:

<u>Terms for which policy was written</u>	<u>Reserve for unearned premium</u>
One year or less	1/2
Two years	First year 3/4 Second year 1/4
Three years	First year 5/6 Second year 1/2 Third year 1/6
Four years	First year 7/8 Second year 5/8 Third year 3/8 Fourth year 1/8
Five years	First year 9/10 Second year 7/10 Third year 1/2 Fourth year 3/10 Fifth year 1/10
Over five years	Pro rata

(d) In lieu of computation according to the table in subsection (c), all of the reserves may be computed, at the insurer's option, on a monthly or more frequent, pro rata basis.

(e) After adopting any one of the methods for computing such reserve, an insurer shall not change methods without the commissioner's approval.

§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 thereon equal to one hundred percent 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(d) and section 431:5-301(e).

§431:5-303 Active life reserves and unearned premium reserves for noncancelable disability insurance. (a) The legal minimum standard for computing the active life reserve, including the unearned premium reserve, of noncancelable disability policies shall be based on conference modification of class III disability experience with interest not to exceed three and one-half percent 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 noncancelable 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.

§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.

§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.

§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 an alien reinsurer not qualified under section 431:3-211 or in any reinsurer which has been disapproved by the commissioner.
 - (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.

§431:5-307 Standard valuation law; life. (a) This section shall be known as the standard valuation law.

(b) Reserve valuation:

- (1) The commissioner shall annually value, or cause to be valued, the reserve liabilities, hereinafter called reserves, for all outstanding life insurance policies, annuity and pure endowment contracts of every life insurer doing business in this State. The commissioner may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or others) used in the calculation of the reserves. 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 herein required of any foreign or alien insurer, the commissioner may accept any 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 herein provided, and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when such certification states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.
- (2) The actual cost of making valuations under this section shall be assessed on the insurer, whose policies are so valued, by the commissioner.
- (3) Any such insurer which at any time has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided.

(c) Computation of minimum standard:

- (1) Old policies: Except as otherwise provided in item (3), the minimum standard for the valuation of all such policies and contracts issued prior to the operative date of section 431:10D-104, shall be that provided by the laws in effect immediately prior to January 1, 1956.
- (2) Except as otherwise provided in item (3), the minimum standard for the valuation of all the policies and contracts issued on or after the operative date of section 431:10D-104 shall be the commissioners reserve valuation methods defined in subsections (d), (e) and (h), three and one-half percent interest; in the

case of policies and contracts, other than annuity and pure endowment contracts, issued on or after June 1, 1976, four percent interest; for such policies issued prior to June 1, 1979, five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other such policies issued on or after June 1, 1979; and the following tables:

- (A) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies — the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the operative date of section 431:10D-104(e)(8), and the Commissioners 1958 Standard Ordinary Mortality Table for the policies issued on or after the operative date; provided that for any category of such 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 such policies issued on or after the operative date of section 431:10D-104(e)(8), 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, or any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.
- (B) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in the policies — the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of section 431:10D-104(e)(7), and for the policies issued on or after such operative date 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 regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.
- (C) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies — the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, ultimate, or any modification of either of these tables approved by the commissioner.
- (D) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies — the Group Annuity Mortality Table for 1951, any modification of the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

- (E) For total and permanent disability 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 regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such 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 insurer, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.
 - (F) For accidental death benefits in or supplementary to policies — for 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 regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies issued after December 31, 1960 and prior to January 1, 1966, either the table or, at the option of the insurer, the Inter-company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.
 - (G) For group life insurance, life insurance issued on the sub-standard basis, and other special benefits — such tables as may be approved by the commissioner.
- (3) Except as provided in item (4), the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation methods defined in subsections (d) and (e) and the following tables and interest rates:
- (A) For individual annuity and pure endowment contracts issued prior to June 1, 1979, excluding any disability and accidental death benefits in such contracts — the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts.
 - (B) For individual single premium immediate annuity contracts issued on or after June 1, 1979, excluding any disability and accidental death benefits in such 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 regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

- (C) For individual annuity and pure endowment contracts issued on or after June 1, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such 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 regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts.
- (D) For all annuities and pure endowments purchased on or after June 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such 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 regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner and seven and one-half percent interest.

After June 1, 1976, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer; provided that an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

- (4) Applicability of this section:
- (A) The interest rates used in determining the minimum for the valuation of:
- (i) all life insurance policies issued in a particular calendar year, on or after the operative date of section 431:10D-104(e)(8),
 - (ii) all individual annuity and pure endowment contracts issued in a particular calendar year after December 31, 1982,
 - (iii) all annuities and pure endowments purchased in a particular calendar year after December 31, 1982,

- under group annuity and pure endowment contracts, and
- (iv) the net increase, if any, in a particular calendar year after 1982, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation rates as defined in this paragraph.
- (B) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one percent:
- (i) for life insurance,
- $$I = .03 + W(R - .03) + \frac{W}{2}(R - .09);$$
- (ii) 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 section, and W is the weighting factor defined in this paragraph;
- (iii) 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 (ii), the formula for life insurance stated in (i) 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 (ii) shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less;
- (iv) 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 (ii) shall apply; and
- (v) 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 (ii) shall apply.
- (C) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such 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.
- (D) The weighting factors referred to in the formulas stated above are given in the following tables:
- (i) weighting factors for life insurance:

Guarantee Duration <u>(Years)</u>	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;

- (ii) 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;
- (iii) weighting factors for other annuities and for guaranteed interest contracts, except as stated in (ii), 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 <u>(Years)</u>	Weighting Factor for Plan Type		
	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:

For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (i) increased by:

Plan Type		
A	B	C

.15 .25 .05

Table III:

For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no

cash settlement options) which 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 which 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 with 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 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 such 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, 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 such adjustment but in installments over five years or more; or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or 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 must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to 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 the change in fund basis of valuation refers to 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.
- (E) The reference interest rate referred to in subsection (B) shall be defined as follows:
- (i) For all 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 next preceding the year of issue, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.
 - (ii) 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 Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.
 - (iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (ii), 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 Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.
 - (iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (ii), 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 Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.
 - (v) 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 Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.

- (vi) 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 (ii), the average over a period of twelve months, ending on June 30 of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.
 - (F) Alternative method for determining reference interest rates: In the event that Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that Moody's Corporate Bond Yield Average - Monthly Average Corporates 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, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the commissioner, may be substituted.
- (d) Commissioners Reserve Valuation Methods:
- (1) Except as otherwise provided in subsections (e) and (h), reserves, according to the commissioners reserve valuation methods, 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 such 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 any such policy shall be the uniform percentage of the respective contract premiums for such benefits (excluding extra premiums on a substandard policy) that the present value, at the date of issue of the policy, of all such 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 (A) over (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 a year 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 such policy.
 - (B) A net one-year term premium for the benefits provided for in the first policy year.

Provided that for any 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 no comparable additional benefit is provided in the first year for such excess, which provides an endowment benefit, a cash surrender value, or a combination thereof, in an

amount greater than such excess premium, the reserve, according to the commissioners 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 such excess premium, shall, except as otherwise provided in subsection (h), be the greater of the reserve as of such policy anniversary calculated as described in the foregoing provisions of this subsection and the reserve as of such policy anniversary calculated as described in those provisions, but with:

- (i) the value defined in (A) being reduced by fifteen percent of the amount of such excess first year premium;
- (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after assumed ending date;
- (iii) the policy being assumed to mature on such date as an endowment; and
- (iv) the cash surrender value provided on such date being considered as an endowment benefit.

In making the above comparison the mortality and interest bases stated in subsections (c)(2) and (c)(3) shall be used.

- (2) Reserves according to the commissioners reserve valuation methods 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 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, shall be calculated by a method consistent with the principals of this subsection (d).

- (e) 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 commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such 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 such 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 such contract, that become payable prior to the end of such 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 such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(f) Minimum aggregate reserves: In no event shall an insurer's aggregate reserves for all life insurance policies excluding disability and accidental death benefits, issued on or after the operative date of section 431:10D-104, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (d), (e), (h), and (i), and the mortality tables and rates of interest used in calculating nonforfeiture benefits for such policies.

(g) Optional reserves bases: Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after the operative date of section 431:10D-104, may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for the category than those calculated according to the minimum standard herein provided. The rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rates of interest used in calculating any nonforfeiture benefits provided for therein. Any such company which at any time shall have adopted any standard valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided, may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided.

(h) Minimum reserve: If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such 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 such policy or contract, or the reserve calculated by the method actually used for such policy or contract using the minimum 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 section are those standards stated in subsections (c)(1), (c)(2) and (c)(4).

Provided that for any 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 such excess and which provides an endowment benefit or a cash surrender value, or a combination thereof, in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such

policy were the method described in subsection (d), ignoring the second paragraph of that subsection. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (d), including the second paragraph of that subsection, and the minimum reserve calculated in accordance with this subsection.

(i) In the case of any plan of life insurance which 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 which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (d), (e) and (h), the reserves which are held under any such plan must:

- (1) Be appropriate in relation to the benefits and the pattern of premiums for that plan, and
- (2) Be computed by a method which is consistent with the principles of this section, as determined by regulations promulgated by the commissioner.

§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.

§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.

§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.

§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 percent of the fair value of the real property, whichever is less.

ARTICLE 6. INVESTMENTS

PART I. GENERAL PROVISIONS

§431:6-101 Definitions pertaining to investments. (a) For purposes of this article:

- (1) Obligation includes bonds, debentures, notes, or other evidences of indebtedness.
 - (2) Institution includes corporations, joint-stock associations, and business trusts.
 - (3) 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.
 - (4) Fixed charges includes interest on funded and unfunded debt, amortization of debt discount, and rentals for leased properties.
 - (5) 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.

§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.

§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 shall relate to assets as shown by the insurer's annual statement as of December 31 preceding date of investment.

§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 dividend 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 as provided in this article.

(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.

§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 percent 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.

§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 chairman 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.

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 seventy-five percent of its minimum required capital, or if a mutual or reciprocal insurer, not less than seventy-five percent 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 invest and keep invested its funds aggregating not less than one hundred percent of its reserves required by this code in cash or premiums in course of collection or in investments eligible in accordance with this article.

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 or the Asian Development Bank.

§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 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 are qualified under any of the following:

- (1) Obligations which are secured by adequate collateral security and bear fixed interest, if during each of any three, including the last two, of the five fiscal years next preceding the date of

acquisition by the insurer, the net earnings of the issuing, assuming, or guaranteeing institution available for its fixed charges, as defined in section 431:6-101, have been not less than one and one-fourth times the total of its fixed charges for such year. In determining the adequacy of collateral security, not more than one-third of the total value of the required collateral shall consist of stock other than stock meeting the requirements of section 431:6-303;

- (2) Fixed interest-bearing obligations, other than those described in item (1), if the net earnings of the issuing, assuming, or guaranteeing institution available for its fixed charges for a period of five fiscal years next preceding the date of acquisition by the insurer, have averaged per year not less than one and one-half times its average annual fixed charges applicable to the period, and if during the last year of the period, the net earnings have been not less than one and one-half times its fixed charges for the year; or
- (3) Adjustment, income or other contingent interest obligations, if the net earnings of the issuing, assuming, or guaranteeing institution available for its fixed charges for a period of five fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than one and one-half times the sum of its annual fixed charges and its average maximum contingent interest applicable to the period, and if during each of last two years of the period, the net earnings have been not less than one and one-half times the sum of its fixed charges and maximum contingent interest for the year.

§431:6-303 Preferred or guaranteed stocks or shares. An insurer may invest any of its funds, in an aggregate amount not exceeding fifteen percent 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 such institution at the date of acquisition by the insurer are eligible as investments under this article; and if qualified under either of the following:

- (1) Preferred stocks or shares shall be deemed qualified if:
 - (A) The net earnings of the institution available for its fixed charges for a period of five fiscal years next preceding the date of acquisition by the insurer must have averaged per year not less than one and one-half times the sum of its average annual fixed charges, if any, its average annual maximum contingent interest, if any, and its average annual preferred dividend requirements applicable to the period; and
 - (B) During each of the last two years of such period, the net earnings must have been not less than one and one-half times the sum of its fixed charges, contingent interest, and preferred dividend requirements for such year. The term preferred dividend requirements shall be deemed to mean cumulative or noncumulative dividends whether paid or not.
- (2) Guaranteed stocks or shares shall be deemed qualified if the assuming or guaranteeing institution meets the requirements of section 431:6-302(1), construed so as to include as a fixed charge

the amount of guaranteed dividends of such issue or the rental covering the guarantee of such dividends.

§431:6-304 Trustees or receivers obligations. An insurer may invest any of its funds, in an aggregate amount not exceeding two percent 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.

§431:6-305 Equipment trust obligations. An insurer may invest any of its funds, in an aggregate amount not exceeding ten percent 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.

§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 mortgage or deed of trust on real property, located in the United States, which meets 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 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 percent.
 - (ii) in all other cases, sixty-six and two-thirds percent.
- (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.

§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 percent 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 percent 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).

§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.

§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 aggregate amount in excess of \$50,000 or more than the amount permissible under section 431:6-105, whichever is the greater.

§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 percent 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 on the real property.

§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 aggregate amount not to exceed twenty percent of its admitted assets unless approved by the commissioner, or if a mutual or reciprocal insurer, not to exceed twenty percent of its admitted assets nor such 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 percent of its admitted assets. Such 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 aggregate amount not exceeding twenty-five percent of its assets in real property including those realty set forth in subsection (a), 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 shall at the lessee's own cost erect, or there has already been 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 such improvements on the real estate;
- (2) The improvements shall remain on the property during the period of the lease, with provisions when such improvements are put upon the property at the cost of the lessee that at the termination of the lease the ownership of such improvements, free of liens, shall vest in the owner of the real estate;
- (3) The lessee shall during the term of the lease, or the unexpired period of the lease if the property is bought subject to the lease, pay to the owner of the real estate, rent in such 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 such real estate, whichever is less.

(c) Real property acquired pursuant to subsection (b) 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 such real property shall be treated as an investment shall not exceed the amount actually invested reduced each year in such 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.

(d) 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 aggregate amount not exceeding three percent 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 such an exchange, the insurer may put up cash in amount not to exceed twenty percent of the fair value of its real property to be so exchanged, in addition to such 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 in item (1) of subsection (b).
- (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.

§431:6-312 Time limit for disposal. (a) Real property acquired by an insurer pursuant to section 431:6-311(d)(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 items (2), (3), (4), and (5) of section 431:6-311(d) 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.

§431:6-313 Foreign securities. (a) An insurer authorized to transact insurance in a foreign country may invest any of its funds, in 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 percent 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.

§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.

§431:6-315 Banks, savings and loan associations and credit unions. (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 savings and loan insurance corporation or similar federal agency.

(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.

§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 percent of its surplus over its capital stock and other liabilities, or thirty-five percent 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 percent of its assets or twenty-five percent 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.

§431:6-317 Common stocks. After satisfying the requirements of section 431:6-201, an insurer may invest any of its funds in common shares of stock in solvent United States corporations that qualify as a sound investment.

§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 percent 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.

§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 percent of its assets or fifty percent of its surplus over its capital and other liabilities, or, if a mutual or reciprocal insurer, fifty percent 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 percent of insurer's assets, whichever is the lesser.
- (d) The insurer shall keep a separate record of all investments acquired under this section.

§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.

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.

§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.

§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).

§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.

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.

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: Issuance.....	\$300
(2)	Organization of domestic insurers and affiliated corporations: (A) Application and all other papers required for issuance of solicitation permit, filing.....	\$500
	(B) Issuance of solicitation permit	\$50
(3)	General agent's license: (A) Issuance, regular license..... (B) Issuance, temporary license.....	\$25
(4)	Subagent's license: (A) Issuance, regular license..... (B) Issuance, temporary license.....	\$25
(5)	Nonresident agent's or broker's license: Issuance.....	\$20
(6)	Solicitor's license: Issuance.....	\$20
(7)	Independent adjuster's license:	

	Issuance.....	\$20
(8)	Public adjuster's license:	
	Issuance.....	\$20
(9)	Surplus line broker's license:	
	Issuance.....	\$50
(10)	Examination for license:	

For each examination, a fee to be established by the commissioner by rule adopted in accordance with chapter 91.

(b) The fees for services of the department of commerce and consumer affairs subsequent to the issuance of a certificate of authority or a license are as follows:

- (1) \$200 per year for all services (including extension of the certificate of authority) for an authorized insurer.
- (2) \$25 per year for all services (including extension of the license) for a regularly licensed general agent.
- (3) \$25 per year for all services (including extension of the license) for a regularly licensed subagent.
- (4) \$15 per year for all services (including extension of the license) for a regularly licensed nonresident broker.
- (5) \$10 per year for all services (including extension of the license) for a regularly licensed solicitor.
- (6) \$15 per year for all services (including extension of the license) for a regularly licensed independent adjuster.
- (7) \$15 per year for all services (including extension of the license) for a regularly licensed public adjuster.
- (8) \$15 per year for all services (including extension of the license) for a licensed surplus line broker.
- (9) The services referred to in items (1) to (8) shall not include services in connection with examinations, investigations, hearings, appeals, and deposits with a depositary other than the department of commerce and consumer affairs.

(c) The commissioner shall notify the holder of the certificate of authority issued under article 3 or the license issued under article 9 by written notice at least thirty days prior to the extension date of such certificate or license. If the fee is not paid before or on the extension date, the fee will be increased by a penalty in the amount of fifty percent of the fee. If the fee and the penalty are not paid within the thirty days immediately following the extension date, the commissioner may revoke the certificate of authority or license and shall not reissue the certificate of authority or license until the fee and penalty have been paid.

(d) All fees and penalties shall be remitted by the commissioner to the director of finance not later than the first business day following collection, and shall be placed to the credit of the general fund.

PART II. TAXES

\$431:7-201 Annual tax statement. Each authorized insurer shall file with the commissioner annually, before March 16 in each year a statement signed by some duly authorized person on its behalf, setting forth the total business transacted, and the amount of gross premiums received by the insurer 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 in order to determine the taxability of premiums. The term gross premiums as used in this part shall not include consideration paid for annuities.

§431:7-202 Taxation. (a) Each authorized insurer, except with respect to all life insurance contracts and ocean marine contracts, shall pay to the director of finance through the commissioner, in the case of domestic insurers a tax of 2.9647 per cent, and in the case of other insurers a tax of 4.2824 per cent, on the gross premiums received 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 shall, with respect to life insurance contracts, pay to the director of finance through the commissioner, in the case of domestic insurers a tax of 1.918 per cent, and in the case of other insurers a tax of 3.197 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) 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.

(e) The tax shall be due and payable on March 15 succeeding the filing of the statement provided for in section 431:7-201. Any insurer failing or refusing to render the statement and to pay the required taxes above stated shall be liable to a penalty of \$25 for each day of delinquency; the taxes may be collected by distress, and the penalty 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 and fine, should any be imposed, are fully paid.

(f) Taxes imposed by subsections (a), (b) and (c) shall be paid as follows:

- (1) Insurers whose annual tax liability for the preceding year was more than \$5,000 shall pay their taxes on a monthly basis. The taxes shall be due and payable on or before the last day of the calendar month following the month in which they accrue;
- (2) Insurers whose annual tax liability for the preceding year was more than \$1,000 and up to \$5,000 shall pay their taxes on a quarterly basis. The taxes shall be due and payable on or before the last day of the calendar month following the quarter in which they accrue; and
- (3) Insurers whose annual tax liability for the preceding year was \$1,000 or less shall pay their taxes as provided for in subsection (e).

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.

All amounts paid under this subsection, other than penalties, shall be allowed as a credit on the annual tax imposed by subsections (a), (b) and (c).

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 annual tax and be allowed as a refund under section 431:7-203. Any insurer failing to pay taxes when due and payable, shall be liable to a penalty of \$25 for each day of delinquency; the taxes may be collected by distraint, and the penalty recovered by an action to be instituted by the commissioner in the name of the State, in any court of competent jurisdiction. The commissioner may suspend the certificate of authority of the delinquent insurer until the taxes and fine, should any be imposed, are fully paid.

§431:7-203 Refunds. In the event 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 shall upon written request made by the person to the commissioner within six years of the date of the payment, authorize a refund thereof out of the general funds of this State by submitting a voucher therefor to the comptroller of this State.

§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, city and county, or any municipality of this State, except as expressly otherwise provided, and excepting also taxes on real property, and taxes on the purchase, use, or ownership of tangible personal property. Nothing herein 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.

§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.

PART III. DEPOSITS

§431:7-301 Deposits of insurers. 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.

§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.

§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.

§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.

§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.

§431:7-306 Director may designate depository. 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 depository to receive and hold any such deposit. Any deposit so held shall be at the expense of the insurer.

§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 431:7-312 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.

§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.

§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.

§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.

§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.

ARTICLE 8. UNAUTHORIZED INSURERS AND SURPLUS LINES

PART I. GENERAL PROVISIONS

§431:8-101 Scope. This article shall apply to the placement of insurance on any subject resident, located, or to be performed in this State, in insurers not authorized to transact insurance in this State.

§431:8-102 Definitions. (a) Authorized insurer means an insurer holding a valid certificate of authority to transact an insurance business in this State.

(b) Surplus lines broker means any general agent licensed under section 431:3-308 to place insurance on risks resident, located, or to be performed in this State with unauthorized insurers.

(c) Surplus lines insurance means any insurance on risks resident, located or to be performed in this State, procured from or placed with an unauthorized insurer in accordance with part III of this article.

(d) Unauthorized insurer means an insurer not holding a valid certificate of authority to transact an insurance business in Hawaii.

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, however, 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 which transactions are subsequent to the issuance of such 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 sickness or blanket accident and sickness insurance or group annuities where the master policy of such groups was lawfully issued and delivered in and 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 the effective date of this code; and
- (7) Transactions in this State relative to a policy issued or to be issued outside this State involving insurance on vessels, craft or hulls, cargos, marine builder's risks, marine protection and indemnity or other risk, including strikes and war risks commonly insured under ocean or wet marine forms of policy.

§431:8-202 Acting for or aiding unauthorized insurer prohibited. (a) No person in this State shall directly or indirectly act as agent 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 such 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;
 - (2) The property and operation of aircraft engaged in interstate or foreign commerce; and
 - (3) Those transactions exempted from the application of section 431:8-201.

§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.

§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.

§431:8-205 Reserved.

§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.

§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 such action or proceeding shall be made in accordance with section 431:2-206. Such service is sufficient if:

(1) Notice of such service and a copy of the court process or the notice, order, pleading, or process in such 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 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 such 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 such 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.

§431:8-208 Defense of action by unauthorized insurer; bond. (a) Before any unauthorized insurer files or causes to be filed in any pleading in any

court action, suit, or proceeding, or in any notice, order, pleading, or process in such administrative proceeding before the commissioner instituted against such person or insurer, by services 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 such unauthorized insurer has not done any of the acts enumerated in section 431:8-102(d).

§431:8-209 Attorney's fees. In an action against an unauthorized insurer upon a contract of insurance issued or delivered in this State to a resident thereof or to a corporation authorized to do business therein, 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 such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff reasonable attorney's fees and include such fees in any judgment that may be rendered in such action. The fee shall not exceed twelve and one-half percent of the amount which 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.

§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.

§431:8-211 Penalties. (a) Any person, other than an insured, who in this State represents or aids an unauthorized insurer in violation of this part may be found guilty of a misdemeanor, and 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.

PART III. SURPLUS LINES INSURANCE

§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:

- (1) The insurance is procured through a licensed surplus lines broker;
- (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 such 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 which is generally acceptable to authorized insurers transacting that kind of business and providing insurance affording substantially the same protection.

§431:8-302 Surplus lines in solvent 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 financially unsound insurers or with insurers engaging in unfair practices.

- (b) Prior to placing insurance with any unauthorized insurer, the broker shall ascertain the financial condition of the insurer and:
- (1) In the case of foreign insurers, shall deliver to the commissioner a current certificate, in proper form, of the regulatory authority in the domicile of the unauthorized insurer to the effect that the insurer has capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction which equals the minimum capital and surplus requirements of this State for that kind of insurer as set out in article 3;
 - (2) In the case of alien insurers, shall submit to the commissioner evidence of the financial responsibility of the insurer. 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 not less than \$1,500,000 for the protection of all its policyholders in the United States 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, shall constitute *prima facie* evidence of such responsibility.
 - (c) The requirements of this section may be satisfied by an insurer possessing less than the capital and surplus set forth in subsection (b) upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of parent company, company underwriting profit and investment income trends, and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than \$500,000.

§431:8-303 Evidence of insurance and affidavits filed with commissioner. Each surplus lines broker shall before March 16 of each year file with the commissioner a statement of all surplus lines insurance transacted during the preceding year, including the following:

- (1) A written report about the placement of any surplus lines insurance, which shall be kept confidential, setting forth:
 - (A) The name and address of the insured,
 - (B) The name and address of each insurer,
 - (C) A description of the subject and location of the risk,
 - (D) The amount of premium charged for the insurance, and
 - (E) Other information as the commissioner may reasonably require;
- (2) An affidavit on a standardized form furnished by the commissioner as to the broker's diligent efforts to place the insurance with authorized insurers, which shall be open to public inspection.
- (3) When business is originated by a surplus lines broker, the affidavit shall affirm that the insured was expressly advised in writing prior to the placement of the insurance that:
 - (A) The surplus lines insurer with which the insurance was to be placed is not licensed in this State and is not subject to its supervision, and
 - (B) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the guaranty funds established under the laws of this State.

§431:8-304 Affidavit filed with commissioner when business referred from general agent. When business is referred from a licensed general agent to a surplus lines broker, the general agent shall file an affidavit with the commissioner, which shall be open to public inspection, affirming that the insured was expressly advised in writing prior to the placement of insurance that:

- (1) The surplus lines insurer with which the insurance was to be placed is not licensed in 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 the guaranty funds established under the laws of this State.

§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 the following:

- (1) The 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,
- (4) The taxes to be collected from the insured,
- (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.

§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."

§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 general agent, when business is referred to a surplus lines broker from a licensed general agent, shall have 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 possible examination.

Nothing in this section shall nullify any agreement by any insurer to provide insurance.

§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.

§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.

§431:8-310 Surplus lines broker license required; qualifications for license. (a) No person shall procure any contract of surplus lines insurance with an unauthorized insurer unless such person is licensed as a surplus lines broker.

(b) The commissioner shall issue a surplus lines broker license to any general agent licensed under article 9 when the agent has:

- (1) Remitted the annual license fee to the commissioner as provided in article 7;
- (2) Submitted a completed license application on a form furnished by the commissioner; and
- (3) Filed with the commissioner, and maintains during the term of the license, in force and unimpaired, a bond in favor of this State in the sum of \$25,000 with corporate sureties approved by the commissioner. The bond shall be conditioned that the broker will comply with this part and will promptly remit the taxes provided by section 431:8-315. No bond shall be terminated unless not less than sixty days prior written notice is given to the broker and the commissioner.

(c) Corporations, including foreign corporations, shall be eligible to be resident surplus lines brokers, upon the following conditions:

- (1) The corporate licensee shall list individuals within the corporation who have satisfied all requirements of this part to become surplus lines brokers; and
- (2) Only those individuals listed on the corporate license shall transact surplus lines business.

(d) Licensing procedure, duration and related matters are governed by article 9.

§431:8-311 Compensation. A licensed surplus lines broker may accept and place surplus lines business from any general agent licensed in this State for the class of insurance involved, and may compensate the agent therefor.

§431:8-312 Records of surplus lines broker. 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 showing such of the following items as may be applicable:

- (1) Amount of the insurance and perils insured;
- (2) Brief description of the property insured and its location;
- (3) Gross premium charged;
- (4) Any return premium paid;
- (5) Rate of premium charged upon the several items of property;
- (6) Effective date of the contract, and the terms thereof;
- (7) Name and address of the insured;
- (8) Name and address of the insurer;
- (9) Amount of tax and other sums to be collected from the insured; and

(10) Any additional information required by the commissioner. 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.

§431:8-313 Surplus lines broker's annual statement. (a) Each surplus lines broker shall before March 16 of each year file with the commissioner a verified statement of all surplus lines insurance transacted during the preceding calendar year.

(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;
- (3) Aggregate of returned premiums paid to insureds;
- (4) Aggregate of net premiums;
- (5) Amount of aggregate tax remitted; and
- (6) Additional information as required by the commissioner.

§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.

§431:8-315 Tax on surplus lines. (a) Before March 16 of each year each surplus lines broker shall pay to the director of finance, through the commissioner a premium tax on surplus lines insurance transacted by such broker during the preceding calendar year. The tax shall be in the amount of 4.68 percent of gross premiums, less return premiums, on taxable surplus lines insurance.

(b) If a surplus lines policy covers risks or exposures only partially in this State the tax so payable shall be computed upon the proportion of the premium which is properly allocable to the risks or exposures located in this State.

(c) The tax on any portion of the premium unearned at the termination of insurance shall be returned to the policyholder.

§431:8-316 Penalty for failure to file statement or remit tax. If any surplus lines broker fails to:

- (1) File an annual statement, or
- (2) Pay the premium tax required by section 431:8-315 after the tax is due,

the surplus lines broker shall be liable for a fine of \$25 for each day of delinquency commencing March 16. The tax may be collected by distraint, or the tax and fine for failure to pay the tax may be recovered by action instituted by the commissioner in any court of competent jurisdiction. The fine for failure to file the annual statement may be recovered by an action instituted by the commissioner in any court of competent jurisdiction.

§431:8-317 Suspension or revocation of license. (a) The commissioner may suspend or revoke any surplus lines broker's license:

- (1) For failure to file an annual statement or to pay the tax as required by section 431:8-313 through section 431:8-316;
- (2) For failure to maintain an office in this State, or to keep records, or to allow the commissioner to examine such surplus lines broker's records as provided in this article;
- (3) For removal of office accounts and records from this State during the period in which such accounts are required to be maintained under this article;
- (4) For failure to maintain the bond required by section 431:8-310; or
- (5) For any of the causes for which a general agent's license may be suspended or revoked under article 9.

(b) The procedures provided in article 9 for the suspension or revocation of general agents' licenses shall apply to suspension or revocation of a surplus lines broker's license.

(c) No broker whose license has been so revoked shall again be so licensed within one year thereafter, nor until any fines or delinquent taxes owing by such broker have been paid.

§431:8-318 Examination 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.

§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.

§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.

ARTICLE 9. LICENSING OF AGENTS, BROKERS, SOLICITORS, AND ADJUSTERS

PART I. GENERAL PROVISIONS

§431:9-101 Scope. This article shall govern the qualifications and procedures for granting licenses to all insurance agents, brokers, surplus lines brokers, nonresident agents or brokers, subagents, solicitors, adjusters, and limited service representatives.

§431:9-102 General agent defined. (a) General agent means any person appointed under section 431:3-203(b)(1) and authorized by the insurer to perform all of the following acts in this State:

- (1) Solicit applications for insurance;
- (2) Collect premiums on insurance applied for or effectuated;
- (3) Appoint subagents and solicitors;
- (4) Arrange insurance on subjects located, resident, or to be performed wholly outside this State in an authorized insurer for which the agent is not licensed;
- (5) In accordance with the provisions of article 8, arrange insurance on subjects located, resident, or to be performed wholly outside this State in an authorized insurer; and
- (6) Any other lawful acts pursuant to this article.

(b) A person may be a general agent for any number of insurers. A domestic insurer appointing subagents or solicitors is required, unless holding a certificate of authority on December 31, 1955, to have one or more employees who have passed any general agent's examination required by section 431:9-206.

(c) A domestic insurer may be appointed as a general agent.

(d) The individual who is in charge of a branch office maintained in this State by a foreign or alien insurer is required to be a general agent.

§431:9-103 Subagent defined. (a) Subagent means any person appointed by a general agent, or by a domestic insurer upon compliance with section 431:9-102(b) to perform the following acts in this State:

- (1) Solicit applications for insurance;

- (2) Collect premiums on insurance so applied for or effectuated; and
- (3) Any other lawful acts pursuant to this article.

(b) A person may be a subagent for any number of principals, except that a subagent may not be appointed with respect to more than one general agent or domestic insurer for life insurance.

- (c) A subagent must be empowered to appoint solicitors.

§431:9-104 Solicitor defined. (a) Solicitor means any individual appointed by a general agent or by a subagent or by a domestic insurer upon compliance with section 431:9-102(b), to perform the following acts in this State:

- (1) Solicit applications for insurance;
- (2) Collect premiums in connection therewith; and
- (3) Any other lawful acts pursuant to this article.
- (b) An individual is not deemed to be a solicitor if:
 - (1) The individual is employed by such principal and devotes full time to clerical work with incidental taking of insurance applications and receiving premiums in the office of the principal, and
 - (2) The individual's compensation neither includes a commission on such business nor is related to the volume of such applications, insurances, or premiums.

§431:9-105 Adjuster defined. (a) Adjuster means any individual who:

- (1) Acts solely on behalf of either the insurer or the insured, as an independent contractor or as an employee of an independent contractor; and
- (2) Investigates for, reports to, or adjusts for the individual's principal relative to claims arising under insurance contracts.

(b) Independent adjuster means an adjuster representing the interests of the insurer.

(c) Public adjuster means an adjuster employed by and solely representing the financial interests of the insured named in the policy.

(d) For the purposes of this article, the following individuals are not deemed to be an adjuster:

- (1) An attorney at law who adjusts insurance losses from time to time incidental to the practice of the attorney's profession;
- (2) An adjuster of marine losses;
- (3) A salaried employee of a general agent, a subagent, an insurer, or of an adjusting corporation or association owned and controlled by insurers; and
- (4) An individual who acts for a self-insurer or for an insured which administers its own group insurance contract.

PART II. LICENSING REQUIREMENTS, PROCEDURES AND ENFORCEMENT

§431:9-201 License required. (a) No person in this State shall act as or hold oneself out to be a general agent, subagent, solicitor, or adjuster unless so licensed by this State.

(b) No general agent, subagent or solicitor in this State shall solicit or take applications for, procure, or place for others any class of insurance for which the general agent, subagent or solicitor is not licensed.

(c) A regular salaried officer or employee of an authorized insurer shall not be required to be licensed by reason of rendering assistance to, or on behalf of a licensed general agent, subagent or solicitor, provided that the salaried officer or employee devotes substantially all of the officer's or employee's time to activities other than the solicitation of applications for

insurance or annuity contracts and receives no commission or other compensation directly dependent upon the amount of business obtained.

(d) Any person violating this section shall be fined not more than \$1,000 for each factually different violation.

§431:9-202 Controlled business. (a) The commissioner shall neither grant nor extend a general agent's, subagent's or solicitor's license to any person, if the commissioner has reasonable cause to believe that:

- (1) During either of the two calendar years immediately preceding the extension date of any such 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 such license or of any such licensee are such as to cause the commissioner reasonably to believe that during the twelve month period immediately following the issuance or extension of the license, if so issued or extended, the aggregate amount of premiums on controlled business would exceed the aggregate amount of premiums on all other insurance business of the applicant or licensee.
- (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.

§431:9-203 General qualifications for license. For the protection of the public, the commissioner shall not issue or extend any such license except in compliance with this article, and shall not issue or extend any such license to any individual less than eighteen years of age.

§431:9-204 Applications for license. (a) Application for any such license shall be made to the commissioner upon forms as prescribed and furnished by the commissioner. As a part of or in connection with any such application, the applicant shall furnish information concerning:

- (1) The applicant's identity, personal history, experience, business record; and
 - (2) Other pertinent facts as the commissioner may reasonably require.
- (b) (1) If the applicant is a partnership or corporation, the application shall furnish in addition to the requirements set forth in subsection (a):
- (A) The names of all partners or officers; and
 - (B) A designation of each individual who is to exercise the powers to be conferred by the license upon the partnership or corporation.
- (2) Each individual shall be required to furnish information to the commissioner as though for an individual license.
- (c) Any person willfully misrepresenting or omitting any fact required to be disclosed in any such application shall be liable for penalties as provided by this code.

§431:9-205 Number of applications. (a) The filing of personal data by an individual in connection with one application for a general agent's or

subagent's license shall be sufficient, regardless of the number of principals to be represented by the licensee or the number of subsequent applications by the same applicant.

(b) The commissioner may, for the commissioner's information from time to time, require any licensed general agent, subagent or solicitor to supply the commissioner with the information called for in an application for license.

§431:9-206 Examinations for license. (a) Each applicant for license as general agent, subagent, solicitor, or adjuster 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:

- (1) Applicants for limited licenses, as travel insurance subagents or solicitors only, under section 431:9-214;
- (2) Applicants who at any time within the five year period next preceding date of application held a license in this State which conferred powers comparable to those being applied for;
- (3) Applicants for license as nonresident agent or broker who have fulfilled qualification requirements in their state of residence and who are deemed by the commissioner to be fully qualified and competent;
- (4) Applicants for a general agent's, subagent's or solicitor's license for life insurance or life disability insurance who hold the designation chartered life underwriter (C.L.U.) from The American College; or
- (5) Applicants for a general agent's, subagent's or solicitor's license for any class of insurance, except life insurance, who hold the designation chartered property and casualty underwriter (C.P.C.U.) from the American Institute for Property and Liability Underwriters, Incorporated.

(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.

§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, general agents, subagents, and applicants a printed manual specifying in general terms the subjects which may be covered in any examination for a particular license.

§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.

§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.

§431:9-210 General agent's and subagent's qualifications and license.

(a) To qualify for a general agent's or subagent's license an applicant must otherwise comply with this article and must:

- (1) Be domiciled in this State;
- (2) Be empowered to be a general agent or subagent:
 - (A) Under its members' agreement, if a partnership, or
 - (B) By its articles of incorporation, if a corporation;
- (3) Have passed, within the period of two years immediately preceding the date of issuance of the license, any examination which is required by section 431:9-206; and
- (4) (A) Have filed a certificate of appointment by one or more authorized insurers, subject to issuance of the license, if for a general agent's license; or
(B) Have filed a certificate of appointment by a licensed general agent, or a domestic insurer as to each authorized insurer, if for a subagent's license.

(b) The commissioner shall issue the license if the commissioner finds that the applicant is so qualified and that the license fee has been paid. Otherwise, the commissioner shall refuse to issue the license.

§431:9-211 Appointment and revocation of general agents and subagents. (a) Each insurer on appointing a general agent, and each general agent or domestic insurer on appointing a subagent in this State shall file written notice of the appointment in duplicate with the commissioner on forms as prescribed and furnished by the commissioner. If then licensed, or as soon as licensed, the commissioner shall mail one copy of the appointment to the licensee.

- (b) Each such appointment shall continue in force until:
 - (1) The commissioner notifies the insurer that the person so appointed is no longer licensed as a general agent by this State, or
 - (2) The commissioner notifies the general agent or domestic insurer that the person so appointed is no longer licensed as a subagent by this State, or
 - (3) The appointment as general agent is:
 - (A) Revoked by the insurer by written notice of such revocation to the general agent, or
 - (B) Terminated by the general agent by written notice of such termination to the insurer, or
 - (4) The appointment as subagent is:
 - (A) Revoked by the general agent or domestic insurer by written notice of such revocation to the subagent, or
 - (B) Terminated by the subagent by written notice of such termination to the general agent or domestic insurer.

(c) Any person who revokes or terminates shall file within ten days with the commissioner a copy of the notice of revocation or termination.

(d) Revocation of an appointment by an insurer or a general agent shall be deemed to be effective as of the date designated in the notice as being the effective date if the notice is actually received by the licensee prior to such designated date; otherwise, as of the earlier of the following dates:

- (1) The date the notice of revocation was received by the licensee;

- (2) The date the notice, if mailed to the licensee at the licensee's last address of record with the insurer, in due course should have been received by the licensee.

§431:9-212 Contents of licenses. General agents', subagents' and solicitors' licenses shall be in such forms as the commissioner prescribes.

§431:9-213 Licenses to partnerships and corporations. (a) A partnership or a corporation shall not be licensed as a general agent or subagent unless each individual to be empowered and designated in the license to exercise the powers conferred by the license is qualified as though the individual were the sole individual to be so empowered.

(b) Any person so designated or empowered by a corporation or partnership must be a resident of this State.

(c) Exercise or attempted exercise of such powers by an individual not so designated, with the knowledge or consent of the licensee, shall constitute cause for the revocation or suspension of the license.

§431:9-214 Limited license. (a) The commissioner may issue limited licenses as travel insurance subagents or solicitors to persons selling travel tickets of a common carrier of persons or property who shall act only as to travel ticket policies of disability insurance or baggage insurance on personal effects.

(b) The commissioner may prescribe and furnish special forms calling for such information as the commissioner deems proper in connection with the application for or extension of such licenses.

(c) The commissioner may issue:

- (1) A limited license to each individual who has charge of vending machines used in this State for the effectuation of such travel insurance;
- (2) A limited license to any individual who sells policies of accident and sickness insurance as a promotional device to improve the circulation of a newspaper in this State; or
- (3) A limited license to creditors for the purposes of enrolling debtors under a group credit life insurance or group credit disability insurance policy, issuing certificates of insurance pursuant thereto, or issuing individual credit life insurance or credit disability insurance policies to debtors.

§431:9-215 Number of licenses required. A general agent, subagent or solicitor is required to have but one license inclusive of all classes of insurance the agent, subagent or solicitor is licensed to handle, regardless of the number of principals whom the agent, subagent or solicitor represents.

§431:9-216 Solicitors; appointment and revocation. (a) Each general agent, subagent or domestic insurer on appointing a solicitor in this State shall file written notice of the appointment in triplicate with the commissioner on forms prescribed and furnished by the commissioner. The commissioner shall mail one copy of the appointment to the licensee, if then licensed, or as soon as licensed.

(b) Each such appointment shall continue in force until:

- (1) The commissioner notifies the general agent, subagent or domestic insurer that the person so appointed is no longer licensed as a solicitor by this State; or
- (2) The appointment is revoked by the general agent, subagent or domestic insurer by written notice of such revocation to the solicitor; or

- (3) The appointment is terminated by the solicitor by written notice of such termination to the general agent, subagent or domestic insurer.
- (c) Any person who revokes or terminates shall file within ten days with the commissioner a copy of the notice of revocation or termination.
- (d) Revocation of an appointment by a general agent, subagent or domestic insurer shall be deemed to be effective as of the date designated in the notice as being the effective date, if the notice is actually received by the solicitor prior to the designated date; otherwise, as of the earlier of the following dates:
- (1) The date the notice of revocation was received by the solicitor; or
 - (2) The date the notice, if mailed to the solicitor at the solicitor's last residence of record with the solicitor's employer, in due course should have been received by the solicitor.

§431:9-217 Solicitor's qualifications and license. (a) To qualify for a solicitor's license, an applicant must otherwise comply with this article and must:

- (1) Be domiciled in this State;
 - (2) Represent only one licensed general agent, subagent or domestic insurer except that a solicitor, representing a general agent, subagent or domestic insurer and licensed for life insurance only or life and disability insurance, may represent one other general agent, subagent or domestic insurer for the solicitation of other classes of insurance; provided that insurance used to provide funds to cover burial expenses only, payable to a funeral director, shall not be construed as the same class of insurance as life insurance for the purposes of this subsection;
 - (3) Have passed the examination provided for in section 431:9-206 within the immediately preceding two year period.
- (b) The commissioner shall issue a solicitor's license only upon application by the applicant and with the consent of the general agent, subagent or domestic insurer to be represented, upon such forms as the commissioner shall prescribe and furnish. Upon termination of such representation, the license shall be returned to the commissioner for cancellation or modification.

§431:9-218 Responsibility of principal for solicitor. All business transacted by a solicitor under such license shall be in the name of the general agent or subagent by whom the solicitor is appointed, and the general agent or subagent shall be responsible for all acts or omissions of the solicitor within the scope of such appointment.

§431:9-219 Nonresident agent or broker. (a) The commissioner may license as a nonresident agent or broker for all classes of insurance an individual who is otherwise qualified under this article, but who is not a resident of or domiciled in this State, if by the laws of the state or province of the individual's residence or domicile a similar privilege is extended to residents of this State.

(b) Any such licensee shall be subject to the same obligations and limitations, and to the commissioner's supervision, as though resident or domiciled in this State.

(c) No such individual shall be so licensed unless the individual files the power of attorney provided for in article 2.

§431:9-220 Process against nonresident licensees. (a) Each licensed nonresident agent or broker shall appoint the commissioner as the agent's or broker's attorney to receive service of legal process issued against the agent or broker in this State upon causes of action arising within this State. Service upon the commissioner as attorney shall constitute effective legal service upon the agent or broker.

(b) The appointment shall be irrevocable for as long as there could be any cause of action against the agent or broker arising out of the agent's or broker's insurance transactions in this State.

(c) Service of process on the commissioner shall be made in accordance with the provisions of section 431:2-206.

§431:9-221 Limitations upon nonresident agent or broker. A nonresident agent or broker is authorized to place insurance on a subject of insurance located in this State, only under all of the following conditions:

- (1) The insured:
 - (A) If an individual, is not domiciled within this State, or
 - (B) If a partnership, each partner is not domiciled within this State, or
 - (C) If a corporation, is a foreign corporation within the meaning of chapter 415 or is a corporation wholly owned by such a foreign corporation, or is a corporation formed or organized under the laws of any territory of the United States;
- (2) Any negotiation between the nonresident agent or broker and the insured, leading up to the placement of the insurance, has taken place outside this State; provided that neither item (1) nor this paragraph shall be applicable to 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;
- (3) The insurance is placed through a licensed general agent in this State of an authorized insurer; and
- (4) The commission paid to the nonresident agent or broker by the licensed general agent in the State does not exceed the usual rate of commission paid to a resident solicitor.

§431:9-222 Qualification for adjuster's license. (a) To qualify for an adjuster's license an applicant must comply with this article and must:

- (1) Be domiciled in this State, or in a state which will permit residents of this State to act as adjusters in such 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; and
- (3) Have successfully passed any examination required under section 431:9-206.

(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.

§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.

§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.

§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.

§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.

§431:9-227 General agent or subagent may adjust without a license.

- (a) (1) On behalf of and as authorized by an insurer, a general agent may from time to time act as an adjuster and investigate and report upon claims without being required to be licensed as an adjuster;
- (2) On behalf of and as authorized by the general agent, with respect to whom a subagent is licensed as subagent, a subagent may from time to time act as an adjuster and investigate and report upon claims without being required to be licensed as an adjuster.

(b) An adjuster who is a general agent or a subagent 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 subsection shall not be applicable to any general agent or subagent whose remuneration for the sale of insurance, on December 31, 1955, was primarily dependent upon the adjustment of losses, or to any general agent, subagent, or an insurer who, on December 31, 1955, was transacting insurance where the general agent's or subagent's remuneration for the sale of such insurance was primarily dependent upon the adjustment of losses.

(c) A license shall not be required of a nonresident independent adjuster for the adjustment in this State of a single loss, or of more than one loss arising out of a catastrophe common to all such losses.

§431:9-228 Place of business. (a) Every licensed general agent, subagent and adjuster, shall have and maintain in this State, or, if a nonresident agent or broker, in the state of the agent's or broker's domicile, a place of business accessible to the public.

(b) The place of business shall be that wherein the licensee principally conducts transactions under the licensee's licenses.

(c) The licensee shall promptly notify the commissioner of change of business address.

(d) The place of business of a subagent shall be obviously separate from that of any general agent who appointed the subagent.

§431:9-229 Records of general agent, subagent, adjuster. (a) Every general agent, subagent, or adjuster shall keep a record of all transactions consummated under such license. This record shall be in organized form according to class of insurance and shall include:

(1) If a general agent or subagent:

(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; and

(B) The names of any other licensees from whom business is accepted, and of persons to whom commissions or allowances of any kind are promised or paid;

(2) 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 such investigation or adjustment; and

(3) Such other and 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 immediately after the date of the completion of such transaction.

(c) This section shall not apply to life or disability insurance if the records required of such insurance are customarily maintained in the offices of the insurer.

§431:9-230 Reporting and accounting for premiums. (a) Every licensed general agent, subagent, solicitor, and adjuster shall have the responsibilities of a trustee for all premium and return premium funds received or collected under this article.

(b) The licensee shall, upon receipt of the funds, 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 or savings and loan association 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.

The licensee shall not be required to maintain a separate bank 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 or savings and loan association charges may be commingled with the premium funds. In the event the bank or savings and loan association 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 persons entitled to such funds. A premium trustee account shall be designated on the records of the bank or savings and loan association 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.

§431:9-231 Sharing commissions. (a) No insurer, general agent, subagent, or solicitor shall compensate or offer to compensate in any manner any person, other than those specified in subsection (b), for procuring or in any manner helping to procure applications for or to place insurance in this State; provided that this provision shall not prohibit the payment of compensation not contingent upon volume of the business transacted, in the form of salaries to the regular employees of any such licensee.

- (b)
- (1) An insurer may so compensate only the following:
 - (A) A licensed general agent appointed by it;
 - (B) A licensed subagent appointed by it in accordance with section 431:9-103;
 - (C) A licensed solicitor appointed by it in accordance with section 431:9-104;
 - (2) A general agent may so compensate only the following:
 - (A) Licensed subagents appointed by the general agent;
 - (B) Licensed solicitors appointed by the general agent;
 - (C) Any general agent who is licensed in this State for the same class of insurance; or
 - (D) Any licensed nonresident agent or broker.
 - (3) A subagent may so compensate only licensed solicitors appointed by the subagent.
 - (4) A surplus lines broker may so compensate only the following:
 - (A) Licensed subagents appointed by the broker;
 - (B) Licensed solicitors appointed by the broker; or
 - (C) Any general agent who is licensed in this State for the class of insurance involved.

(c) No such licensee shall be promised or allowed any compensation on account of the procuring of applications for or the placing of classes of insurance which the licensee is not licensed to procure or place.

(d) The commissioner may suspend or revoke the licenses of all licensees participating in any violation of this section.

§431:9-232 Extension of licenses. (a) If the licensee is qualified for the license, the license shall be extended.

(b) No license shall contain an expiration date, but all licenses must be extended from time to time in order to continue to be valid.

- (c) (1) When the commissioner issues or extends a license, the commissioner shall:
 - (A) Determine the extension date; the extension date is that date prior to which the license must be extended, and
 - (B) Notify the licensee in writing.

This date shall be any date not less than one year and not more than three years after date of issue or extension.

§431:9-233 Temporary licenses. (a) The commissioner may issue a general agent's, subagent's or solicitor's temporary license in the following circumstances:

- (1) To the surviving spouse, next of kin, employee, or personal representative of a licensed general agent, subagent or solicitor upon such agent's or solicitor's death;
- (2) To the spouse, next of kin, employee, or legal guardian of a licensed general agent, subagent or solicitor disabled because of sickness, insanity or injury;
- (3) To the spouse, next of kin or employee of a licensed general agent, subagent or solicitor who is drafted or volunteers for service in the armed services of the United States;
- (4) To a member of a partnership or officer or employee of a corporation licensed as general agent or subagent upon the death or termination of service of an individual designated in the partnership's or corporation's license to exercise powers thereunder; or
- (5) To the individual placed in charge of a branch office maintained in this State by a foreign or alien insurer upon the death or disability of its general agent.

(b) An individual to be eligible for any such temporary license must be qualified as for a regular license except as to experience, training or the taking of any examination.

(c) Any fee paid to the commissioner for issuance of a temporary license as specified in section 431:7-101 shall be credited toward the fee required for a regular license if issued to replace the temporary license prior to the expiration of the temporary license.

§431:9-234 Temporary licenses, duration and powers. (a) No temporary license shall be effective for more than six months, and the commissioner may refuse so to license again any person who has previously been so licensed. The commissioner may in the commissioner's discretion renew such license for any period not to exceed a total period of twelve months.

(b) Any temporary license is permitted to be issued only for a class of insurance for which the applicant's predecessor was licensed.

§431:9-235 Denial, suspension, revocation of licenses. (a) The commissioner may suspend, revoke or refuse to extend any license issued under this article or any surplus lines broker's license 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 willfully violates or knowingly participates in the violation of any provision of this article;
- (3) If the licensee has obtained or attempted to obtain any such license through willful misrepresentation or fraud, or has failed to pass any examination required by section 431:9-206;

- (4) If the licensee has misappropriated, or converted to the licensee's own use, or has illegally withheld moneys required to be held in a fiduciary capacity;
- (5) If the licensee has, with intent to deceive, 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;
- (8) If the licensee issues or purports to issue any binder as to any insurer named therein as to which the licensee is not then authorized so to bind; or
- (9) 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 such causes as 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.

§431:9-236 Procedure for refusal, suspension, or revocation. The commissioner may suspend, revoke, or refuse to extend any such license for any cause specified in this article:

- (1) By order given to the licensee not less 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 such hearing the license shall be suspended; or
- (2) By an order on hearing made 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.

§431:9-237 Duration of suspension. Every order suspending any license shall specify the period during which suspension will be effective, and which period shall in no event exceed one year.

§431:9-238 Power to fine. (a) After hearing and in addition to or in lieu of the suspension, revocation, or refusal to extend any such license, the commissioner may levy a fine upon the licensee in 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 general fund.

§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, or
- (2) Any fine levied upon the licensee pursuant to section 431:9-238 and section 431:9-240 has been fully paid.

§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.

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.

§431:10-102 Definitions. As used in this part:

- (1) Contract means any policy of life, disability, credit life, credit disability, homeowners insurance, and motor vehicle no-fault insurance covering personally owned or personally leased private passenger motor vehicles prepared for delivery by an insurer.
- (2) Flesch reading ease test means the test set forth in section 431:10-106.
- (3) 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 no-fault insurance, including but not limited to fraternal benefit societies, nonprofit health service corporations, nonprofit hospital service corporations, and health maintenance organizations.
- (4) Text includes all printed material in the contract except:
 - (A) The insurer's name and address;
 - (B) The name, number, or title of the contract;
 - (C) The table of contents or index;
 - (D) Any captions or subcaptions;
 - (E) Any specification pages, schedules, or tables;

- (F) Any language required by federal law, regulation, or agency interpretation or any written certification to exclude such language;
- (G) Any language required by any collective bargaining agreement;
- (H) Any medical terminology; and
- (I) Any definitions.

§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.

§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 gives no undue prominence to any endorsements, riders, or other portions of the text; and
- (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.

§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.

§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.

§431:10-107 Filing of certificate. Every insurer shall file 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). Whenever the score is lower than the minimum allowed under section 431:10-104(1), the certificate shall indicate the lower score and request the contract be approved under section 431:10-108. In determining the accuracy of any certificate, the commissioner may require the insurer to submit a copy of the contract and any additional information.

§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.

PART II. GENERAL RULES

§431:10-201 Scope. The provisions of this part shall apply to all classes of insurance except:

- (1) Ocean marine insurance, and
- (2) Surplus line insurance, as defined in section 431:8-102, and
- (3) Life or disability insurances, provided the contracts are neither issued for delivery in this State nor delivered in this State.

§431:10-202 Definitions. For purposes of this part:

- (a) 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.
- (b) Policy means the written instrument in which a contract of insurance and any endorsement or addendum thereto is set forth.

§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, or disability 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 or disability 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.

§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.

§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 or disability insurances.

§431:10-206 Application for insurance: consent of insured required. No life or disability 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.

§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, 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.

§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 photostatic or other process copy or reduction 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 or disability 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.

§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.

§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 data 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 sugar cane 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 sugar cane 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.

§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.

§431:10-212 Contract limitations for mentally retarded and handicapped children. 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 mental retardation 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.

§431:10-213 Automobile liability; coverage for damage by uninsured or underinsured motorist. (a) No automobile liability or motor vehicle liability policy insuring against loss for bodily injury or death suffered by any person arising out of the ownership, maintenance or use of a motor vehicle shall be delivered, issued for delivery, or renewed in this State unless the policy provides coverage for the protection of the persons insured who are legally entitled to recover damages from owners or operators of uninsured motor vehicles. The policy shall:

- (1) Provide coverage in limits for bodily injury or death set forth in section 287-7, and
- (2) Be filed with and approved by the commissioner. This subsection shall apply to any motor vehicle registered or principally garaged in this State.

(b) Each insurer shall offer to each policyholder or applicant for a motor vehicle liability policy optional additional insurance 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.

(c) The term underinsured motor vehicle means a motor vehicle with respect to the ownership, maintenance or use for which the limits of available liability insurance and self-insurance applicable at the time of loss is insufficient to pay losses and damages. A motor vehicle shall be deemed uninsured for the purposes of this section if, after the occurrence of a loss described in this section, the owner or operator of the motor vehicle is unknown.

§431:10-214 Right to return policy. (a) There shall be printed on or attached to every individual life insurance policy and every individual disability 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 said 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 agent 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.

§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.

§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.

§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.

§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, agent, solicitor, 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.

§431:10-219 Multi-peril policies, premiums stated separately. Insurers issuing multi-peril policies shall state separately 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 attach a separate rate sheet to the policy. The rate sheet prescribed by the commissioner 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.

§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.

§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.

§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 willful 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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§431:10-230 Payment discharges insurer. Whenever the proceeds of, or payments under, a policy or contract issued by a life or disability insurer 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.

§431:10-231 Exemption of proceeds; disability. The proceeds of all contracts of disability 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.

§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.

§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.

§431:10-234 Spouses' right in life insurance policy. (a) Every life insurance policy made payable to or for the benefit of the spouse of the insured, and every life insurance policy assigned, transferred, or in any way made payable to a spouse or to a trustee for the benefit of a spouse, 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.

(b) Without the consent of one's spouse, a married person may contract, pay for, take out, and hold a policy on the life or health of one's spouse or children, or against loss by such spouse or children due to disablement by accident. Premiums paid on the policy by a married person 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 others.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

§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 percent 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.

ARTICLE 10A. ACCIDENT AND SICKNESS INSURANCE CONTRACTS

PART I. INDIVIDUAL ACCIDENT AND SICKNESS POLICIES

§431:10A-101 Applications and exceptions. This part shall apply to all policies of accident and 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 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.

§431:10A-102 Accident and sickness insurance policy defined. The term, policy of accident and sickness insurance, includes any policy or contract covering the class of insurance described in section 431:1-205.

§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 seventeen years, and any other person dependent upon the policyholder.

§431:10A-104 Form of policy. (a) A policy of accident and 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;
- (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 and twenty point. The text shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;
- (5) The exceptions and reductions of indemnity are set forth in the policy and, except the required and optional provisions set forth in section 431:10A-105 and section 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.

§431:10A-105 Required provisions. Except as provided in section 431:10A-107, each policy of accident and 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 the same appear below, provided that the insurer may substitute corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the specified caption, or by such appropriate individual or group captions or subcaptions as the commissioner may approve. The provisions 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:
 - 1- 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 such three-year period.
 - 2- 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 from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."
 - (B) The policy provision set forth in paragraph 1 in item (2)(A) shall not be so construed as 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 items (1) through (4) of section 431:10A-106 in the event of misstatement with respect to age or occupation or other insurance.
- (C) A policy which 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 paragraph 1 in item (2)(A) 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 days (insert a number not less than seven for weekly premium policies, ten for monthly premium policies, and thirty-one for all other policies) 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 which contains a cancellation provision may add at the end of the above provision: "subject to the right of the insurer to cancel in accordance with the cancellation provision."
- (C) A policy in which the insurer reserves the right to refuse any renewal shall have at the beginning of the above provision: "Unless not less than five 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 the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such 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."

- (B) The last sentence of the above provision may be omitted from any 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.
- (5) (A) "Notice of Claim: Written notice of claim must 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 such 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."
- (B) In a policy providing a loss of time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision: "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 said 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 such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such 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 said notice is actually given."
- (6) "Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such 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 such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce

- any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in 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 will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."
- (9) (A) "Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such 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 such beneficiary or to such estate. All other indemnities will be payable to the insured."
- (B) The following provisions, or either of them, may be included with the above provision 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 such indemnity, up to an amount not exceeding \$ (insert an amount which shall not exceed \$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 such payment."
- (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 such loss, be paid directly to the hospital or person rendering such 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 such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished."

- (12) (A) "Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of 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."
- (B) The first clause of the above provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

§431:10A-106 Optional provisions. Except as provided in section 431:10A-107, no policy of accident and 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 approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions are optional provisions. Any such provision contained in the policy shall be preceded individually by the specified caption or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve. 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 such portion of the indemnities provided in this policy as 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 such 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 the more recent. In applying this provision, the classification of occupational risk and the premium shall be such 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 such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state 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 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 or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, 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 such 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 such policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such 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 such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such 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 such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."
- (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 such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such 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 such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."
- (B) If the provision set forth in item (4)(A)(i) is included in a policy which also contains the provision set forth in item

- (4)(A)(ii), there shall be added to the caption of the item (4)(A)(i) provision the phrase, "expense incurred benefits".
- (C) The insurer may, at its option, include in the provision set forth in item (4)(A)(i) a definition of other valid coverage, approved as to form by the commissioner, which definition 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 such definition the term shall not include group insurance, automobile medical payment insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the provision set forth in item (4)(A)(i) with respect to any insured, any amount of benefit provided for such 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 item (4)(A)(i), no third party liability coverage shall be included as other valid coverage.
- (D) If the provision set forth in item (4)(A)(ii) is included in a policy which also contains the provision set forth in item (4)(A)(i), there shall be added to the caption of the item (4)(A)(ii) provision the phrase, "other benefits".
- (E) The insurer may, at its option, include in the provision set forth in item (4)(A)(ii) a definition of other valid coverage, approved as to form by the commissioner, which definition 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 such 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 item (4)(A)(ii) with respect to any insured, any amount of benefit provided for such 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 item (4)(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, shall exceed 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 the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two 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 such coverage upon the insured below the sum of \$200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."

- (B) The above policy provision 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.
- (C) The insurer may, at its option, include in subsection (B) a definition of valid loss of time coverage approved as to form by the commissioner, which definition 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 such coverages. In the absence of such definition such terms shall not include any coverage provided for such 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 therefrom."
- (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, stating when, not less than five days thereafter, such cancellation shall be effective; and 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 such later date as may be specified in such notice. In the event of cancellation, the insurer will 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 such date is hereby amended to conform to the minimum requirements of such 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."
 - (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."

§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, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

§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.

§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.

§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.

§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.

§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.

§431:10A-113 Filing procedure. The commissioner may make reasonable rules and regulations 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. This provision shall not abridge any other authority granted the commissioner by law.

§431:10A-114 Age limit. If any policy of accident and 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.

§431:10A-115 Coverage of newborn children. (a) All policies providing family coverage 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.

§431:10A-116 Coverage for specific services. Every person insured under a policy of accident and 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 and/or visual examination or a correction of any visual or muscular anomaly, and the supplying of ophthalmic materials, lenses, contact lenses, spectacles, eye-glasses 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 such policy, contract, plan, or agreement shall not be denied when such 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.

§431:10A-117 Franchise plan. The term employees as used in this section shall include the officers, managers, and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership.

Insurance may be issued pursuant to this part on a franchise plan under the terms of which accident and 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:
 - (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 under 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.

PART II. GROUP AND BLANKET DISABILITY INSURANCE

§431:10A-201 Definitions. For the purposes of this article:

- (1) (A) Blanket disability insurance policy means any policy or contract of disability insurance which conforms with the description and complies with one of the following requirements:
 - (i) A policy issued to any common carrier of passengers, which carrier shall be deemed the policyholder, covering a group defined as all persons who may become such passengers, and whereby such passengers shall be insured against loss or damage resulting from death or bodily injury either while, or as a result of, being such passengers.

- (ii) 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, and covering all the members of any such organization against loss from accidents resulting from hazards incidental to duties in connection with such organizations.
 - (iii) A policy issued in the name of any established organization whether incorporated or not, having community recognition and operated for the welfare of the community and its members and not for profit, which shall be deemed the policyholder, and covering 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 on behalf of such organization or in the activities thereof.
 - (iv) A policy issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employees against death or bodily injury resulting while, or from, being exposed to such exceptional hazards.
 - (v) A policy covering students or employees issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder.
 - (vi) A policy issued to a substantially similar group who, in the discretion of the commissioner, may be properly eligible for blanket disability insurance.
- (B) Nothing in this section shall be deemed to affect the liability of policyholders for the death of or injury to, any such member of such group.
- (C) Individual applications shall not be required from individuals covered under a blanket disability insurance contract.
- (2) The term employees shall be deemed to include as employees of a single employer, the compensated officers, managers and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and 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 policy may provide that the term employees shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The term employee may be deemed to include retired employees.
- (3) The term employer shall be deemed to include any municipal corporation or governmental unit, agency or department thereof as well as private individuals, firms, corporations, and other persons.
- (4) Group disability insurance means that form of disability insurance covering groups of persons, with or without their dependents and family members, and issued under a master policy to:
- (A) Such groups as qualify for group life insurance under section 431:10D-201 to section 431:10D-211 of this code; or

- (B) An automobile club formed for purposes other than obtaining group insurance, covering the members of the club.

§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.

§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 disability 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 section 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.

§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.

§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.

§431:10A-206 Coverage of newborn children. All group or blanket policies providing family coverage on an expense incurred basis shall provide coverage for newborn children in compliance with section 431:10A-115.

§431:10A-207 Coverage for specific services. Every person insured under a group or blanket policy of disability insurance shall be entitled to the reimbursements and coverages specified in section 431:10A-116.

PART III. MEDICARE SUPPLEMENT POLICIES

§431:10A-301 Definitions. For the purposes of this part:

- (1) **Applicant** means:
 - (A) In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits, and
 - (B) In the case of a group medicare supplement policy or subscriber contract, the proposed certificate holder.
- (2) **Certificate** means, for the purposes of this part, any certificate issued under a group medicare supplement policy, which policy has been delivered or issued for delivery in this State.
- (3) **Medicare supplement policy** means a group or individual policy of disability insurance or a subscriber contract of a nonprofit medical indemnity or service association 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 by reason of age. The term does not include:

- (A) A policy or contract 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, or
 - (B) A policy or contract of any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (i) is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;
 - (ii) has been maintained in good faith for purposes other than obtaining insurance; and
 - (iii) has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members.
 - (C) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this part or rule adopted thereunder, or issued to employees or members as additions to franchise plans in existence on the effective date of the applicable rule.
- (4) Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act, as amended.

§431:10A-302 Applicability. This part shall apply to disability insurance policies and group contracts and individual subscriber contracts of a nonprofit medical indemnity or hospital service association, which are delivered or issued for delivery in this State on or after the date specified in rules adopted by the commissioner in accordance with those sections.

§431:10A-303 Rules. All rules which the commissioner adopts to implement this part shall be adopted under chapter 91.

§431:10A-304 Standards for policy provisions. (a) The commissioner shall issue reasonable rules to establish specific standards for policy provisions. Such standards shall be in addition to and in accordance with applicable laws of this State, including the provisions of part I of this article, and 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.
- (b) The commissioner may issue 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 for coverage under any medicare supplement policy.

(c) A medicare supplement policy shall not deny a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition. The policy 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.

§431:10A-305 Minimum standards for benefits. The commissioner shall issue reasonable rules to establish minimum standards for benefits under medicare supplement policies.

§431:10A-306 Loss ratio standards. Medicare supplement policies shall be expected to return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable rules to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. For the purposes of rules issued under this section, medicare supplement policies 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 individual policies.

§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 shall be delivered or issued for delivery in this State and no certificate shall be delivered pursuant to a group medical supplement policy 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. Such outline of coverage shall include:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the exceptions, reductions and limitations contained in the policy;
- (3) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and
- (4) 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 shall prescribe, by rule, a standard form and contents of an informational brochure for persons eligible for medicare by reason of age 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 by reason of age 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 by reason of age, 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 disability insurance policies and subscriber contracts sold to persons eligible for medicare by reason of age, other than:

- (1) Medicare supplement policies or subscriber contracts;
- (2) Disability income policies;
- (3) Basic, catastrophic or major medical expense policies or subscriber contracts;
- (4) Single premium, nonrenewable policies or subscriber contracts; or
- (5) Other policies or subscriber contracts defined in section 431:10A-301.

(e) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of information in connection with the replacement of disability insurance policies, subscriber contracts or certificates by persons eligible for medicare by reason of age.

§431:10A-308 Notice of free examination. Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page stating in substance that the applicant shall have the right to return the policy or certificate within ten 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. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for medicare by reason of age 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, the applicant is not satisfied for any reason.

§431:10A-309 Approval of forms. (a) No medicare supplement policy or certificate under a group medicare supplement policy that is subject to this part shall be delivered or issued for delivery in this State, after the date specified in rules adopted by the commissioner, unless the minimum standards of such rules are met or exceeded with regard to it, or unless the form of such policy is an approved form in accordance with this section.

(b) The insurer shall submit each such policy form and group certificate form, including the form of any riders or endorsements of applications which may be attached to or made a part of such form, and the schedule of premium rates to the commissioner. The commissioner may require a certification from the insurer that, to the best of the certifier's knowledge and belief, such form meets the requirements of such rules and of all applicable Hawaii laws and rules. The commissioner may also require the insurer 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 under section 431:10A-306.

(c) The commissioner may disapprove any such form or withdraw approval of a previously approved form 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.
- (d) A policy form 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 submission;
 - (3) It fully meets all submission requirements; and
 - (4) It is received by the commissioner.
- (e) The commissioner shall promptly give written notice to the insurer of the commissioner's approval of a policy form or, if a form is disapproved or approval is withdrawn, of such disapproval or withdrawal together with the reasons for it and of the procedure by which the insurer may request and be granted a hearing on the merits of such action.
- (f) The commissioner, by rule, may establish requirements and procedures for medicare supplement policy form submission.

PART IV. EXTENDED HEALTH INSURANCE

§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.

§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 disability 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 disability 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.

§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 percent 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.

§431:10A-404 Persons authorized to transact insurance. Notwithstanding the provisions of article 9, any person licensed to transact disability insurance as a general agent, subagent or solicitor 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.

§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.

§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 shall have been approved by the commissioner or thirty days shall 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 assumption 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 disability 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.

§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.

§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.

§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.

§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.

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.

§431:10B-102 Scope. All life insurance and all disability insurance in connection with loans or other credit transactions shall be subject to the provisions of 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 the provisions of 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.

§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.

§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 disability 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 disability insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

§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.

§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.

§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.

§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. Forms and rates so filed shall be approved at the expiration of thirty days after filing, unless earlier approved or disapproved by the commissioner. The commissioner by written notice to the insurer may, within the thirty-day period, extend the period for approval or disapproval for an additional thirty days.

(b) The commissioner shall, within the waiting period or any extension thereof after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders and premium rates, disapprove any such form or any premium rates if the benefits provided are not reasonable in relation to the premium charge, or if the form contains provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the coverage, or are contrary to any provision of the code, or of any rule or regulation promulgated thereunder.

(c) The benefits provided by any such 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 fifty percent or may not reasonably be expected to be at least fifty percent. In the determination of the reasonableness of the relation of benefits and premiums consistent with a fifty percent loss ratio, the commissioner may establish a common authorized premium rate for similar or substantially similar coverage by class of creditor. The commissioner may approve a higher rate than such common rate where a creditor's experience under a specific policy form reasonably indicates an ultimate loss ratio higher than fifty percent, but the commissioner shall limit the use of such higher rate to those creditors whose experience was the basis of the approval of such higher rates. The commissioner shall require insurers to file such information as the commissioner deems necessary to determine that this standard is met each two years, or more often in the commissioner's discretion, on forms recommended by the National Association of Insurance Commissioners for that purpose. Upon giving such notice as is required by law, the commissioner may withdraw approval of any such form including the rate set forth therein, on the ground that a reasonable relation of benefits to premiums no longer exists or may approve a higher or lower rate if justified by experience.

The commissioner shall promulgate a rate that shall be deemed acceptable as satisfying this standard without any actuarial or statistical filing; provided that for a one-year period, or for such longer period as the commissioner feels is required to produce credible mortality and morbidity data, a creditor may make an identifiable charge to a debtor not to exceed the following:

- (1) Life: (declining balance term) Seventy-five cents per year per \$100 of initial insured indebtedness to be paid in equal installments over a one-year period. If premiums or identifiable charges are calculated on other than an advance single premium basis, they shall not exceed the actuarial equivalent of the foregoing.

If premiums are payable on other than a single premium basis, they shall not exceed the substantial actuarial equivalent of the foregoing 75 cent rate.

Premiums and premium rates for insurance covering obligations payable in other than substantially equal monthly installments during the period of coverage shall be determined in a manner resulting in a rate not exceeding the substantial actuarial equivalent of the foregoing 75 cent rate.

- (2) Disability: The disability rates as set forth below shall be the maximum rates applicable to policies which exclude all disabilities resulting from intentional self-inflicted injury, pregnancy, flights in non-scheduled aircraft, and pre-existing illness, disease, or physical condition for which the debtor received or was professionally advised to obtain, medical advice, consultation, or treatment during the six-month period preceding the effective date of the debtor's coverage and which caused disabilities within the six months following the effective date of coverage. Premiums or identifiable charges for (i) coverage other than shown above, and (ii) maturities or waiting periods other than those shown below, must be actuarially consistent with those shown below.

Number of
Months in
Which

Indebtedness Is Repayable	Non-Retroactive Benefits			Retroactive Benefits		
	30-day	14-day	7-day	30-day	14-day	7-day
0-12	.80	1.50	2.30	1.70	2.20	3.00
13-24	1.60	2.00	3.20	2.50	3.00	4.00
25-36	2.30	2.50	4.15	3.30	3.80	5.00
37-48	2.90	3.00	4.70	3.80	4.30	6.00
49-60	3.30	3.50	5.15	4.30	4.70	7.00

A credit insurance policy issued under the above life and disability may exclude from the classes eligible for insurance, classes of debtors determined by age and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of specified ages.

In order to determine whether or not the benefits provided in a particular policy form submitted by an insurer are reasonable in relation to the premium charged for the policy and to facilitate the submission and approval of policy forms and premium rates to be used in connection therewith, the commissioner shall give full consideration and make reasonable allowances for mortality cost or morbidity cost and other relevant factors and trends. Any such changed maximum rate of premium or identifiable charge shall not affect any insurance then in force on debtors.

- (d) After the one-year period, or such longer period deemed necessary by the commissioner as provided in subsection (c), the commissioner shall by regulation establish *prima facie* acceptable premium rates, except as set forth below, which shall be usable without statistical justification when filed together with an otherwise acceptable policy form submission. The rates shall produce or shall reasonably be expected to produce a ratio of losses incurred to premiums earned of at least fifty percent. The regulation shall specify the plans of benefits to which the premium rates apply.

(e) 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 established rate and shall base the commissioner's determination on the fifty percent loss ratio standard, except where the deviated rate exceeds 75 cents per \$100 initial insurance per year for reducing term credit life insurance and its actuarial equivalent for other forms of credit life insurance, a reasonable variance from the fifty percent loss ratio standard may be required. Such deviation may be limited to the debtors or creditors whose experience was the statistical basis for the filing.

(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 and the commissioner shall approve or disapprove such filings in accordance with the fifty percent 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 such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement, or rider or premium rate, shall be issued or used until the expiration of thirty days after it has been so filed, unless the commissioner gives the commissioner's prior written approval.

(h) The commissioner may, at any time after a hearing held not less than twenty days after written notice to the insurer, withdraw the commissioner's approval of any such 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 and these forms shall be approved by the commissioner if (1) they conform with the requirements specified in said subsections; (2) 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 (3) 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.

S431:10B-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.

§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 431:9-214 shall be required for such acts. An agent's or broker'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.

§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.

§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.

§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.

§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 willful, 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.

ARTICLE 10C. MOTOR VEHICLE INSURANCE

PART I. GENERAL PROVISIONS

§431:10C-101 Short title. This article shall be known and may be cited as the "Hawaii motor vehicle insurance law".

§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 no-fault insurance coverage;
- (2) Those persons truly economically unable to afford insurance are provided for under the public assistance provisions of this article.

§431:10C-103 Definitions. As used in this article:

- (1) Accidental harm means bodily injury, death, sickness, or disease caused by a motor vehicle accident to a person.
- (2) Criminal conduct means:
 - (A) The commission of an offense punishable by imprisonment for more than one year;
 - (B) The operation or use of a motor vehicle with the specific intent of causing injury or damage; or
 - (C) 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.
- (3) Injury means accidental harm not resulting in death.
- (4) Insured motor vehicle means a motor vehicle:
 - (A) Which is insured under a no-fault policy; or
 - (B) The owner of which is a self-insurer with respect to such vehicle.
- (5) 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.
- (6) Maximum limit means the total no-fault benefits payable per person or, on the person's death, to the person's survivor on account of accidental harm sustained by the person in any one motor vehicle accident shall be \$15,000, regardless of the number of motor vehicles involved or policies applicable.
- (7) Monthly earnings means:
 - (A) In the case of a regularly employed person, one-twelfth of the average annual compensation before state and federal income taxes at the time of injury or death;
 - (B) 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
 - (C) 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 of such person paid from the time such person would reasonably have been expected to be regularly employed.
- (8) 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.
- (9) 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.

- (10) (A) No-fault benefits, sometimes referred to as personal injury protection benefits, with respect to any accidental harm means:
- (i) all appropriate and reasonable expenses necessarily incurred for medical, hospital, surgical, professional nursing, dental, optometric, ambulance, prosthetic services, its products and accommodations furnished, and x-ray. The foregoing expenses may include any nonmedical remedial care and treatment rendered in accordance with the teachings, faith, or belief of any group which depends for healing upon spiritual means through prayer;
 - (ii) all appropriate and reasonable expenses necessarily incurred for psychiatric, physical, and occupational therapy and rehabilitation;
 - (iii) monthly earnings loss measured by an amount equal to the lesser of:
 - (I) \$900 a month; or
 - (II) the monthly earnings for the period during which the accidental harm results in the inability to engage in available and appropriate gainful activity.
 - (iv) all appropriate and reasonable expenses necessarily incurred as a result of such accidental harm, including, but not limited to:
 - (I) expenses incurred in obtaining services in substitution of those that the injured or deceased person would have performed not for income but for the benefit of the person or the person's family up to \$800 a month;
 - (II) funeral expenses not to exceed \$1,500; and
 - (III) attorney's fees and costs to the extent provided in section 431:10C-208(a);
- Provided that the term, when applied to a no-fault policy issued at no cost under the provisions of section 431:10C-422(2)(B), shall not include benefits under items (i), (ii) and (iii) for any person receiving public assistance benefits.
- (B) No-fault benefits shall be subject to:
- (i) an aggregate limit of \$15,000 per person or such person's survivor where each applicable policy provides only the basic no-fault coverage; or
 - (ii) an aggregate limit of the expanded limits where the insured has contracted for it under an optional additional coverage.
- (11) No-fault insured means:
- (A) The person identified by name as insured in a no-fault policy complying with section 431:10C-301; and
 - (B) While residing in the same household with a named insured, the following persons not identified by name as an insured in any other contract of no-fault policy complying with this article:
 - (i) a spouse or other relative of a named insured, and

- (ii) 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, even though the person temporarily lives elsewhere.
- (12) No-fault policy means an insurance policy which meets the requirements of section 431:10C-301.
- (13) Operation, maintenance or use with respect to a motor vehicle includes occupying, entering into and alighting from it, but does not include:
- (A) Conduct in the course of loading or unloading the vehicle, unless the accidental harm occurs in the immediate proximity of the vehicle; and
- (B) Conduct within the course of a business of repairing, servicing, or otherwise maintaining vehicles, unless the conduct occurs outside the premises of such business.
- (14) 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.
- (15) Person means, when appropriate to the context, not only individuals, but corporations, firms, associations, and societies.
- (16) Person receiving public assistance benefits means:
- (A) Any person receiving benefits consisting of medical services or direct cash payments through the department of social services and housing; or
- (B) Any person receiving benefits from the Supplemental Security Income Program under the Social Security Administration.
- (17) Regulation means any rule and regulation promulgated by the commissioner pursuant to chapter 91.
- (18) Replacement vehicle means a specific, comparable, and available vehicle in as good or better overall condition than the total loss vehicle.
- (19) Self-insurer, with respect to any motor vehicle, means a person who has satisfied the requirements of section 431:10C-105.
- (20) 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.
- (21) 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.
- (22) 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.

- (23) Uninsured motor vehicle means any of the following:
- (A) A motor vehicle for which there is no bodily injury liability insurance or self-insurance applicable at the time of the accident; or
 - (B) An unidentified motor vehicle that causes an accident resulting in injury provided the accident is reported to the police or proper governmental authority, physical or independent evidence exists of its involvement, and claimant notifies the claimant's insurer within thirty days or as soon as practicable thereafter, that the claimant or the claimant's legal representative has a legal action arising out of the accident.
- (24) 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.

§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 no-fault 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 no-fault policy upon such vehicle which provides the coverage required by this article and shall maintain the no-fault 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-118(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.

§431:10C-105 Self-insurance. The motor vehicle insurance required by section 431:10C-104 may be satisfied by any owner of a motor vehicle if:

- (1) Such owner provides a surety bond, proof of qualifications as a self-insurer, or other securities affording security substantially equivalent to that afforded under a no-fault policy, providing coverage at all times for the entire motor vehicle registration period, as determined and approved by the commissioner under regulations; 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 no-fault policy had been applicable to such vehicle.

§431:10C-106 Specialty insurers not prohibited. (a) Nothing in this article shall prevent an insurer from offering no-fault insurance policies for only motor vehicles with fewer than four wheels.

(b) Nothing in this article shall prevent an insurer from offering no-fault insurance policies for only U-drive motor vehicles.

§431:10C-107 Verification of insurance: motor vehicles. (a) Every insurer shall issue to its insureds a no-fault insurance identification card for each motor vehicle for which the basic no-fault coverage is written. The identification card shall contain the following:

- (1) Name of make and factory or serial number of the motor vehicle; provided, however, 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 at all times and shall be exhibited to a law enforcement officer upon demand.

(c) The commissioner shall issue a certificate of self-insurance periodically, as necessary, for use in each motor vehicle insured under section 431:10C-105.

§431:10C-108 Unlawful use of no-fault 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 no-fault insurance identification card; or
- (2) For any person to display or cause or permit to be displayed a no-fault insurance identification card knowing that the no-fault policy was canceled as provided in section 431:10C-111 and section 431:10C-112.

§431:10C-109 No-fault identification card after cancellation of policy; return to insurer, civil sanctions. (a) When a no-fault 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 no-fault 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 no-fault 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 and section 607-17, the insurer shall be awarded reasonable attorney's fees and court costs. If the no-fault 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-118 shall not be precluded.

§431:10C-110 Application for coverage, restriction against rejection of and grounds for rejection. An insurer authorized to issue a no-fault policy,

including a general agent, subagent or solicitor, may not reject an application for a no-fault policy or optional additional insurance which insurers are required to make available, covering a motor vehicle, unless:

- (1) The principal operator of the vehicle does not have a license which permits operation of the vehicle; or
- (2) The application is not accompanied by at least six months premium for the coverage. Nothing in this paragraph shall prohibit an insurer, at its discretion, from accepting a minimum of two months' premium and issuing a policy; provided that a temporary no-fault identification card may not be issued for a period exceeding the period for which premiums have been paid or earned. A no-fault identification card in compliance with section 431:10C-107 shall be issued by the insurer once any outstanding balance for the policy is paid. This paragraph shall apply only to the first application of a person for a no-fault policy and shall not apply to applications for commercial and fleet vehicles.

§431:10C-111 Restriction against cancellation or non-renewal. (a) An insurer may not cancel or refuse to renew a no-fault policy, including required optional additional insurance meeting the provisions 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; or
 - (2) Premium payments for the policy are not made after reasonable demand therefor.
- (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-408(b)(1)(A) or (B) at the time of the refusal to renew.

(c) In any case of cancellation or refusal to renew, the insurer shall continue all no-fault and optional additional coverages in force, to the date of expiration or for thirty days following notice, whichever date occurs first.

(d) Within fifteen days of a cancellation and the return of the no-fault 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.

§431:10C-112 Notice of cancellation or non-renewal; effect on term of coverage. (a) In any case of cancellation or refusal to renew, the insurer shall give written notice to the insured not less than thirty days prior to the effective date of the cancellation or refusal to renew. Cancellation or refusal to renew shall not be deemed valid unless 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.

§431:10C-113 Violation of rejection, cancellation and non-renewal 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.

§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.

§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 \$2 a year on each motor vehicle insured by each insurer or self-insurer. This fee is due and payable in full on an annual basis by means and at a time to be determined by the commissioner.

(b) The commissioner shall deposit these 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) Fifty percent to the commissioner to be expended for the operation of the drivers' education program provided in section 286-128(m); and
- (2) Fifty percent to the superintendent of education to support the drivers' education program administered by the department of education for high school students;

Provided that all fees received under subsection (a), which are derived from motorcycles, motor scooters or similar vehicles, shall be expended by the University of Hawaii community college employment training office for the operation of a drivers' education program for operators of motorcycles, motor scooters or similar vehicles.

(d) The commissioner shall make all necessary rules and regulations for the execution of this section and the distribution of this fund.

§431:10C-116 Challenges to no-fault 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.

§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 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 violations bureau of the district court of the first circuit.
- (2) Notwithstanding any provision of the Hawaii Penal Code, each violation shall be deemed a separate offense and shall be subject to a fine not less than \$100 nor more than \$1,000 and the fine

shall not be suspended; provided if the person is convicted of not having had a no-fault policy in effect at the time the citation was issued, the fine for the first offense shall be \$100, with a minimum of \$400 for each additional offense. 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; nor
 - (B) Any operator of a motor vehicle owned by that person's employer during the normal scope of that person's employment.
- (3) In the case of multiple violations, the court shall in addition to any other penalty impose the following penalties:
- (A) Imprisonment of not more than thirty days;
 - (B) Suspension or revocation of the drivers' licenses of the driver and of the registered owner;
 - (C) Suspension or revocation of the motor vehicle registration plates of the vehicle involved;
 - (D) 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
 - (E) Any combination of such penalties.
- (b) Any person, in the capacity of a licensed or unlicensed motor vehicle insurer, general agent, subagent, solicitor, 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, general agent, subagent, solicitor, 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.
- (2) The imposition of any civil penalty under subsections (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.

§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 no-fault 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 no-fault insurance coverage on the date of the accident which is the subject of the tort action.

§431:10C-119 Insurer's requirements. (a) Prior to licensing an insurer to transact no-fault or the optional additional 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; and

- (2) 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.
- (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 may, prior to issuing a certificate of self-insurance to any person, 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) The commissioner shall promulgate regulations to permit any licensed health insurer to secure a license to engage in the business of motor vehicle insurance to provide only those no-fault benefits described in section 431:10C-103(10) and optional major medical coverages.

§431:10C-120 Prohibitions, penalty. (a) No insurer shall issue or offer to issue any policy which the insurer represents is a no-fault policy unless such insurer meets the requirements of this article.

(b) Any insurer, any general agent, agent, solicitor, or representative of an insurer who violates subsection (a) shall be subject to the provisions of section 431:10C-117(e).

§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-308(a) through (c) 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.

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.

§431:10C-202 Making of motor vehicle insurance rates. (a) All premium rates for motor vehicle insurance shall be made in accordance with the following provisions:

- (1) Rates shall not be excessive, inadequate or unfairly discriminatory, as defined in section 431:14-103;
- (2) Due consideration shall be given to:
 - (A) Past and prospective loss experience in this State, catastrophic hazards, if any, reasonable margin for profit and contingencies, dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policy-holders, members or subscribers;
 - (B) Reasonable margin for profit from and contingencies in the administration of motor vehicle insurance sold;
 - (C) Past and prospective expenses in the sale and administration of motor vehicle insurance; and
 - (D) Investment income from reserves, unearned insurance premiums, and other unearned proceeds received on account of motor vehicle insurance sold, and all other factors that may be deemed relevant, such as but not limited to types of vehicles, occupations, and involvement in past accidents, provided they are established to have a probable effect upon losses or expense, or rates; and
 - (E) Optionally, to past or prospective loss, sales, and administrative costs experience in the nation or regionally, whenever such consideration will serve to reduce rates;
- (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 such 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. Such 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) The commissioner shall be prohibited from setting, maintaining or in any way fixing the rates charged by motor vehicle insurers for motor vehicle insurance issued in conformity with this article as either no-fault insurance or as optional additional insurance except as provided in part IV of this article. Each insurer licensed to underwrite no-fault insurance in the State shall establish its own rate schedule. The commissioner shall, however, monitor and survey the several companies' rate making methods and systems. The commissioner shall require of each insurer and of each self-insurer any and all information, data, internal memoranda, studies, and audits, the commissioner deems desirable for the purpose of evaluation, comparison and study of the methods and schedules.

(d) Notwithstanding subsection (c), commencing on December 16, 1985 and ending on December 31, 1988, all insurers of any motor vehicle

shall provide a ten percent reduction off premium charges each insurer assesses for each new and renewal policy for no-fault benefits and medical payment coverage for any motor vehicle which is equipped with seat belt assemblies as required under any federal motor vehicle safety standard issued pursuant to Public Law 89-563, the federal National Traffic and Motor Vehicle Safety Act of 1966, as amended, or which is so equipped even if not required to be under any federal motor vehicle standard.

(e) Notwithstanding subsection (c), and in addition to all other premium reductions required under this section, commencing on October 1, 1986 and ending on September 30, 1989, all insurers of any motor vehicle shall provide a 1.5 percent reduction for bodily injury liability, property damage liability, no-fault benefits, uninsured motorist, and underinsured motorist coverages, and a 0.75 percent reduction for collision coverage off premium charges each insurer assesses for each new and renewal policy, based on the anticipated effects of section 281-78. Commencing on October 1, 1989 and ending on September 30, 1990, at the discretion of and as determined by the commissioner, based on the difference between the actual and anticipated effects of section 281-78, all insurers of any motor vehicle shall provide a refund or credit to each insured at the time of renewal of a no-fault policy.

(f) 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 subsection shall not apply to advisory organizations referred to in section 431:14-111 which are not involved in rate making under this article.

§431:10C-203 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 motor vehicle insurance at least thirty days before the proposed effective date of the filing.

(b) The commissioner may also 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.

§431:10C-204 Intervention by commissioner to adjust rates. (a) Notwithstanding the provisions of section 431:10C-202(c), the commissioner shall, in the commissioner's discretion, intervene at any time to adjust rates for the no-fault, mandatory or optional additional coverages being assessed by any or all insurers, upon a finding that all or any rates are excessively high or unconscionably below the actual costs of provision of the coverage being assured. In the establishment of individual rate schedules, each insurer shall conform fully to section 431:10C-202(a)(2) and (a)(4).

(b) The commissioner shall not set any rates as provided in subsection (a) without a public hearing at which all affected and interested parties have a full opportunity to examine, comment and present evidence on the impact and application of the proposed establishment, or revision of rates. The commissioner shall publish a notice of the date, time and place of the public hearing at least once in each of three successive weeks in a newspaper of general circulation.

§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.

§431:10C-206 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 any of the requirements of this article or any applicable provision of article 14, the commissioner shall, unless the commissioner has good cause to believe that such noncompliance is willful, 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 willful, 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, nor
- (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.

§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.

§431:10C-208 Increase in premiums prohibited. No premium on any no-fault 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 in insurance premiums.

§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.

§431:10C-210 Publication of premium rates. The commissioner shall publish annually, in a newspaper of general circulation in the State, a list of all motor vehicle insurers with representative annual premiums for motor vehicle insurance.

§431:10C-211 Claimant's attorney's fees. (a) A person making a claim for no-fault 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 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 percent of the no-fault benefits paid, 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.

§431:10C-212 Administrative hearing on insurer's denial of claim. (a) If a claimant 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 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 claimant's objections.

(b) The commissioner has jurisdiction to review any denial of benefits where:

- (1) The disputed amount does not exceed \$5,000 as of the date of the denial; or
- (2) The disputed amount exceeds \$5,000 solely because an insurer or self-insurer has failed to comply with section 431:10C-304.

(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.

§431:10C-213 Arbitration. (a) A claimant or insurer may submit any dispute relating to a no-fault 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 658.

(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.

§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 chapters 76 and 77.

§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 auditor. 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 the motor vehicle no-fault 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 rendering of such service. The charges shall be collected and paid into the general fund of this State.

- (d) (1) Each insurer licensed to transact motor vehicle no-fault or optional additional insurance business in this State shall provide the commissioner with periodic reports on every aspect of the no-fault and the optional additional insurance business the insurer transacts in the State, including, but not limited to, reports

on the investment, reserve, reinsurance, loss and profit experience, rate making and schedules, claims received and paid.

- (2) Each insurer shall, not less frequently than quarterly, report to the commissioner 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 no-fault and optional additional insurance policy transactions.

(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.

§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.

PART III. COVERAGES AND RIGHTS

§431:10C-301 Required motor vehicle policy coverage. (a) In order to meet the requirements of a no-fault policy as provided in this article, 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 the express or implied permission of the named insured, 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.
- (b) A motor vehicle insurance policy shall include:
- (1) Liability coverage of not less than \$35,000 for all damages arising out of accidental harm sustained by any one person as a result of any one accident applicable to each person sustaining accidental harm arising out of ownership, maintenance, use, loading, or unloading of the insured vehicle;
 - (2) Liability coverage of not less than \$10,000 for all damages arising out of injury 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, or the insured vehicle; and
 - (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 section 287-7, 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, however, that the coverage required under this section shall

not be applicable where any insured named in the policy shall reject the coverage in writing.

§431:10C-302 Required optional additional insurance. (a) In addition to the no-fault coverages described in section 431:10C-301, every insurer issuing a no-fault policy shall make available to the insured the following optional insurance 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 as the commissioner, by regulation, 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 no-fault benefits;
- (3) Additional coverages and benefits with respect to any injury, death, 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 (b)(2);
- (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;
- (5) Terms, conditions, exclusions, and deductible clauses, coverages and benefits which:
 - (A) Are consistent with the required provisions of such 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; and
- (6) At appropriately reduced premium rates, deductibles applicable only to claims of a no-fault insured or of the insured's survivors in case of the insured's death in the amounts of \$100, \$300, and \$500 from all no-fault benefits otherwise payable; provided that if two or more no-fault 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.

(b) In accordance with the regulations promulgated 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 actions may be brought against the insurer.

§431:10C-303 Right to no-fault 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 no-fault 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 no-fault benefits as defined in section 431:10C-103(10):

- (1) No-fault insureds as defined in section 431:10C-103(11); 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.

§431:10C-304 Obligation to pay no-fault benefits. Every no-fault and self-insurer shall provide no-fault benefits for accidental harm as follows:

- (1) Except as otherwise provided in section 431:10C-305(d):
 - (A) In the case of injury arising out of a motor vehicle accident, the insurer shall pay, without regard to fault, to the following persons who sustain accidental harm as a result of the operation, maintenance or use of the vehicle, an amount equal to the no-fault benefits payable to that person as a result of the injury:
 - (i) any person, including the owner, operator, occupant, or user of the insured motor vehicle;
 - (ii) any pedestrian (including a bicyclist); or
 - (iii) any user or operator of a moped as defined in section 249-1; or
 - (B) In the case of death of any person listed in item (1)(A), arising out of a motor vehicle accident, the insurer shall pay, without regard to fault, to the legal representatives of such person who sustains accidental harm as a result of the operation, maintenance or use of the vehicle, for the benefit of the surviving spouse and any dependent, as defined in section 152 of the Internal Revenue Code of 1954, as amended, an amount equal to the no-fault benefits payable to the spouse and dependent as a result of the death of such person, subject to the provisions of section 431:10C-103(10);

Provided that subsections (A) and (B) shall not apply in the case of injury to or death of any operator of a motorcycle or motor scooter as defined in section 286-2 arising out of a motor vehicle accident.

- (2) Payment of no-fault benefits shall be made as the benefits accrue, except that in the case of death, payment of the benefits may be made immediately in a lump sum payment, at the option of the beneficiary.
- (3)
 - (A) Payment of no-fault 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.
 - (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 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.
 - (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 the claimant an itemized list of all the required documents.
- (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 percent per month.

- (5) No part of no-fault 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 no-fault benefits due, all attorney's fees and costs of settlement or suit necessary to effect the payment of any or all no-fault 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 such contract.
- (6) Any insurer who violates the provisions of this section shall be subject to the provisions of section 431:10C-117(b) and (c).

§431:10C-305 Source of payment.

- (a) (1) A claim for no-fault benefits for accidental harm of a person who is not an occupant of any motor vehicle involved in an accident may be made against the no-fault insurer of any involved vehicle; provided that this subsection shall not apply to any operator of a motorcycle or motor scooter as defined in section 286-2.
(2) The no-fault 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 no-fault 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 item (2), no-fault 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 no-fault insurance applicable to the injured person shall apply.

No person shall recover no-fault benefits from more than one insurer for accidental harm as a result of the same accident.

- (2) All no-fault 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 set out in section 431:10C-103(10)(1)(C) or 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 percent of the person's monthly earnings as monthly earnings are defined in section 431:10C-103(7); and
 - (C) This section shall be inapplicable 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 no-fault benefits and, upon payment thereof, the no-fault 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 no-fault policy of the customer's insured motor vehicle shall be primary over the policy on the temporary substitute vehicle.
- (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 no-fault 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 no-fault 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.

Provided, that this subsection does not preclude recovery in other capacities under a no-fault policy covering a vehicle which the person did not occupy at the time of the accident.

§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) (A) Death occurs to such person in such a motor vehicle accident;
- (B) Injury occurs to such person which consists, in whole or in part, in a significant permanent loss of use of a part or function of the body; or
- (C) Injury occurs to such person which consists of a permanent and serious disfigurement which results in subjection of the injured person to mental or emotional suffering;
- (2) Injury occurs to such person in a motor vehicle accident in which the amount paid or accrued exceeds the medical-rehabilitative limit established in section 431:10C-308 for expenses provided

in section 431:10C-103(10)(A) and (B); provided that the expenses paid shall be presumed to be reasonable and necessary in establishing the medical-rehabilitative limit; or

- (3) Injury occurs to such person in such an accident and as a result of such injury that the aggregate limit of no-fault benefits outlined in section 431:10C-103(10) payable to such person are exhausted.

(c) Subsections (a) and (b) shall apply whether or not the injured person is entitled to receive no-fault 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 no-fault benefits to such injured person unless such claim meets the requirements of subsection (b).

(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 such 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 which causes injury or damage to person or property; or
- (C) Engages in conduct resulting in punitive or exemplary damages.

(f) No provision of this section shall be construed to abolish tort liability with respect to property damage arising from motor vehicle accidents.

§431:10C-307 Rights of subrogation. Whenever any person effects a tort liability recovery for accidental harm, whether by suit or settlement, which duplicates no-fault benefits already paid under the provisions of this article, the no-fault insurer shall be subrogated to fifty percent of the no-fault benefits, up to the maximum limit specified by section 431:10C-103(6), paid to such person.

§431:10C-308 Medical-rehabilitative limit. (a) The commissioner shall annually revise the medical-rehabilitative limit in the following manner:

- (1) The commissioner shall determine the percentage change in the medical care category of the consumer price index for all urban consumers for the Western region as published by the bureau of labor statistics from April of the previous year to April of the current year;
- (2) The medical-rehabilitative limit for the next no-fault policy term year shall be the current medical-rehabilitative limit increased or decreased by the product of the current medical-rehabilitative limit multiplied by the percentage change in the medical care index;

- (3) The medical-rehabilitative limit shall then be rounded to the nearest \$100 for actual use, but the exact value shall be used in subsequent determinations under this section; and
 - (4) The commissioner shall use the amount of \$5,000 as the initial threshold base on which calculations shall be made in accordance with this section for the purpose of determining the medical-rehabilitative limit for the next no-fault policy term year.
- (b) For the purposes of this section, the no-fault policy term year shall commence annually on September 1 and terminate the following August 31. For each term year, the commissioner shall make the tabulation of data necessary for the computation of the medical-rehabilitation limit during the period April 1 to March 31 preceding the September 1 start of the no-fault policy term year.

§431:10C-309 Total loss motor vehicle claims. When a no-fault 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.

§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(18), 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.
- (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.

§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.

§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.

§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.

§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.

§431:10C-315 Statute of limitations. (a) No suit shall be brought on any contract providing no-fault 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 no-fault or optional additional benefits;
- (3) Two years after the entry of a final order in arbitration; or
- (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.

(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 no-fault 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.

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 automobile insurance in this State.

(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.

§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.

§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 no-fault, mandatory public liability and property damage policies complying with this part applicable to the accidental harm or other damage, or, in the case of financial inability of a no-fault insurer or self-insurer to perform its obligations, as if the assignee had written the applicable no-fault insurance, undertaken the self-insurance, or lawfully obligated itself to pay no-fault benefits.

§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.

§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 agents;
- (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 chairman and vice chairman 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.

§431:10C-406 Regulations, review, and appellate procedure. (a) The commissioner shall make and promulgate all necessary and appropriate regulations for the execution of the commissioner's duties under this article 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.

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 no-fault policies and any optional additional insurance an eligible person or user applies for. The commissioner shall, by regulation, 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 no-fault and tort

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.

(b) The plan shall provide all no-fault benefits and services, and tort liability coverage to the limits and coverages specified in this article for all classes of persons, motor vehicles and motor vehicle uses specified in this article upon the payment of premiums as provided in subpart C, as follows:

(1) The plan shall provide no-fault benefits and policies for each of the following classes, and each class shall be able to secure a no-fault and tort 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 automobile 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; or
- (v) driving under the influence of an intoxicating liquor as provided in section 291-4 or any drug, except marijuana, as provided in section 291-7.

(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 subsection (C) or the exclusive use of a vehicle for domestic-household-familial purposes.

(2) The plan shall provide no-fault benefits and policies for all classes of persons, motor vehicles, and motor vehicle uses, at the premiums specified under subpart C, at the options of the owners, for the following classes, which the commissioner, by rules, shall further define and regulate:

(A) All licensed drivers receiving public assistance benefits consisting of medical services or direct cash payments through the department of social services and housing, or benefits from the supplemental security income program under the social security administration; provided that the licensed drivers 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 social services and housing as being necessary for medical or employment purposes.

- (B) Any licensed physically handicapped driver, including drivers with any auditory limitation.

Each category of driver/owner under subsections (A) and (B) may secure no-fault coverage through the plan at the individual's option, provided any previous no-fault policy has expired or has been cancelled. Any person becoming eligible for plan coverage under subsection (A) shall first exhaust all paid coverage under any no-fault policy then in force before becoming eligible for plan coverage.

Any person eligible or becoming eligible under rules adopted by the commissioner under subsection (B), 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 social services and housing indicating that the person is a bona fide public assistance recipient as defined in subsection (A). The certificate shall be deemed a policy for the purposes of chapter 431 upon the issuance of a valid no-fault insurance identification card pursuant to section 431:10C-107.

- (3) Under the joint underwriting plan, all basic no-fault coverages, including the basic no-fault policy, the mandatory \$35,000 public liability and the \$10,000 property damage policies shall be offered by every insurer to each eligible applicant assigned by the bureau. In addition, optional additional coverages shall be offered by every insurer in conformance with section 431:10C-302, for each class except that defined in item (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).

§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 no-fault benefits through the plan whenever:

- (1) No insurance benefits under no-fault 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 no-fault 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 no-fault benefits; or
- (2) Such person was:
 - (A) The owner or registrant of an uninsured or insured motor vehicle at the time of its involvement in the accident out of which such person's accidental harm arose; or
 - (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; or
 - (C) The owner or operator of a motorcycle or motor scooter as defined in section 286-2.

(c) Any person eligible for benefits under this part, or who becomes eligible to file a claim or an action against the mandatory public liability or property damage policies, shall, upon the bureau's determination of such eligibility, be entitled to:

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- (1) The full no-fault benefits as if such victim had been covered as an insured at the time of the accident producing the accidental harm.
- (2) The rights of claim and action against the insurer, assigned under section 431:10C-403, with reference to the mandatory public liability policy for accidental harm, and with reference to the mandatory property damage policy for property damage sustained.

Any claims of an eligible assigned claimant against either mandatory public liability or property damage policies, or the basic no-fault policy, shall be filed with the insurer assigned and shall be subject to all applicable conditions and provisions of subparts A and B, 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 regulation promulgated by the commissioner, each self-insurer shall be assessed its equitable proration of all costs and claims paid under this article 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 such coverage at the premium rates applicable under subpart C.

(e) If a person qualifies for assignment or benefits under this article, the joint underwriting plan or any insurer to whom the claim is assigned by the plan shall be subrogated to the rights of such person and shall have a claim for relief or a cause of action, separate from that of such persons, to the extent that:

- (1) It has paid no-fault benefits; and
- (2) Elements of damage compensated for by the plan, with reference to the mandatory public liability policy for accidental harm and to the mandatory property damage policy for property damage sustained, are paid.

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;

- provided that no premium rate shall exceed the comparable rate not under the plan by a factor of more than two.
- (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.
 - (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.

§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 item (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 item (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), no premium shall be assessed for the basic no-fault, the mandatory public liability, or the mandatory property damage policies; and all policies shall conform to the provisions of section 431:10C-407(b)(2); and
 - (B) For the physically limited driver 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 item (3).

§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.

§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.

PART V. MOTORCYCLES AND MOTOR SCOOTERS

§431:10C-501 Motorcycle or motor scooter excluded from article. (a)

All motorcycles and motor scooters required to be registered under chapter 286 shall be exempt from this article; provided that:

- (1) No person shall drive a motorcycle or motor scooter upon any public street, road or highway of this State at any time unless such vehicle is insured at all times under a liability insurance policy as provided in section 431:10C-503.
 - (2) In the case of accidental harm arising out of a motorcycle or motor scooter accident to any passenger of such motorcycle or motor scooter, or any pedestrian, motorcycles and motor scooters shall not be exempt from section 431:10C-301, section 431:10C-304 and section 431:10C-306;
 - (3) In the case of accidental harm arising out of an accident involving a motorcycle or motor scooter and a motor vehicle, the owner or operator of a motorcycle or motor scooter shall not be exempt from section 431:10C-306.
- (b) Any person who violates this section shall be subject to citation by the police, and for each violation shall be subject to a non-suspendable fine of not less than \$100, or more than \$1,000, or thirty days imprisonment, or a one-year driver's license suspension or any combination thereof.

§431:10C-502 Verification of insurance: motorcycles and motor scooters. (a) Every insurer shall issue to its insureds a proof of insurance card for each motorcycle or motor scooter for which a liability policy under this section is written. 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 which 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;
- (4) Effective dates of coverage including the expiration date.

The proof of insurance card shall be carried on the person operating the insured motorcycle or motor scooter, or in the insured motorcycle or motor scooter at all times and shall be exhibited to a law enforcement officer upon demand.

(b) Any person who violates this section shall be subject to a citation by the police and shall be subject to a non-suspendable fine of not less than \$100 or more than \$1,000, or thirty days imprisonment, or a one year driver's license suspension, or any combination thereof, for each violation.

§431:10C-503 Required motorcycles and motor scooters policy coverage. (a) An insurance policy covering a motorcycle or motor scooter shall provide insurance to pay, on behalf of the owner or any operator of the insured vehicle, sums which 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 the charge of the insured

which arise out of the ownership, operation, maintenance, or use of the vehicle:

- (1) Liability coverage of not less than \$25,000 for all damages arising out of accidental harm sustained by any one person as a result of any one accident applicable to each person sustaining accidental harm; and
 - (2) Liability coverage of not less than \$10,000 for all damages arising out of injury 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.
- (b) At the option of the owner, each insurer shall:
- (1) Offer medical payment coverage up to \$15,000 to pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical and dental services, and necessary ambulance, hospital, professional nursing, and funeral services; and
 - (2) Offer an income disability plan.

ARTICLE 10D. LIFE INSURANCE AND ANNUITIES

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.

§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 percent 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 subsection (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 (§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 percent 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 (§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 percent 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 percent 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 (§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 percent 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 (§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 items (1) through (9) not applicable to single premium policies shall to that extent not be incorporated therein. This section shall not apply to any provision of a life insurance policy relating to disability benefits or to additional benefits in event of death by accident or accidental means, nor to annuities and pure endowment contracts.

§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 percent 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 percent 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 percent 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 item (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.

§431:10D-104 Standard nonforfeiture law; life insurance contracts. (a) This section shall be known as the Standard Nonforfeiture Law for Life Insurance.

(b) **Nonforfeiture provisions - life:**

(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 which 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 insurer will 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 such value as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer 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 which 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 insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such 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 which 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 insurer will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.
- (E) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums,

or which 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, such 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 insurer 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 insurer 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 paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.
- (2) Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.
- (3) The insurer 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) Cash surrender value - life:
 - (1) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by 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 which 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 which would have fallen due on and after the anniversary, and
 - (B) The amount of any indebtedness to the insurer on account of or secured by the policy. Provided that for any policy issued on or after the operative date of subsection (e)(8) as

defined therein, which 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 item (1) shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

Provided further that for any family policy issued on or after the operative date of subsection (e)(8) as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one, the cash surrender value referred to in item (1) shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

- (2) Any cash surrender value available within thirty days after any policy anniversary, of the future guaranteed benefits provided for by the policy including any existing paid-up additions, decreased by any indebtedness to the insurer on account of or secured by the policy.

(d) Paid-up nonforfeiture benefit - life: 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 which 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) The adjusted premium - life:

- (1) This paragraph shall not apply to policies issued on or after the operative date of item (8) as defined therein. Except as provided in subsection (e)(4), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding extra premiums on a substandard policy, that 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 percent 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 percent of the adjusted premium for the first policy year;
- (D) Twenty-five percent 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) This paragraph shall not apply to policies issued on or after the operative date of item (8) as described therein. Provided that in applying the percentages specified in subsections (C) and (D), no adjusted premium shall be deemed to exceed four percent of the amount of insurance or uniform amount equivalent thereto. Whenever the plan or term of a policy has been changed, either by request of the insured or automatically in accordance with the policy, the date of inception of the changed policy for the purposes of determining a nonforfeiture benefit or cash surrender value shall be the date as of which the age of the insured is determined for the purposes of the changed policy.
- (3) This paragraph shall not apply to policies issued on or after the operative date of item (8) as described therein. In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this paragraph shall be deemed to be the uniform 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 date of issue as the benefits under the policy; provided that in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten was the amount provided by the policy at age ten.
- (4) This paragraph shall not apply to policies issued on or after the operative date of item (8) as described therein. The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by the adjusted premiums for the term insurance.

The foregoing (A) and (B) being calculated separately and as specified in subsection (e)(1), (2), and (3), except that for the purposes of subsection (e)(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 (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 (A).

- (5) This paragraph shall not apply to policies issued on or after the operative date of item (8) as described therein. Except as otherwise provided in items (6) and (7) of subsection (e), 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 an age not more than three years younger than the actual age of the insured, and such 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 percent a year, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided that 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 percent of the rates of mortality according to the applicable table. Provided further that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner.

- (6) This paragraph shall not apply to ordinary policies issued on or after the operative date of item (8) as defined therein. In the case of ordinary policies issued on or after the operative date of this paragraph as defined herein, 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 such rate of interest shall not exceed three and one-half percent a year, except that a rate of interest not exceeding four percent a year may be used for policies issued after June 1, 1976 and prior to June 1, 1979, and a rate of interest not exceeding five and one-half percent a year may be used for policies issued on or after June 1, 1979, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent a year may be used, and provided further that 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; provided that 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; provided further that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner. After June 1, 1959, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this item (6) after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of this item (6) for such insurer), this item (6) shall become operative with respect to the

- ordinary policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this item (6) for such insurer shall be January 1, 1966.
- (7) This paragraph shall not apply to industrial policies issued on or after the operative date of item (8) as defined therein. In the case of industrial policies issued on or after the operative date of this paragraph as defined herein, 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 such rate of interest shall not exceed three and one-half percent a year, except that a rate of interest not exceeding four percent a year may be used for policies issued on or after June 1, 1976 and prior to June 1, 1979, and a rate of interest not exceeding five and one-half percent a year may be used for policies issued on or after June 1, 1979, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent a year may be used, provided further that 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; provided further that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner. After May 8, 1965, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of this paragraph for such insurer), this paragraph shall become operative with respect to the industrial policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1968.
- (8) This paragraph shall apply to all policies issued on or after the operative date of this paragraph as defined herein. Except as provided in subsection (F), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such 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 percent 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 percent of the nonforfeiture net level premium as hereinafter defined.

Provided that in applying the percentage specified in (iii), no nonforfeiture net level premium shall be deemed to exceed four percent 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 item (8) shall be the date as of which the rated age of the insured is determined.

- (A) 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 such policy on which a premium falls due.
- (B) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which 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 immediately after the change. 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.
- (C) Except as otherwise provided in subsection (F), the recalculated future adjusted premiums for any such policy shall be such 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 such 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.
- (D) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:
- (i) one percent 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 percent of the increase, if positive, in the nonforfeiture net level premium.
- (E) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing the value defined in (i) by the value defined in (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.
 - (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.
- (F) Notwithstanding any other provisions of this paragraph to the contrary, in the case of a policy issued on a substandard basis which 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 which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.
- (G) 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; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall 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, whether or not required by 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 such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.
- (vi) Any ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated 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.
- (vii) Any industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated 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.
- (H) The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent 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 percent.
- (I) Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which 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.
- (J) After the effective date of this item (8), any company may file with the commissioner a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1989, which shall be the operative date of this paragraph for such company. If a

- company makes no such election, the operative date of this paragraph for such company shall be January 1, 1989.
- (K) In the case of any plan of life insurance which 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 which is of such a nature that minimum values cannot be determined by the methods described in subsections (b), (c), (d), and (e), then:
- (i) The commissioner must 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), (c), (d), and (e);
 - (ii) The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;
 - (iii) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must 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 regulations promulgated by the commissioner.

(f) Calculation of values - life: Any cash surrender value and any paid-up 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), 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 such 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 of this section, 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 which does not differ by more than two-tenths of one percent 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 such anniversary, of the future guaranteed benefits which 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 which would have fallen due on and after such anniversary. Provided that 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, such percentage:

- (1) Must 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 percent 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) Must be such that no percentage after the later of the two policy anniversaries specified in item (1) may apply to fewer than five consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (e)(1), (2), (3), (4), and (5) or subsection (e)(8), whichever is applicable, 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 the other subsections of 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 as items (1) through (6) in subsection (f) shall conform with the principles of this subsection.

- (h) Exceptions. 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, 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 percent of the amount on insurance at the beginning of the policy year; nor
 - (8) Policy which shall be delivered outside this State through an agent 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) Operative date. After January 1, 1956, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date within six months from January 1, 1956. After the filing of such notice, then upon such specified date (which shall be the operative date for such insurer), this section shall become operative with respect to the policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this section for such insurer shall be six months from January 1, 1956.

§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 less 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 percent 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 item (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 which 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 percent 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) Reinstate. 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 percent 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.

§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 percent 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.

§431:10D-107 Standard nonforfeiture law; individual deferred annuities.

(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;
- (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 an agent or other representative of the insurer issuing the contract.

(c) In the case of contracts issued on or after June 1, 1981, 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, the insurer will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (e), (f), (g), (h), and (j).
- (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 (e), (f), (h), and (j). The insurer shall reserve the right to defer the payment of the cash surrender benefit for a period of six months after demand therefor with surrender of the contract.

- (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.
- (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 company 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 prior to the period would be less than \$20 monthly, the company 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 (e), (f), (g), (h), and (j) 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.
 - (1) With respect to contracts providing for flexible considerations, 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 a rate of interest of three percent per annum of percentages of the net considerations paid prior to that time, decreased by the sum of:
 - (A) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent per annum; and
 - (B) The amount of any indebtedness to the company on the contract, including interest due and accrued and increased by any existing additional amounts credited by the insurer to the contract.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of \$30 and less a collection charge of \$1.25 per consideration credited to the contract during that contract year. The percentages of net considerations shall be sixty-five percent of the net consideration for the first contract year and eighty-seven and one-half percent of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent of the portion of the total net consideration for any renewal contract year which exceeds by not more than two

times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent.

- (2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually with two exceptions:

- (A) The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent of the net consideration for the first contract year plus twenty-two and one-half percent of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.
- (B) The annual contract charge shall be the lesser of \$30 or ten percent of the gross annual consideration.

- (3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety percent and the net consideration shall be the gross consideration less a contract charge of \$75.

(e) 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.

(f) 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 percent 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.

(g) 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.

(h) For the purpose of determining the benefits calculated under subsections (f) and (g), 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 is to be the latest date for which election shall be permitted by the contract, but is not to 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.

(i) 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.

(j) 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.

(k) 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 the provisions of subsections (e), (f), (g), (h), and (j), 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) After June 1, 1979, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before June 1, 1981. After the filing of the notice, then upon the specified date, which shall be the operative date of this section for the insurer, this section shall become operative with respect to annuity contracts thereafter issued by the insurer. If an insurer makes no election, the operative date of this section for the insurer shall be June 1, 1981.

§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.

§431:10D-109 Scope of contestable clauses. A clause in any policy of life insurance providing that such policy shall be contestable 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.

§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.

§431:10D-111 Premium deposits. (a) A life insurer may, under such policy provisions or agreements as have been approved by the commissioner consistent with this section, contract for and accept premium deposits in addition to the regular premiums specified in the policy, for the purpose of paying future premiums, or to facilitate conversion of the policy, or to increase the benefits thereof.

(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.

§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.

§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.

§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.

§431:10D-115 Dealing in dividends. No life insurer nor any of its representatives, general agents, subagents, solicitors, 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.

§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.

§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.

§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 subsections (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.

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.

§431:10D-202 Employee groups. 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, 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 shall be paid either:
 - (A) Wholly from the employer's fund or funds contributed by him, or
 - (B) Partly from such funds and partly from funds contributed by the insured employees.

No policy may be issued on which the entire premium is to be derived from funds contributed by the insured employees. A policy on which part of the premium is to be derived from funds provided in accordance with item (2)(B) may be placed in force only if at least seventy-five percent of the then eligible employees, excluding any as to whom evidence of insurability is not satisfactory to the insurer, elect to make the required contributions. Except as provided in item (3), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must 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.
- (4) The policy must cover at least ten employees at date of issue.

- (5) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustees.

§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 percent of the then eligible debtors elect to pay the required charges. Except as provided in item (3), a policy on which no part of the premium is to be derived from the collection of such identifiable charges must 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 percent 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.
- (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.

§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 percent 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 item (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 must 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 must cover at least twenty-five members at date of issue.
- (5) The amount of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union.

§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 in the same industry 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 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;
- (C) Retired employees; and
- (D) The trustees or their employees, or both, if their duties are principally connected with such trusteeship.

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 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 such 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 percent 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 item (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 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 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 percent 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 such 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.

§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 percent are covered and extended to other classes as seventy-five percent 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 percent 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 percent 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 general agents, subagents, solicitors, and salesmen.

§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 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 percent 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 percent 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 item (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, 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 less 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 must cover at least twenty-five persons at date of issue.
- (7) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the association.
- (8) As used herein, public employees means employees of the United States government, or of any state, or of any political subdivision or instrumentality or department or bureau or board or commission of any of them, or the national guard as an association in nature under its existing form.

§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 percent 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 percent 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 item (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.
- (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.
- (8) As used in this section, the term mutual benefit society has the same meaning as that ascribed to it in section 432:1-103. 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 disability benefit funds with respect to the insurance program.

§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 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 percent 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 percent 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 item (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 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.
- (6) The policy must cover at least twenty-five persons at date of issue.
- (7) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the association.
- (8) As used herein professional persons means persons practicing a profession requiring examination and licensing under chapters 448, 453, 464, 466, and 605.

§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 percent 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.

§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 which 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 item (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 percent of the then eligible members, excluding any as to whom evidence of insurability is not satisfactory to the insurer, must elect to make the required contributions.
- (4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the credit union.
- (5) As used herein a credit union means a credit union chartered under the provisions of the Federal Credit Union Act or the Hawaii Credit Union Act, chapter 410.

§431:10D-212 Spouses and dependents of insured individuals. Except for a policy issued under section 431:10D-203 and section 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, provided that in the case of a dependent other than a spouse of the insured individual the amount of insurance for the dependent shall not be in excess of fifty percent of the coverage of the insured individual or \$5,000 whichever is less, and provided further that in the case of a dependent whose age at death is under six months, the amount shall not be in excess of \$2,000.
- (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.
- (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.
- (4) For purposes of this section:
 - (A) A dependent shall be a child of the insured individual:
 - (i) under eighteen years of age; or
 - (ii) under twenty-three years of age who is attending an educational institution and relying upon the insured individual for financial support; or
 - (iii) regardless of age who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the insured individual for support and maintenance.
 - (B) The term individual shall be deemed to include a person or a member of any group provided in section 431:10D-202 and section 431:10D-204 through section 431:10D-210.

§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

which 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 less 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 items (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 application for the individual policy shall be made, and the first premium paid to the insurer, within not less than thirty days, after such termination, and provided further that:
- (A) 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.
- (B) The individual policy shall be in an amount not in excess of the amount of life insurance which 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 less than thirty days after such termination, and provided further that any amount of insurance which 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 which is considered to cease because of such termination; and
- (C) 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 item (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 he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within not less 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 items (8) and (9), and before such an individual policy shall have become effective, the amount of life insurance which 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, whether or not application for the individual policy or the payment of the first premium therefor has been made.

(b) Provisions set forth in items (6) to (10) shall not apply to policies issued to a credit union to insure its members.

(c) Provisions set forth in items (6) and items (8) to (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 which 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.

§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.

§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.

PART III. INDUSTRIAL LIFE INSURANCE

§431:10D-301 Scope. This part shall apply only to industrial life insurance contracts.

§431:10D-302 General life insurance provisions applicable. The following provisions 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.

§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.

§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.

§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 percent 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 agent 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.
- (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.

§431:10D-306 Title on policy. There shall be a title on the face of each policy briefly describing its form.

§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.

§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.

§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.

§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.

§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.

§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.

§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.

ARTICLE 10E. PROPERTY INSURANCE

§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.

§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 issue, place, procure, or accept any insurance contract 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.

§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.

ARTICLE 10F. SURETY INSURANCE

§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.

§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.

§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.

§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.

ARTICLE 11

RESERVED

ARTICLE 12. MASS MERCHANDISING OF INSURANCE

§431:12-101 Definitions. As used in this article:

- (1) 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.
- (2) Employer includes any firm, corporation, partnership, sole proprietorship, trust, estate, and unincorporated association or nonprofit organization; it also includes the State, any county, and any municipal corporation and any governmental unit, agency or department thereof.
- (3) Insurer means an insurer authorized to transact the business of motor vehicle, property and casualty insurance in the State.
- (4) Mass merchandise means to sell and mass merchandising means a sale of insurance wherein:

- (A) The insurance is offered to employees of particular employers, and
- (B) The employer has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees.
- (5) Mass merchandising plan or plan means a program, design or scheme of the insurance to be mass merchandised, including terms, coverages, and premiums.
- (6) 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.
- (7) 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.
- (8) Motor vehicle insurance means a no-fault insurance policy and optional additional insurance as defined in article 10C.

§431:12-102 Applicability. This article shall apply to motor vehicle insurance and to property and casualty insurance as defined in section 431:1-206 and section 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, property and casualty insurance and the rules and regulations 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.

§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.

§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.

§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 such 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.

§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.

§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 agent, subagent or solicitor of insurance 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.

§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.

§431:12-109 Cancellation and nonrenewal. Except as provided¹ 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 will, prior to the expiration of the thirty day period, afford the employer a reasonable opportunity to consult with the insured and to present facts in opposition to cancellation or nonrenewal.

§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.

§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.

§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.

§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.

§431:12-114 Licenses. No person shall act as an insurance agent, subagent or solicitor, in connection with mass merchandising of insurance, unless the person is licensed as such under the provisions of article 9.

§431:12-115 Establishment and maintenance of office. 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.

§431:12-116 Rules. The commissioner shall adopt rules necessary to effectuate the purposes of this article.

ARTICLE 13. UNFAIR METHODS OF COMPETITION AND UNFAIR AND DECEPTIVE ACTS AND PRACTICES IN THE BUSINESS OF INSURANCE

PART I. GENERAL PROVISIONS

§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.

§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.

§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 conspicuously 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 contract of life insurance or of life annuity 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 term 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,
 - (ii) the refusal, cancellation or limitation is required by law or regulatory mandate; or
 - (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; or
 - (F) To terminate, or to modify coverage or to refuse to issue or refuse to 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 subsection shall not apply to disability insurance sold by a casualty insurer; provided further that this subsection 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.
- (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 item (7) or item (8) shall be construed as including within the definition of discrimination or rebates any of the following practices:
- (A) In the case of any contract of life insurance or life annuity, 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 for 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.
 - (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) 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, or
 - (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) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;
 - (G) 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;
 - (H) 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;
 - (I) Attempting to settle claims on the basis of an application which was altered without notice, or knowledge or consent of the insured;
 - (J) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;
 - (K) 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;
 - (L) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician 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;
 - (M) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;
 - (N) 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.
- (11) 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 shall mean any written communication primarily expressing a grievance.
- (12) 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, agent, broker, or individual.

(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.

§431:13-104 Favored agent 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 agent or broker or group of agents or brokers.

(b) No person who lends money or extends credit may:

- (1) Solicit insurance for the protection of real property, after a person indicates interest in securing a first mortgage credit extension, until such person has received a commitment in writing from the lender as to a loan or credit extension;
- (2) Unreasonably reject a contract of insurance furnished by the borrower for the protection of the property securing the credit or lien. 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 credit transaction;
- (3) Require that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge, in connection with the handling of any contract of insurance required as security for a loan on real estate, 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, without the prior written consent of the borrower, mortgagor or purchaser taken at a time other than the making of the loan or extension of credit, information relative to a

contract of insurance which is required by the credit transaction, for the purpose of replacing such insurance;

- (5) Require any procedures or conditions of duly licensed agents, brokers or insurers not customarily required of those agents, brokers 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 on real and personal property 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 agent of the borrower's choice, subject only to the lender's right to reject a given insurer or agent 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.

This 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.

(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.

§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.

§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.

§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.

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 section 431:13-201 or may obtain judicial review of the order in the manner provided for by chapter 91.

§431:13-202 Penalty for violation of cease and desist orders. 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.

§431:13-203 Regulations. The commissioner may promulgate reasonable rules and regulations 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 section 431:13-104, but the regulations shall not enlarge upon or extend the provisions of section 431:13-103 or section 431:13-104.

§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.

ARTICLE 14. RATE REGULATION

PART I. CASUALTY, SURETY, PROPERTY, MARINE AND TRANSPORTATION RATE REGULATION

§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 rate making 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.

§431:14-102 Scope. (a) This article shall apply to:

- (1) 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.
- (2) 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:
- (A) Statute, or by interpretation thereof, or
- (B) Ruling of the commissioner, if not defined or interpreted, or

- (C) 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) Disability insurance;
- (3) With respect to insurance described in subsection (a)(1), 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) With respect to insurance described in subsection (a)(2):
- (A) 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
- (B) Insurance of hulls of aircraft, including their accessories and equipment, or against liability arising out of the ownership, maintenance or use of aircraft.

§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, such 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 such 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 such 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 which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.
- (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 which 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 method or means, other than common majority ownership of such risks, or except where:
(A) A common stock ownership in and management control of such 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 such filings may be amended from time to time;
(C) Health care providers, as defined in section 671-1 which could have joined the patient's 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) 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.

§431:14-104 Rate filings. (a) Every insurer shall file in triplicate with the commissioner, except as to specific inland marine risks which by general custom of the business are not written according to manual rate or rating plans, every manual of classifications, rules and rates, every rating plan, and every other rating rule, and every modification of any of the foregoing which it proposes to use. Every such filing shall state its proposed effective date, and shall indicate the character and extent of the coverage contemplated. Every filing made in relation to workers' compensation insurance shall also include a report on investment income.

(b) When a filing is not accompanied by the information upon which the insurer supports such 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 such event the waiting period shall commence as of the date the information is furnished. The information furnished in support of a filing may include:

- (1) The experience or judgment of the insurer or rating organization making the filing,
- (2) Its interpretation of any statistical data it relies upon,
- (3) The experience of other insurers or rating organizations, or
- (4) Any other relevant factors.

(c) A filing and any supporting information shall be open to public inspection after the filing becomes effective.

(d) Specific inland marine rates on risks specially rated, made by a rating organization, shall be filed with the commissioner.

(e) An insurer may satisfy its obligation to make such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings, and by authorizing the commissioner to accept such filings on its behalf; provided, that nothing contained in this article shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(f) The commissioner shall review filings as soon as reasonably possible after they have been made in order 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.

(g) Subject to the exception specified in subsection (h), 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 or rating organization which made the filing that the commissioner needs the additional time for the consideration of the filing. Upon written application by such insurer or rating 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.

(h) The following rates shall become effective when filed:

- (1) Specific inland marine rates on risks specially rated by a rating organization; and

- (2) Any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order, rule, or regulation of a public body, not covered by a previous filing.

Such rates shall be deemed to meet the requirements of this article until such time as the commissioner reviews the filing and so long as the filing remains in effect.

(i) The commissioner may, by written order, 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 and rating organizations. The commissioner may make such examination 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)(7).

(j) 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, such rate shall be deemed effective retroactive to the date of the insured's application.

(k) 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 (i) or (j). This subsection shall not apply to contracts or policies for inland marine risks as to which filings are not required.

§431:14-105 Reserved.

§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(h) the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall send to the insurer or rating organization which 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 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 subject to section 431:14-104(i) has become effective; or
- (2) After a special surety or guaranty filing subject to section 431:14-104(i) has become effective,

the commissioner finds that such filing does not meet the requirements of this article, the commissioner shall send to the insurer or rating organization which 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 and rating organization who made such filing. The notice shall specify the matters to be considered at the hearing. If after a hearing the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall issue an order specifying in what respects the filing fails to meet such 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 and rating 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.

- (d) (1) Any person or organization aggrieved with respect to any filing which is in effect may make written demand to the commissioner for a hearing thereon; provided, however, that the insurer or rating organization which 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 such demand must show that such 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 such a hearing, the commissioner shall, within thirty days after receipt of the demand, hold a hearing. The hearing shall be held upon not less than ten days' written notice to the aggrieved party and to every insurer and rating organization which made such filing.
 - (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 and rating 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.
- (e) No manual of classifications, rules, rating plan, or any modification of any of the foregoing which establishes standards for measuring variations in hazards or expense provisions, or both, and which 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.
- (f) The notices, hearings, orders, and appeals referred to in this section are in all applicable respects subject to chapter 91, unless expressly provided otherwise.

§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, its articles of agreement or association or its certificate of incorporation, and of its bylaws, 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; and
 - (4) A statement of its qualifications as a rating organization.
- (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 agreement or association, or certificate of 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 change in the documents or information filed pursuant to items (1) through (3) of subsection (a).

(d)(1) Subject to rules and regulations which 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 such rules and regulations 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 or regulation 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 or regulation is unreasonable in its application to subscribers, the commissioner shall order that the rule or regulation shall not be applicable to subscribers.
- (3) If the rating organization fails to grant or reject an insurer's application for subscription within thirty days after it was made, the insurer may request a review by the commissioner, in accordance with item (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 rate making or in other matters within the scope of this article is authorized, provided the filings resulting from such cooperation are subject to all the provisions of this article which are applicable to filings generally. The commissioner may review such cooperative activities and practices and if, after a hearing, the commissioner finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with this article, the commissioner may issue a written order specifying in what

respects such activity or practice is unfair or unreasonable or otherwise inconsistent with this article, and requiring the discontinuance of such 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.

§431:14-108 Deviations. (a) Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by the organization, except that any such 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 rate making 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.

§431:14-109 Appeal by minority. (a) 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.

§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.

§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 rate making, 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 rate making 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.

§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.

§431:14-113 Examination. (a) The commissioner shall at least once in five years, make or cause to be made an examination of each rating organization licensed in this State as provided in section 431:14-107, and the commissioner may, as often as the commissioner may deem it expedient, make or cause to be made an examination of 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) Reports on examination are not to be made public until the organization examined has had an opportunity to review the proposed report and to have a hearing thereon. Once filed with the commissioner, the report shall be available for public inspection and shall be admissible in evidence as a public record.

§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 rate making and the application of rating systems.

(d) The commissioner may make reasonable rules and regulations necessary to effect the purposes of the rating laws.

§431:14-115 False or misleading information. No person or organization shall willfully 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.

§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.

§431:14-117 Penalties. (a) The commissioner may, if the commissioner finds any person or organization has violated any provision of this article, impose a penalty of not more than \$500 for each violation, but if the commissioner finds the violation to be willful 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.

(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.

§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 supreme court. The review shall be taken and had in the manner provided in chapter 91.

§431:14-119 Publication of approved workers' compensation rate filings. The insurer or rating organization submitting the workers' compensation rate filing shall publish a notice of an approved filing in a newspaper of general circulation in this State in a form approved by the commissioner.

§431:14-120 Additional powers for workers' compensation rate filing and rate making. 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.

ARTICLE 15. INSURERS SUPERVISION, REHABILITATION AND LIQUIDATION

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.

§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.

§431:15-103 Definitions. (a) For the purposes of this article:

- (1) Ancillary state means any state other than a domiciliary state.
- (2) Creditor is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.
- (3) 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 section 431:15-202. Formal delinquency proceeding means any liquidation or rehabilitation proceeding.
- (4) Doing business includes any of the following acts, whether effected by mail or otherwise:

- (A) The issuance or delivery of contracts of insurance to persons resident in this State;
 - (B) The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;
 - (C) The collection of premiums, membership fees, assessments, or other consideration for such contracts;
 - (D) The transaction of matters subsequent to execution of such contracts and arising out of them; or
 - (E) Operating under a license or certificate of authority, as an insurer, issued by the insurance division.
- (5) 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.
- (6) Fair consideration is given for property or obligation:
- (A) 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
 - (B) When such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.
- (7) Foreign country means any other jurisdiction not in any state.
- (8) 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.
- (9) Guaranty association means the Property and Casualty Post-Assessment Guaranty Association created by part I of article 16, the Life and Health Guaranty Fund 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 now in existence in or hereafter created by the legislature of any other state.
- (10) Insolvency or insolvent means:
- (A) For an insurer issuing only assessable fire insurance policies:
 - (i) the inability to pay any obligation within thirty days after it becomes payable, or
 - (ii) 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.
 - (B) 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:

- (i) any capital and surplus required by law for its organization, or
 - (ii) the total par or stated value of its authorized and issued capital stock.
- (C) As to any insurer licensed to do business in this State as of the effective date of this code who does not meet the standard established under subsection (B), the term insolvency or insolvent shall mean, for a period not to exceed three years from the effective date of this code, 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.
- (D) For purposes of this section liabilities shall include but not be limited to reserves required by statute or by insurance division general regulations or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.
- (11) 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.
- (12) Preferred claim means any claims with respect to which the terms of this article accord priority of payment from the general assets of the insurer.
- (13) Receiver means receiver, liquidator, rehabilitator, or conservator as the context requires.
- (14) Reciprocal state means any state other than this State in which in substance and effect section 431:15-307(a), section 431:15-403, section 431:15-404, and section 431:15-406 through section 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.
- (15) 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 which have become liens upon specific assets by reason of judicial process.
- (16) Special 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.
- (17) State means any state, district or territory of the United States and the Panama Canal Zone.
- (18) Transfer includes 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.

§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 section 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 subsection (b);
- (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 in order 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 subsection (b), 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 section 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 agent or broker, in any action on or incident to the obligation; or
- (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 an agent or broker 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.

§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

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- (11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policy-holders, 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).

§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.

§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.

§431:15-108 Continuation of delinquency proceedings. This article applies to proceedings commenced after 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.

§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.

§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.

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 reinsurance 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 sequesterator, 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 willfully 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.

§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.

§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 money 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, broker, 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.

§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 or rehabilitation is entered or the petition is denied.

§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.

§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.

§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.

§431:15-308 Continuance of coverage. (a) All policies, other than life or health 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 health 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 health 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).

§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.

§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. 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;
- (5) Hold hearings, 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 which 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, in order to forestall garnishment and attachment proceedings against such debts; and
 - (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;
 - (C) To pursue any creditor's remedies available to enforce his claims.
 - (7)
 - (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 which 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 such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such 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 such sums as 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 as 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 such obligation and may defend only in the absence of a defense by such 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 section 431:15-315 through section 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.

§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 either by telegram or telephone 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 agents 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.

§431:15-312 Duties of agents. (a) Every person who receives notice in the form prescribed in section 431:15-311 that an insurer whom the agent 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 agent's records to each policyholder or other person named in any policy issued through the agent by the insurer, if the agent has a record of the address of the policyholder or other person. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent 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 agent, 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 general agent satisfies the notice requirement for any agents under contract to it. Each agent obligated to give notice under this section shall file a report of compliance with the liquidator.

(b) Any agent 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 agent's license may be suspended, said 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.

§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.

§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).

§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.

§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.

§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 the provision of 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.

§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).

§431:15-319 Set offs 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 set off 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 set off;
- (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.

§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.

§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.

§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.

§431:15-323 Recovery of premiums owed.

(a) (1) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to

recover from such person any part of an unearned premium that represents commission of such person. Credits or set offs or both shall not be allowed to an agent, broker or premium finance company for any amounts advanced to the insurer by the agent, broker or premium finance company on behalf of, but in the absence of a payment by, the insured.

- (2) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency as shown on the records of the insurer.

(b) Upon satisfactory evidence of a violation of this section, the commissioner may pursue either one or both of the following courses of action:

- (1) Suspend or revoke or refuse to renew the licenses of such offending party or parties; or
(2) Impose a penalty of not more than \$1,000 for each and every act in violation of this section by said party or parties.

(c) Before the commissioner shall take any action as set forth in subsection (b), the commissioner shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation, and fixing a time and place, at least ten days thereafter, when a hearing on the matter shall be held. After such hearing, or upon failure of the accused to appear at such hearing, the commissioner, if the commissioner shall find such violation, shall impose such of the penalties under subsection (b) as the commissioner deems advisable.

(d) When the commissioner shall take action in any or all of the ways set out in subsection (b), the party aggrieved may appeal from said action to the circuit court of the first judicial circuit.

§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 such 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) Such 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 and 2;
(2) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;
(3) Equitable allocation of disbursements to each of the guaranty funds or associations, or foreign guaranty associations entitled thereto;
(4) The securing by the liquidator from each of the funds or associations 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 such priorities. No bond shall be required of any such funds or associations; and

- (5) A full report to be made by each fund or association to the liquidator accounting for all assets so disbursed to the fund or association, all disbursements made therefrom, any interest earned by the fund or association on such assets and any other matter as the court may direct.

(c) The liquidator's proposal shall provide for disbursements to the funds or associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such funds or associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal the amount of such 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 shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty fund or association, or any foreign guaranty fund or association covering life or health 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 such application shall be given to the 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 mails, first class postage prepaid, at least thirty days prior to submission of such 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).

§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.

§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 set off, 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.

§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 which 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(g).

(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.

§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.

§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.

§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.

§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.

§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 such 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:

(a) Class 1. The costs and expenses of administration, including but not limited to the following:

- (1) The actual and necessary costs of preserving or recovering the assets of the insurer;
- (2) Compensation for all services rendered in the liquidation;
- (3) Any necessary filing fees;
- (4) The fees and mileage payable to witnesses;
- (5) Reasonable attorney's fees; and
- (6) The reasonable expenses of a guaranty fund or association, or foreign guaranty association in handling claims.

(b) Class 2. 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. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(c) Class 3. 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, 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.

(d) Class 4. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(e) Class 5. Claims of the federal or 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 such claims shall be postponed to the class of claims under subsection (h).

(f) Class 6. Claims filed late or any other claims other than claims under subsections (g) and (h).

(g) Class 7. 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 law.

(h) Class 8. The claims of shareholders or other owners.

§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.

§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 under subsection (b) to satisfy their claims under article 16 or similar laws of other states, if the claims have been filed pursuant to rules established under section 431:15-325(a) and (d). 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 which 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 general 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.

§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 state treasurer, 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 state treasurer 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 state treasurer and paid by the liquidator in accordance with section 431:15-332. Any sums remaining which under section 431:15-332 would revert to the undistributed assets of the insurer shall be transferred to the state treasurer 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.

§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.

§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.

§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.

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.

§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.

§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, agents' 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 agents 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.

§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.

§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.

§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.

§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.

§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.

§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.

§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(h).

§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.

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.

§431:16-102 Purpose. The purpose of this part is to provide a mechanism for the payment of covered claims under insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers.

§431:16-103 Scope. This part shall apply to all types of direct insurance, but shall not be applicable to the following:

- (1) Life, annuity, health, or disability 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 life or credit disability insurance;
- (5) Insurance of warranties or service contracts;
- (6) Title insurance;
- (7) Ocean marine insurance; and
- (8) Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk.

§431:16-104 Construction. This code shall be liberally construed to effect the purpose under section 431:16-102 which will constitute an aid and guide to interpretation.

§431:16-105 Definitions. As used in this code:

- (1) 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 next preceding the date the insurer becomes an insolvent insurer.
- (2) Association means the Hawaii Insurance Guaranty Association created under section 431:16-106.
- (3) 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.
- (4) 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 percent 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.
- (5) Covered claim means an unpaid claim, including one for unearned premiums, submitted by a claimant, which 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 such insurer becomes an insolvent insurer after the effective date of this part 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 or insured is the state in which its principal place of business is located at the time of the insured event; or
 - (B) The property from which the claim arises is permanently located in this State.Covered claim shall not include any amount awarded as punitive or exemplary damages; sought as a return of premium under any retrospective rating plan; or due any reinsurer, insurer,

- insurance pool, or underwriting association, as subrogation recoveries or otherwise.
- (6) 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 determined to be insolvent by a court of competent jurisdiction.
- (7) Member insurer means any person who:
 - (A) 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
 - (B) Is licensed to transact insurance in this State.
- (8) Net direct written premiums means direct gross premiums written in this State on insurance policies to which this part applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. Net direct written premiums does not include premiums on contracts between insurers or reinsurers.
- (9) Person means any individual, corporation, partnership, association, or voluntary organization.

§431:16-106 Creation of association. There is created a non-profit unincorporated legal entity to be known as the Hawaii Insurance Guaranty Association. All insurers defined as member insurers in section 431:16-105(7) 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.

(b) All meetings and records of the board of directors shall be open to all member insurers except for those meetings and records pertaining to the solvency, liquidation, rehabilitation, or conservation of any member insurer deemed confidential. A member insurer shall provide written designation of its representative or representatives to the board meetings.

§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. If no members are selected within sixty days after the effective date of this part, the commissioner may appoint the initial members of the board of directors.

(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.

§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 determination of the insolvency arising within thirty days after the determination of insolvency, or before the policy expiration date if less than thirty days after the determination of

insolvency, or before the insured replaces the policy or causes its cancellation, if he does so within thirty days of the determination, but such obligation shall include only that amount of each covered claim which is in excess of \$100 and is less than \$300,000, except that the association shall pay the full amount of any covered claim arising out of a workers' compensation policy. In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.
- (3) Assess insurers amounts necessary to pay the obligations of the association under subsection (a)(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under section 431:16-113, 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 and 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 percent 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 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. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such 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 such settlements, releases and judgments may be properly contested.
- (5) Notify such persons as the commissioner directs under section 431:16-110(b)(1).
- (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 such 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 shall pay the other expenses of the association authorized by this part.
- (b) The association may:
- (1) Employ or retain such 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 such contracts as are necessary to carry out the purpose of this part.
 - (5) Perform such other acts as are necessary or proper to effectuate the purpose of this part.

§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 shall, after notice and hearing, promulgate, 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 will be performed.
 - (2) Establish procedures for handling assets of the association.
 - (3) Establish the amount and method of reimbursing members of the board of directors under section 431:16-107(c).
 - (4) 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 such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.
 - (5) Establish regular places and times for meetings of the board of directors.
 - (6) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.
 - (7) 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.
 - (8) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner.
 - (9) 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. Such a 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.

§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.
 - (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 percent 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 code shall be subject to judicial review by the circuit court of the first judicial circuit.

§431:16-111 Effect of paid claims. (a) Any person recovering under this code 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 such 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 such causes of action as the insolvent insurer would have had if such 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 receiver, liquidator or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that 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.

§431:16-112 Nonduplication of recovery. (a) Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first the person's rights under such policy. Any amount payable on a covered claim under this part shall be reduced by the amount of any recovery under such insurance policy. If there are any other policies issued by an insolvent insurer applicable to the covered claim, then all such policies must first be exhausted before any claim can be deemed a covered claim subject to being covered by the association.

(b) Any person having a claim or legal right of recovery under any governmental insurance or guaranty program which is also a covered claim, shall be required to exhaust first the person's right under such program. Any amount payable on a covered claim under this part shall be reduced by the amount of any recovery under such insurance or program.

(c) Any person having a claim which 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, and if it is 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.

§431:16-113 Prevention of insolvencies. To aid in the detection and prevention of insurer insolvencies: (a) The board of directors may, upon majority vote:

- (1) Make recommendations to the commissioner for the detection and prevention of insurer insolvencies; and
- (2) Respond to requests by the commissioner to discuss and make recommendations regarding the status of any member insurer whose financial condition may be determined by the commissioner to be hazardous to policyholders or the public. Such recommendations shall not be considered public documents.

- (3) 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 in a financial condition hazardous to the policyholders or the public. 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 such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from reporting to the board of directors when the commissioner has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public. 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.

- (b) The board of directors may, at the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association and submit such report to the commissioner.

§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.

§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, disability, credit mortgage guaranty, and ocean marine. Prior to recoupment, each member insurer shall submit its plan for recoupment to the commissioner. 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 Guarantee Association an accounting of its recoupments. The Hawaii Insurance Guarantee 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 agents' commissions.

§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, or the commissioner or the commissioner's representatives for any action taken by them in the performance of their powers and duties under this part.

§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, shall be stayed for up to six months, and such 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 such insured, may apply to have such judgment, order, decision, verdict, or finding set aside by the same court, administrator or other entity that made such judgment, order, decision, verdict, or finding and shall be permitted to defend such 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 or its authorized representative to such of the insolvent insurer's claim records, and may permit access to such other records which 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 or its representative with copies of such records upon the request by the board and at the expense of the board.

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.

§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 disability 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.

§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 item (2), and
- (2) Persons who are owners of or certificate holders under such policies or contracts and who:
 - (A) Are residents, or
 - (B) Are not residents, but only under all of the following conditions:

- (i) the insurers which issued such policies or contracts are domiciled in this State,
 - (ii) such insurers never held a license or certificate of authority in the states in which such persons reside,
 - (iii) such states have associations similar to the association created by this part, and
 - (iv) such persons are not eligible for coverage by such associations.
- (b) (1) This part shall provide coverage to the persons specified in subsection (a) for direct, nongroup life, disability, annuity and supplemental policies or contracts, for certificates under direct group policies and contracts, except as limited by this part.
- (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 holder;
 - (B) Any policy or contract of reinsurance, unless assumption certificates have been issued;
 - (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 plan or program of an employer, association or similar entity to provide life, disability, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or similar entity 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 or experience rating credits, 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; and

- (G) Any annuity contract or group annuity certificate which is not issued to or owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.
- (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) \$100,000 in disability insurance benefits, including any net cash surrender and net cash withdrawal values;
 - (C) \$100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; Provided, however, that in no event shall the association be liable to expend more than \$300,000 in the aggregate with respect to any one life under subparagraphs (A), (B) and (C).

§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.

§431:16-205 Definitions. As used in this part:

- (a) Account means any of the three accounts created under section 431:16-206(a).
- (b) Association means the Hawaii Life and Disability Insurance Guaranty Association created under section 431:16-206.
- (c) 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.
- (d) Covered policy means any policy or contract within the scope of this part under section 431:16-203.
- (e) Impaired insurer means a member insurer which, after the effective date of this code, is not an insolvent insurer, and
 - (1) Is deemed by the commissioner to be potentially unable to fulfill its contractual obligations, or
 - (2) Is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
- (f) Insolvent insurer means a member insurer which after the effective date of this code, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.
- (g) 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; or
- (7) Any entity similar to any of the above.
- (h) Moody's Corporate Bond Yield Average means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.
- (i) Person means any individual, corporation, partnership, association, or voluntary organization.
- (j) Premiums means amounts 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 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.
- (k) Resident means any person who resides in this State at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. 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.
- (l) Supplemental contract means any agreement entered into for the distribution of policy or contract proceeds.
- (m) Unallocated annuity contract means any annuity contract or group annuity certificate which 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.

§431:16-206 Creation of the association. (a) There is created a non-profit 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 disability 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.

§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.

§431:16-208 Powers and duties of the association. (a) If a member insurer is an impaired domestic 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 monies, 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) (1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in subsection (b)(2), the association shall, in its discretion, either:
- (A) Take any of the actions specified in subsection (a), subject to the conditions therein, or
 - (B) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for: disability claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.
- (2) The association shall be subject to the requirements of subsection (b)(1) only if:
 - (A) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations;
 - (i) the delinquency proceeding shall not be dismissed.
 - (ii) neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management, and

- (iii) it shall not be permitted to solicit or accept new business or have any suspended or revoked license restored, and
 - (B) (i) if the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this State, or;
 - (ii) if the impaired insurer is a foreign or alien insurer:
 - (I) it has been prohibited from soliciting or accepting new business in this State,
 - (II) its certificate of authority has been suspended or revoked in this State, and
 - (III) a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.
- (c) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:
- (1) (A) Guaranty, 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 monies, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or
 - (2) With respect only to life and disability insurance policies, provide benefits and coverages in accordance with subsection (d).
- (d) When proceeding under subsections (b)(1)(B) or (c)(2), the association shall, with respect to only life and disability insurance policies:
- (1) 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:
 - (A) With respect to group policies, not later than the earlier of the next renewal date under such 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 such policies;
 - (B) With respect to individual policies, not later than the earlier of the next renewal date (if any) under such policies or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to such policies.
 - (2) Make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty days' notice of the termination of the benefits provided; and
 - (3) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (d)(4), if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy 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 had a right only to make changes in premium by class.

- (4) (A) In providing the substitute coverage required under subsection (d)(3), the association may offer either to reissue the terminated coverage or to issue an alternative policy.
 - (B) 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.
 - (C) The association may reinsure any alternative or reissued policy.
- (5) (A) Alternative policies adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.
 - (B) 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.
 - (C) 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.
- (6) 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 commissioner or by a court of competent jurisdiction.
- (7) 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.
 - (e) When proceeding under subsections (b)(1)(B) or (c) 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).
 - (f) 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 such policy or coverage under this part with respect to such 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.
 - (g) 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.

(h) 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.

(i) In carrying out its duties under subsections (b) and (c), the association may, subject to approval by the court:

- (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;
- (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.

(j) If the association fails to act within a reasonable period of time as provided in subsections (b)(1)(B), (c) and (d), the commissioner shall have the powers and duties of the association under this part with respect to impaired or insolvent insurers.

(k) 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.

(l) The association shall have standing to appear before any court in this State with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part. 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 a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

- (m) (1) Any person receiving benefits under this part shall be deemed to have assigned the rights under, and any causes of action 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 items (1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such policy or contracts.
- (n) 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; and
 - (6) Exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or disability 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.
- (o) 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.

§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 percent per annum on and after the due date.

(b) There shall be two assessments, as follows:

- (1) Class A assessments shall be made 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 made whether or not related to a particular impaired or insolvent insurer.
- (2) Class B assessments shall be made 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 made 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 \$150 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 or 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 such premiums received on business in this State for such 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 made 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.

(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 such 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.

(e) The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed two percent of such 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. 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.

(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 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.

§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 the effective date of this part 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.
- (d) The plan of operation may provide that any or all powers and duties of the association, except those under section 431:16-208(n)(3) and section 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. Such a 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.

§431:16-211 Duties and powers of the commissioner. In addition to the duties and powers enumerated elsewhere in this part:

(a) 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 percent 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 company 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 company. Any final action or order of the commissioner shall be subject to judicial review in the circuit 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.

§431:16-212 Prevention of insolvencies. To aid in the detection and prevention of insurer insolvencies or impairments:

(a) 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 such company restricts 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.

Such notice shall be mailed to all commissioners within thirty days following the action taken or the date on which such action occurs.

- (2) To report to the board of directors when the commissioner has taken any of the actions set forth in item (1) or has received a report from any other commissioner indicating that any such action has been taken in another state. Such 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 such company may be an impaired or insolvent insurer.
- (4) To furnish to the board of directors the NAIC 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. Such 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 his 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. Such 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 such 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 such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such 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.

§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 percent 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.

§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) All meetings and records of the board of directors shall be open to all member insurers except for those meetings and records pertaining to the solvency, liquidation, rehabilitation, or conservation of any member insurer deemed confidential. A member insurer shall provide written designation of its representative or representatives to the board meetings.

(c) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 431:16-208. Nothing in subsection (b) shall limit the duty of the association to render a report of its activities under section 431:16-215.

(d) 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(m). 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.

- (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 subsections (e)(2) to (e)(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 section 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 subsection (e)(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.

§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.

§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.

§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 sixty 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.

§431:16-218 Prohibited advertisement of association act in insurance sales; notice to policyholders. (a) No person, including an insurer, agent 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. Provided, however, that this section shall not apply to the Hawaii Life and Disability Insurance Guaranty Association or any other entity who does not sell or solicit insurance.

(b) Within one hundred eighty days of the effective date of this part, the association shall prepare a summary document describing the general purposes and current limitations of this part and complying with subsection (c). This document should 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 prior to or 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, exclusions and conditioned on continued residence in this State;
- (3) State that the insurer and its agents 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 agent 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 agent, 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.

§431:16-219 Prospective application. This part shall not apply to any insurer which is insolvent or unable to fulfill its contractual obligations on the effective date of this code.

ARTICLE 17. INSURANCE INFORMATION PROTECTION ACT

§431:17-101 Disclosure of information; when allowed. No corporation, co-partnership, association, individual, or group of individuals, which has made a loan in connection with which insurance is required to be carried by the borrower, shall disclose any information contained in or relating to the required insurance policy to third parties, unless the disclosure is:

- (1) Consented to by the borrower, in writing, in a separate document after the loan has been granted;
- (2) Expressly authorized by state or federal law;
- (3) An ordinary and necessary part of the process of effectuating and servicing the loan agreement;
- (4) Pursuant to court order;
- (5) Made to the borrower's insurance company, agent, or solicitor;
- (6) Made necessary by the borrower's failure to maintain or renew insurance pursuant to the terms of a loan or similar agreement; or
- (7) Made to a person for the purpose of monitoring the borrower's maintenance of the insurance required pursuant to the terms of a loan or similar agreement.

§431:17-102 Receipt of information; use; when allowed. No person shall receive or use for any purpose information contained in or relating to a required insurance policy from any corporation, co-partnership, association, individual, or group of individuals, which has made a loan in connection with which insurance is required to be carried by the borrower, unless such receipt and use is:

- (1) Consented to by the borrower, in writing, in a separate document after the loan has been granted;
- (2) Expressly authorized by state or federal law;
- (3) An ordinary and necessary part of the process of effectuating and servicing the loan agreement;
- (4) Pursuant to court order;
- (5) By the borrower, the borrower's insurance company, agent or solicitor, in connection with the policy; or
- (6) By a person for the purpose of monitoring the borrower's maintenance of the insurance required pursuant to the terms of a loan or similar agreement.

§431:17-103 Freedom of choice of insurance companies. No corporation, co-partnership, association, individual, or group of individuals, which has made a loan in connection with which insurance is required to be carried by the borrower, shall recommend the placing of insurance with a specified insurer or through a specified insurance agent or broker once an insurance policy has been supplied by the borrower and accepted by the corporation, co-partnership, association, individual, or group of individuals which has made the loan.

§431:17-104 Written disclosure; request for; result. Contact of the borrower by the corporation, co-partnership, association, individual, or

group of individuals, which has made the loan, to obtain the borrower's written consent to disclosure does not constitute a violation of this article.

§431:17-105 Violation; penalties. Violation of any provision of this article shall constitute a bar to the recovery of any part of the interest in any proceeding at law. Violation of any provision of this article shall also be a misdemeanor. The commissioner, after a hearing under chapter 91, may revoke or suspend the license of any person licensed pursuant to article 9 who is guilty of a violation of any provision of this article.

§431:17-106 Violation; injunction. The attorney general, the corporation counsel or county attorney of any county may bring suit in any court of competent jurisdiction to enjoin any violation or threatened violation of this article on the attorney general's, corporation counsel's or county attorney's own complaint or on the complaint of any person. The borrower or the borrower's insurance broker, agent or solicitor may bring a private action to have the acts enjoined. The borrower's insurance agent or solicitor may sue to recover any commission lost as a result of another person's unlawful use of policy information. The court may award reasonable attorney's fees in any action brought by a private party.

ARTICLE 18

RESERVED

ARTICLE 19. CAPTIVE INSURANCE COMPANIES

§431:19-101 Definitions. As used in this article:

- (1) **Affiliated company** means any company in the same corporate system as a parent or a member organization by virtue of common ownership, control, operation, or management.
- (2) **Association** means any legal association of individuals, corporations, partnerships, or associations, except labor organizations, that has been in continuous existence for at least one year, the member organizations of which collectively:
 - (A) 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; or
 - (B) Have complete voting control over an association captive insurance company incorporated as a mutual insurer.
- (3) **Association captive insurance company** means any company that insures risks of the member organizations of the association, and their affiliated companies.
- (4) **Captive insurance company** means any pure captive insurance company or association captive insurance company formed or licensed under this article.
- (5) **Member organization** means any individual, corporation, partnership, or association that belongs to an association.
- (6) **Parent** means a corporation, partnership or individual that directly or indirectly owns, controls or holds with power to vote more than fifty percent of the outstanding voting securities of a pure captive insurance company.
- (7) **Pure captive insurance company** means any company that insures risks of its parent and affiliated companies.

§431:19-102 Licensing; authority. (a) Any captive insurance company, when permitted by its articles of association or charter, may apply to the commissioner for a license to do any and all insurance set forth in subsection (g); provided that:

- (1) No pure captive insurance company may insure any risks other than those of its parent and affiliated companies;
- (2) No association captive insurance company may insure any risks other than those of the member organizations of its association, and their affiliated companies;
- (3) No captive insurance company may provide personal motor vehicle or homeowner's insurance coverage or any component thereof; and
- (4) No captive insurance company may accept or cede reinsurance 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 license authorizing it to do insurance business in this State;
- (2) Its board of directors holds at least one meeting each year in this State;
- (3) It maintains its principal place of business in this State; and
- (4) It appoints a resident registered broker or agent to accept service of process and to otherwise act on its behalf in this State. Whenever the registered broker or agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the director of commerce and consumer affairs shall be an agent of such captive insurance company upon whom any process, notice or demand may be served.

(c) Before receiving a license, a captive insurance company shall file with the commissioner a certified copy of its charter and bylaws, a statement under oath of its president and secretary showing its financial condition, and 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;
- (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 captive insurance company shall pay to the commissioner a nonrefundable fee of \$1,000 for examining, investigating, and processing its application for license. In addition, it shall pay a license fee for the year of registration and a renewal fee for each year thereafter of \$300.

(f) If the commissioner is satisfied that the documents and statements filed by the captive insurance company complies with this article, the commissioner may grant a license authorizing it to do insurance business in this State until April 1 thereafter, which license may be renewed.

(g) 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; and
- (7) Title insurance.

§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.

§431:19-104 Minimum capital; letter of credit, security. (a) No pure captive insurance company or association captive insurance company incorporated as a stock insurer shall be issued a license unless it shall possess and thereafter maintain unimpaired paid-in capital of an amount established and deemed appropriate by the commissioner. The amount for pure captive insurance companies may differ from the amount for association captive insurance companies.

(b) The capital may be in the form of cash, in the form of an irrevocable letter of credit issued by a bank chartered by this State or a member bank of the Federal Reserve System, or other security approved by the commissioner.

§431:19-105 Minimum surplus; letter of credit, security. (a) No captive insurance company shall be issued a license unless it shall possess and thereafter maintain a free surplus of an amount established and deemed appropriate by the commissioner. The amount for pure captive insurance companies may differ from the amount for association captive insurance

companies. The amount for association captive insurance companies incorporated as stock insurers may differ from the amount for association captive insurers incorporated as mutual insurers.

(b) The surplus may be in the form of cash, in the form of an irrevocable letter of credit issued by a bank chartered by this State or member bank of the Federal Reserve System, or other security approved by the commissioner.

§431:19-106 Formation of captive insurance companies in this State.

(a) A pure captive insurance company shall be incorporated as a stock insurer with its capital divided into shares and held by the stockholders.

(b) An association captive insurance company may be incorporated:

- (1) As a stock insurer with its capital divided into shares and held by the stockholders; or
- (2) As a mutual insurer without capital stock, the governing body of which is elected by the member organization of its association.

(c) A captive insurance company shall have not less than three incorporators of whom not less than two shall be residents of this State.

(d) Before the articles of incorporation are transmitted to the department of commerce and consumer affairs, the incorporators shall petition the commissioner to issue a certificate setting forth the commissioner's finding that the establishment and maintenance of the proposed corporation 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 purposes of the incorporators;
- (2) The character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors; and
- (3) Such other aspects as the commissioner deems advisable.

(e) The articles of incorporation, certificate, and the organization fee shall be transmitted to the department of commerce and consumer affairs, which shall record both the articles of incorporation and the certificate.

(f) The capital stock of a captive insurance company incorporated as a stock insurer shall be issued at not less than par value.

(g) At least one of the members of the board of directors of a captive insurance company incorporated in this State shall be a resident of this State.

(h) Captive insurance companies formed under this article shall have the privileges and be subject to the general corporation law as well as this article. In the event of conflict between the general corporation law and this article, the latter shall control.

§431:19-107 Financial statements and other reports. (a) Each captive insurance company shall submit to the commissioner a statement of financial condition audited by an independent certified public accountant on or before the last day of the sixth month following the end of the company's fiscal year. The financial statement shall be on a form prescribed by the commissioner and shall include, but not be limited to, actuarially appropriate reserves for:

- (1) Known claims and expenses associated therewith;
- (2) Claims incurred but not reported and expenses associated therewith;
- (3) Unearned premiums; and
- (4) Bad debts, reserves for which shall be shown as liabilities.

An actuarial opinion regarding reserves for known claims and expenses associated therewith and claims incurred but not reported and expenses associated therewith shall be included in the audited financial statement. 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.

(b) 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.

§431:19-108 Examinations and investigations. At least once a year, and whenever the commissioner determines it to be prudent, the commissioner, or a designated agent, shall visit each captive insurance company and thoroughly inspect and examine its affairs to ascertain its financial condition, its ability to fulfill its obligations, and whether it has complied with this article. The commissioner, upon application, may enlarge the one-year period to three years; provided the captive insurance company is subject to a comprehensive annual audit during that period of a scope satisfactory to the commissioner by independent auditors approved by the commissioner. The expenses and charges of the examination shall be paid to the State by the company or companies examined and the director of finance shall issue warrants for the proper charges incurred in all examinations.

§431:19-109 Grounds and procedures for suspension and revocation of license. (a) The license of a captive insurance company to do business in this State may be suspended or revoked by the commissioner for any of the following reasons:

- (1) Insolvency or impairment of capital or surplus;
- (2) Failure to meet the requirements of section 431:19-104 or section 431:19-105;
- (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 charter or bylaws;
- (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 as required by 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 license; and
- (9) Failure otherwise to comply with the laws of this State.

(b) If the commissioner, upon examination, hearing, or other evidence, finds that any captive insurance company has committed any of the acts specified in subsection (a), the commissioner may suspend or revoke the license if the commissioner deems it in the best interest of the public and the policyholders of such captive insurance company, notwithstanding any other law.

§431:19-110 Legal investments. Each pure captive insurance company shall be subject to the restrictions on allowable investments provided under article 6.

§431:19-111 Reinsurance. (a) Any captive insurance company may provide reinsurance on risks ceded by any other insurer.

(b) Any captive insurance company may take credit for reserves on risks ceded to a reinsurer; provided that no captive insurance company shall reinsure a risk or part thereof with an insurer unless the insurer has been approved by the commissioner and, prior to approval, has:

- (1) Filed with the commissioner a power of attorney executed by reinsurer proposing to accept reinsurance, in a form approved by the commissioner, authorizing the director of commerce and consumer affairs to accept service of process on behalf of a reinsurer. The power of attorney shall be and remain effective as to all cases of reinsurance by a reinsurer;
- (2) Paid to the commissioner an initial fee of \$100 and thereafter an annual fee of \$100 payable before April 1 of each year;
- (3) Filed a certified copy of its charter and bylaws with the commissioner; and
- (4) Filed a statement under oath of its president and secretary showing its financial condition and any other statements and materials required by the commissioner.

§431:19-112 Rating organizations; memberships. No captive insurance company shall be required to join a rating organization.

§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, nor shall any captive insurance company, its insured, or its parent or any affiliated company, or any member organization of its association, receive any benefit from any such plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of such captive insurance company.

§431:19-114 Rules. The commissioner may adopt rules pursuant to chapter 91 to implement this article.

§431:19-115 Laws applicable. No insurance laws of this State other than those contained in this article, or contained in specific references contained in this article, shall apply to captive insurance companies.

ARTICLE 20 TITLE INSURANCE AND TITLE INSURERS

§431:20-101 Scope. This article relates only to title insurers and title insurance policies.

§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.

§431:20-103 General insurance law applicable. The following provisions of this code shall apply to title insurance and to title insurers:

- (1) Section 431:1-103 and section 431:1-105;
- (2) Section 431:1-212, section 431:1-213, and section 431:1-214;
- (3) Section 431:2-101 to section 431:2-106, and section 431:2-108 to section 431:2-110;
- (4) Section 431:2-201 to section 431:2-204, and section 431:2-207 to section 431:2-212;
- (5) Section 431:2-302, section 431:2-303, section 431:2-305 and section 431:2-306;
- (6) Section 431:3-101 to section 431:3-105;
- (7) Section 431:3-201 to section 431:3-203, section 431:3-205, section 431:3-206, and section 431:3-209 to section 431:3-220;
- (8) Section 431:3-301, section 431:3-305, section 431:3-307, and section 431:3-308;
- (9) Section 431:4-102 to section 431:4-127;
- (10) Section 431:4-202 to section 431:4-207;
- (11) Section 431:5-101;

- (12) Section 431:5-201 to section 431:5-203;
- (13) Section 431:5-305, section 431:5-306, and section 431:5-308 to section 431:5-311;
- (14) Article 6, Part I, Part IV and Part V;
- (15) Section 431:6-201;
- (16) Section 431:6-301 to section 431:6-320;
- (17) Article 7, Part I and Part III;
- (18) Section 431:7-201 to section 431:7-205;
- (19) Section 431:9-202 to section 431:9-205;
- (20) Article 9, Part II;
- (21) Section 431:10-211, section 431:10-216 to section 431:10-218, section 431:10-220, section 431:10-221, section 431:10-224, section 431:10-225, and section 431:10-235 to section 431:10-238;
- (22) Section 431:13-101 to section 431:13-106;
- (23) Section 431:13-201 and section 431:13-202; and
- (24) Article 15.

§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.

§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, and 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.

§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.

§431:20-107 Capital requirements. A title insurer shall not transact any insurance in this State unless it has a paid-in capital represented by shares of stock of at least \$250,000.

§431:20-108 Guarantee fund; limit of risk. (a) Every title insurer, before issuing any policy, shall deposit \$100,000 with the insurance commissioner or other designated official of its domicile or with the insurance commissioner of this State as a "Guarantee Fund" for the security and protection of the holders of, or beneficiaries under, its title policies.

(b) Any such deposit may be made either in lawful money of the United States or in any of the securities authorized for investment by domestic incorporated insurers.

(c) If the deposit is made in this State, it shall first be approved by the insurance commissioner, who shall forthwith make a special deposit thereof with the director of finance of this State for the purpose specified in subsection (a).

(d) Except as provided in subsection (f), assets in such deposits in this State may, with the approval of the commissioner, be withdrawn or exchanged from time to time for other assets of like character and value.

(e) As long as the depositing insurer continues solvent, it shall receive the interest and dividends on any assets in the deposit.

(f) Except on withdrawal of the insurer from this State, or substitution pursuant to subsection (d), assets in the deposit in this State shall be subject to final sale, transfer and disposal of the proceeds thereof by the commissioner only on the order of a court of competent jurisdiction and for the security and protection of the holders of, or beneficiaries under, the depositing insurer's title insurance policies.

§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 the effective date of this code, such title insurer shall have three years after the effective date of this code to comply with any such increase requirement.

§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 percent 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.

§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.

§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 percent 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.

§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.

§431:20-114 Surplus funds. Every title insurer shall annually set apart a sum equal to ten percent of its premiums collected during the year. Such sums shall be allowed to accumulate until a fund is created equal in amount to twenty-five percent of the aggregate of the subscribed capital stock of the insurer. Such funds shall be known as the "title insurance surplus fund". Where, pursuant to the laws of its domicile, a title insurer is required to and does establish and maintain a special fund or reserve equal to or in excess of the title insurance surplus fund herein provided for, its compliance with such laws shall constitute compliance with this section.

§431:20-115 Purpose of fund. The title insurance surplus fund shall be maintained as a further security to holders and beneficiaries of the title policies issued by the insurer. If at any time the fund is impaired by reason of a loss, the amount by which it is impaired shall be restored in the manner provided for its accumulation. The reporting of a loss is an impairment of the fund for the purposes of this section.

§431:20-116 Reserved.

§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.

§431:20-118 Prohibition on rebates and inducements. (a) No title insurer, controlled escrow company, nor 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.
- (3) Quote any fee or make any charge for a title policy to any person which 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.

§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.

§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.

§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.

- (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.

§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.

§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 (14).

§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.

§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 willful 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.

CHAPTER 432. BENEFIT SOCIETIES **ARTICLE 1. MUTUAL BENEFIT SOCIETIES**

PART I. GENERAL PROVISIONS

§432:1-101 Scope; exemptions. The provisions of this article shall apply to mutual benefit societies as defined herein. Except as expressly provided in this article, mutual benefit societies shall be exempt from the provisions of the insurance code. No law enacted after the effective date of this article shall apply to mutual benefit societies unless such societies are expressly designated therein.

§432:1-102 Applicability of other laws to nonprofit medical indemnity or hospital service associations: health care coverage for senior citizens. Part III of article 10A of the insurance code shall apply to nonprofit medical indemnity or hospital service associations. Such associations shall be exempt from the provisions of part I of article 10A; provided that such exemption is in compliance with applicable federal statutes and regulations.

§432:1-103 Applicability of this article to existing societies and union mutual benefit societies. (a) None of the provisions of this article shall apply to, or in any way be held to affect, mutual benefit and fraternal societies which have been in existence and functioning within the State continuously for ten years prior to May 8, 1937.

(b) The provisions of this article shall apply to labor union mutual benefit societies, which are also regulated by Public Law 85-836, but the commissioner may waive any of the specific requirements of this article if the commissioner is satisfied that the labor union members and their dependents belonging to the mutual benefit society will not be adversely affected by the waiver. Each labor union mutual benefit society shall file with the

commissioner annually a copy of the report filed under Public Law 85-836 and a complete financial report prepared by a certified public accountant.

§432:1-104 Definitions. For the purposes of this article:

- (1) Commissioner means the insurance commissioner of the State of Hawaii.
- (2) Mutual benefit society is any corporation, unincorporated association, society, or entity:
 - (A) Organized and carried on for the primary benefit of its members and their beneficiaries and not for profit, and:
 - (i) making provision for the payment of benefits in case of sickness, disability, or death of its members, or disability, or death of its members' spouses or children, or
 - (ii) making provision for the payment of any other benefits to or for its members, whether or not the amount of the benefits is fixed or rests in the discretion of the society, its officers, or any other person or persons; and the fund from which the payment of the benefits shall be defrayed is derived from assessments or dues collected from its members, and the payment of death benefits is made to the families, heirs, blood relatives, or persons named by its members as their beneficiaries; or
 - (B) Organized and carried on for any purpose, which:
 - (i) regularly requires money to be paid to it by its members, whether the money be in the form of dues, subscriptions, receipts, contributions, assessments or otherwise, and
 - (ii) provides for the payment of any benefit or benefits or the payment of any money or the delivery of anything of value to its members or their relatives, or to any person or persons named by its members as their beneficiaries, or to any class of persons which includes or may include its members, whether or not the amount or value of the benefit, benefits, money, or thing of value is fixed, or rests in the discretion of the society, its officers, or any other person or persons; or
 - (C) Organized and carried on for any purpose, whose requirements and provisions although not identical with, are determined by the commissioner to be substantially similar to, those enumerated in subsections (A) and (B).

Participating in a prepaid legal service plan subject to chapter 488 shall not in itself make a corporation, unincorporated association, society, or entity a mutual benefit society and subject to this article. It shall be deemed to be a fiduciary company within the meaning of section 402-1 and shall, in all respects, unless otherwise specifically provided, be subject to part I of chapter 402, relating to fiduciary companies.

§432:1-105 Penalty. There shall be a fine of not more than \$1,000 or imprisonment of not more than one year, or both, for:

- (1) Any person who is found in the State as officer, member, principal, agent, solicitor, or in any other capacity, soliciting or conducting or operating the business of a mutual benefit society, as

- defined in section 432:1-104, not qualified and licensed to operate the business in conformity with this article, or
- (2) Any trustee, officer or other person in charge of the affairs of any such society, who authorizes, sanctions or permits the issuance of any certificate, policy or contract, for the payment of benefits in violation of this article, or
- (3) Any person who violates any other provision of this article relating to mutual benefit societies.

PART II. ORGANIZATION

§432:1-201 Incorporation by charter. Any mutual benefit society may be or become incorporated by charter as provided in sections 416-19 and 416-20, notwithstanding any limitations under the corporation law as to the purposes for which charters may be granted. Any society so chartered as a corporation shall be subject in all respects to this article.

§432:1-202 Constitution and bylaws; officers; government of society.

(a) Mutual benefit societies promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of \$25 shall, subject to the approval of the commissioner, have the power to make a constitution and bylaws for the government of the society, the admission of its members, the management of its affairs, and the fixing and readjusting of the rates of contribution of its members. The societies shall have the power to amend the constitution and bylaws and such other powers as are necessary to carry into effect the object and purpose of the society, but shall not suspend temporarily any part of its constitution or bylaws as the same are governed by this article.

(b) Each mutual benefit society shall elect or otherwise appoint among its officers a president and a treasurer, who shall be residents of the State.

(c) After the organization of a society is completed and a certificate of compliance with law is granted by the commissioner, the society shall be governed by its administrative board or body in accordance with its constitution and bylaws.

(d) Upon compliance with this article any society engaged in transacting business or operating in this State may exercise all of the rights conferred by this article, and all of the rights, powers and privileges possessed by it under its constitution and bylaws, rules and regulations, or articles of incorporation or charter not inconsistent with this article.

§432:1-203 Actions or proceedings. (a) An action or special proceeding may be maintained, by the president or treasurer of the society, to recover any property, or upon any cause of action, for or upon which all the associates may maintain an action or special proceeding, by reason of their interest or ownership therein, either jointly or in common. An action may likewise be maintained by the president or treasurer to recover from one or more members of the society such member's or members' proportionate share of any moneys lawfully expended by the society for the benefit of the associates, or to enforce any lawful claim of the society against its member or members.

(b) An action or special proceeding may be maintained, against the president or treasurer of the society, to recover any property, or upon any cause of action, for or upon which the plaintiff may maintain an action or special proceeding, against all the associates, by reason of their interest or ownership, or claim of ownership therein, either jointly or in common, or their liability therefor, either jointly or severally, and any order, decree,

judgment, or other ruling in any such case shall be binding upon the society and the members thereof.

(c) The death or legal incapacity of a member of the society shall not affect an action or special proceeding, brought as prescribed in subsections (a) and (b). If the officer, by or against whom it is brought, dies, is removed, resigns, or becomes otherwise incapacitated, during the pendency thereof, the court shall make an order, directing it to be continued by or against such officer's successor in office, or any other officer, by or against whom it might have been originally commenced.

(d) In such an action, the officer against whom it is brought cannot be arrested; and a judgment against such officer shall not authorize an execution to be issued against the officer's property, or the officer's person; nor shall the docketing thereof bind the officer's real property or personal property. Where the judgment is for a sum of money, an execution issued thereupon shall require the levying officer to satisfy the judgment out of any personal or real property belonging to the society, or owned, jointly or in common, by all the members thereof.

(e) Where an action has been brought against an officer, or a counter-claim has been made, in an action brought by an officer, as prescribed in this section, another action, for the same cause, shall not be brought against the members of the society, or any of them, until after final judgment in the first action, and the return, wholly or partly unsatisfied or unexecuted, of an execution issued thereupon. After the return, the party in whose favor the execution was issued, may maintain an action, as follows:

- (1) Where such party was the plaintiff, or a defendant recovering upon a counterclaim, such party may maintain an action against the members of the society, or, in a proper case, against any of them, as if the first action had not been brought, or the counter-claim had not been made, as the case requires; and such party may recover, as part of such party's damages, the costs of the first action, or so much thereof, as the sum, collected by virtue of the execution, was insufficient to satisfy;
- (2) Where such party was a defendant, and the case is not within item (1), such party may maintain an action, to recover the sum remaining uncollected, against the persons who composed the society, when the action against such party was commenced, or the survivors of them.

(f) This section shall not affect the right of the person, in whose favor the judgment in the first action was rendered, to enforce a bond or undertaking, given in the course of the proceedings therein.

(g) This section shall not prevent an action from being brought by or against all the members of a society, except as prescribed in this section. Where an action is brought against the members of the society, as prescribed in this section, the time between the commencement of the action by or against the officer, and the return of the first execution issued upon the final judgment rendered therein, shall not be a part of the time limited by law, for the commencement of the second action.

PART III. AUTHORITY TO OFFER BENEFITS

§432:1-301 Registration with commissioner: certificate of registration and authorization to solicit members. (a) Before doing business or engaging in any act, any society as defined in section 432:1-104(2) shall file with the commissioner:

- (1) Copies of its constitution or organic instrument under which it purports to operate, and the bylaws, and rules and regulations, if any;
- (2) If a society promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of \$25:
 - (A) Copies of all proposed forms of benefit certificates, applications and circulars to be issued by the society, and
 - (B) A bond in the sum of \$25,000 with sureties approved by the commissioner. The bond shall be conditioned upon the return of the advance payments referred to below, if the organization is not completed within one year; and
- (3) Any additional information as the commissioner may require.

(b) Upon the filing of the information required by subsection (a), if it appears to the commissioner's satisfaction that the purposes of the society are lawful, the commissioner shall issue a certificate registering the society and licensing it to operate in the State.

(c) In the case of any society offering or promising to pay death, sick, disability, or other benefits in an amount equal to or in excess of \$25, if the commissioner is satisfied that the purposes of the society are not for profit but for the benefit of its members, the commissioner shall authorize the society to solicit members as provided in section 432:1-303.

§432:1-302 Commissioner refusal to authorize certificate or solicitation; appeal to circuit court. (a) If the commissioner reasonably believes that the financial plan of the society is unsound or not feasible from an actuarial or other accounting standpoint, the commissioner shall refuse to issue a certificate, authorize the society to solicit members, or engage in business.

(b) Any person aggrieved by the decision of the commissioner refusing to issue the certificate, or to authorize the society to solicit members, or to engage in business, may within twenty days after the decision appeal to the circuit court of the circuit in which the society proposes to have its principal place of business. The procedure upon appeal shall be the same as in the case of other appeals to the circuit court in civil cases. The court shall hear the appeal without a jury.

§432:1-303 Authority to offer death, sick, disability, or other benefits; conditions. (a) Each society promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of \$25 may solicit members for the purpose of completing its organization upon receipt from the commissioner of the certificate and authority required in section 432:1-301, and shall collect from each applicant the amount of not less than one regular monthly payment in accordance with its table of rates as provided by its constitution and bylaws, and shall issue to each applicant a receipt for the amount so collected.

(b) Except as hereinafter provided, no society shall incur any liability other than for the advance payments, nor issue any benefit certificate, nor allow, or offer or promise to pay, or allow to any person any death benefit until:

- (1) Actual bona fide applications for death certificates have been secured upon at least one hundred lives for at least \$25 each, and all the applicants for death benefits have been regularly examined by a qualified practicing physician, and certificates of the examination have been duly filed with and approved by the administrative board or body of the society; and
- (2) At least one hundred applicants have been accepted for membership; and

- (3) There has been submitted to the commissioner, under oath of the president and secretary, or corresponding officers of the society, a list of applicants including the following information about each applicant:
 - (A) Name and address,
 - (B) Date examined,
 - (C) Date of approval,
 - (D) Date accepted as member,
 - (E) If subordinate branches have been established, the name and number of the subordinate branch of which each applicant is a member,
 - (F) Amount of benefits to be granted, and
 - (G) The rate of stated periodical contributions which shall be sufficient to provide for meeting the mortuary obligations contracted when valued for death purposes upon the basis of a recognized table of mortality or any mutual benefit standard based on at least twenty years' experience, and for disability benefits by tables based upon reliable experience, and for combined death and permanent total disability benefits by tables based upon reliable experience; and
- (4) It has been shown to the commissioner by the sworn statement of the treasurer or corresponding officer of the society that at least one hundred applicants have paid in cash at least one regular monthly payment as provided under subsection (a), which payments in the aggregate shall amount to at least five times the maximum amount of death benefit offered or promised to be paid to any one member.
- (c) If the society does not offer or promise to pay any death benefits in excess of \$25 upon the death of a member, but merely offers or promises to pay disability benefits by reason of sickness or injury, or to pay any other benefits, with or without provision of death benefit in excess of \$25, the society shall, before receiving a certificate of compliance with law from the commissioner, prove to the commissioner that at least one hundred members have each paid in, in cash, at least six regular monthly payments to the disability fund. Such payments in the aggregate shall:
 - (1) Amount to at least twenty times the maximum amount of disability or other benefits offered or promised to be paid to any one member during or within a period of thirty days,
 - (2) Be credited to the disability, sick or other benefit fund, and
 - (3) During the period of organization of the society, be held in trust to be returned to the applicants or members who have made payment of the same, if and in case the organization of the society is not completed within one year.

§432:1-304 Authority to offer death, sick, disability, or other benefits; special deposit and control of certain funds. Except as provided in this section and section 432:1-305, all regular payments received for account of death benefit, disability or other benefit funds, during the period of organization of a society, shall not be used for the payment of any expenses of the society, but shall be placed on deposit or in trust in some bank or trust company approved by the commissioner, payable to the society but under the joint control with the commissioner. In case the organization of the society is not completed within one year, the funds shall be returned to the applicants or members who made payments of the respective amounts. If, however, the organization is completed and the commissioner issues a certificate of

compliance with the law, the funds so deposited in trust, together with interest, if any, shall be released by the commissioner in favor of the society.

§432:1-305 Authority to offer death, sick, disability or other benefits; restrictions on use of funds. (a) At no time shall the society, except as provided in subsection (c), use more than twenty-five percent of the payments up to \$100,000 and seven percent of the payments in excess of \$100,000, received from its members or applicants in the form of admission fees, dues, contributions or assessments of any nature for expenses other than taxes, in connection with the management or operation of the death benefit, sick, disability, or other benefit funds.

(b) Any commissions or other payments or allowances to persons soliciting membership in or making collections for the society shall be included in the foregoing expenditures and no part of the commissions, payments or allowances may be in addition thereto; provided, that any society which exacts a membership fee of its new members not in excess of \$10 for each membership may pay commissions or other payments to persons soliciting membership out of the fund created by the membership fees, and the amounts so paid as commissions or as such other payments out of such fund shall not be considered as expenses within the meaning of section 432:1-304 and section 432:2-305.

(c) Any association or society organized and operating solely as a nonprofit medical indemnity or hospital service association or society may use for such expenses, in addition to taxes, not more than thirty-five percent of the payments received from its members or applicants in the form of admission fees, dues, contributions, or assessments of any nature.

§432:1-306 Authority to offer death, sick, disability, or other benefits; deposit or bond. (a) After the organization of the society is completed, and before a certificate of compliance is granted by the commissioner, the society shall deposit with the commissioner one-half the maximum amount required to be maintained in its death benefit and disability, or sick, or other benefit fund, as provided in section 432:1-401, either in cash or in securities approved by the commissioner.

(b) In lieu of such deposit, the society shall file with the commissioner a good and sufficient bond in the amount prescribed in subsection (a), signed by the society as principal with one or more sureties to be approved by the commissioner and running to the commissioner and the commissioner's successors in office. The bond shall be conditioned that the surety or sureties on the bond shall be answerable in the amount of the bond for all judgments, decrees or orders given, made or rendered against the principal on the bond by any court of the State for payment of money.

§432:1-307 Authority to offer death, sick, disability, or other benefits; certificate of existence. The commissioner may make such examination and require such information from time to time as the commissioner may deem advisable. Upon presentation of satisfactory proof that the society has complied with this article, and any other applicable law, the commissioner shall issue to the society a certificate to that effect. The certificate shall be *prima facie* evidence of the existence of the society as of the date of the certificate. The commissioner shall cause a record of the certificate to be made and a certified copy of the record may be given in evidence with the same effect as the original certificate.

PART IV. FINANCIAL AND REPORTING REQUIREMENTS

§432:1-401 Benefit funds. Each society shall at all times maintain:

- (1) In its death benefit fund, at least five times the maximum amount of death benefit offered or promised to be paid to any one member, and
- (2) In its sick, disability or other benefit fund, at least twenty times the maximum amount of sick, disability or other benefits, whichever maximum amount is greater, offered or promised to be paid to any one member during or within a period of thirty days.

§432:1-402 Investments of certain mutual benefit societies. No domestic mutual benefit society promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of \$25 shall invest any of its assets other than as authorized and provided for in respect to domestic insurance companies and societies under the provisions of article 6 of the insurance code, which provisions are hereby extended to and made applicable to the mutual benefit societies.

§432:1-403 Nonprofit medical, hospital indemnity associations; tax exemption. Every association or society organized and operating under this article solely as a nonprofit medical indemnity or hospital service association or society or both shall be, from the time of such organization, exempt from every state, county and municipal tax, except unemployment compensation tax. Nothing in this section shall be deemed to exempt the association or society from liability to withhold the taxes payable by its employees and to pay the same to the proper collection officers, and to keep such records, and make such returns and reports, as may be required in the case of other corporations, associations or societies similarly exempted from such taxes.

§432:1-404 Annual exhibits. (a) Each society shall file with the commissioner annually, on or before April 30 in each year, a statement under oath, and in such form and detail as the commissioner shall prescribe. Those societies promising or offering to pay death, sick, disability, or other benefits shall set forth in the statement the following:

- (1) The total business transacted and the amount of gross receipts received by the society during the year ending December 31 last preceding;
- (2) The resources and liabilities of the society at the close of business on December 31;
- (3) The receipts and expenditures; and
- (4) The computation of the loss or gain of the society during the calendar year.

(b) Labor union mutual benefit societies shall file annually a copy of the report filed under Public Law 85-836 and a complete financial report prepared by a certified public accountant.

PART V. EXAMINATION POWERS AND RECEIVERSHIP

§432:1-501 Examination by commissioner, assistance of other officers.

(a) The powers, authorities and duties relating to examinations vested in and imposed upon the commissioner under article 2 of the insurance code are extended to and imposed upon the commissioner in respect to examinations of mutual benefit societies. The provisions of section 401-3 relative to examination of fiduciary companies shall not apply to mutual benefit societies.

(b) The commissioner in the exercise of any of the commissioner's functions, powers and duties under this article, may use the staff or any members of the staff of the commissioner of financial institutions and may appoint and constitute them as agents for such purpose.

§432:1-502 Receiver; appointment, powers, duties. (a) The commissioner shall give immediate notice thereof to the society and demand that irregularities be promptly corrected, impairments of assets be made good, that all unsafe or unauthorized practices be discontinued, or that there be compliance with the laws in question, if, upon the examination of any mutual benefit society, as defined in section 432:1-104(2), the commissioner ascertains and finds that:

- (1) The laws of the State relating to such societies are not being fully observed;
- (2) That any irregularities are being practiced;
- (3) That the assets have been or are in danger of being impaired;
- (4) That the society is conducting its affairs in an unsafe manner so that continuance of its business would be hazardous to the public; or
- (5) That it is necessary for the protection of the members or creditors of the society.

(b) If the commissioner's demand issued under subsection (a) is not complied with within a reasonable time fixed by the commissioner, but not exceeding thirty days after the notice, then upon the request of the commissioner, application shall be made by the attorney general on the commissioner's behalf, to a judge or court of competent jurisdiction for the appointment of a receiver for the society. If it appears that any of the facts enumerated in the application as the ground for a receivership exists, the court or judge shall immediately appoint a competent person as receiver, and shall determine such receiver's bond and prescribe the receiver's duties, and may make such other or further orders as shall seem proper.

(c) Except as otherwise provided by the court or judge, any receiver appointed under this article shall have, exercise and perform all of the powers and duties of a receiver of a fiduciary company, as conferred and prescribed in section 402-5, which is made applicable.

§432:1-503 Closing of doors without notice. If, upon the examination of any society, it is found to be insolvent, or if it is deemed necessary by the commissioner for the protection of the interests of its members or the public, the commissioner may at once close the doors of the society without any notice and take charge of the books, assets and affairs of the society until the appointment of a receiver as provided by law.

PART VI. REQUIRED PROVISIONS AND BENEFITS

§432:1-601 Contract limitations for mentally retarded and handicapped children. All individual and group hospital or medical service plan contracts, delivered or issued for delivery in this State after May 8, 1968, which provide that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (2) chiefly dependent upon the policyholder, subscriber or employee as the case may be, for support and maintenance, provided proof of such incapacity and dependency is furnished to the hospital service or medical indemnity association by the policyholder, subscriber or employee within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by such association.

§432:1-602 Newborn children coverage. (a) All individual and group hospital and medical service corporation contracts which provide coverage for a family member of the subscriber shall, as to such family member's coverage, also provide that the benefits applicable for children shall be payable or provided with respect to a newly born child of the subscriber 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 subscription fee or premium is required to provide coverage for the child, the contract may require that notification of birth of a newly born child and payment of the required fee or premium must be furnished to the service corporation within thirty-one days after the date of birth in order to have coverage continue beyond such thirty-one day period. The requirements of this section shall apply to all subscriber contracts delivered or issued for delivery in this State more than one hundred twenty days after the effective date of this section.

(b) No provision in subsection (a) shall be construed to provide or include coverage for routine well-baby services.

§432:1-603 Reimbursement for psychological services. Notwithstanding any provision of any individual or group hospital or medical service plan contract, whenever the contract 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.

CHAPTER 432

ARTICLE 2. FRATERNAL BENEFIT SOCIETIES

PART I. STRUCTURE AND PURPOSE

§432:2-101 Scope of article. This article relates only to fraternal benefit societies, as defined herein, which desire to be authorized to pay benefits in accordance with this article after July 10, 1961. This article shall not apply to prepaid legal service plans subject to chapter 488 even though the plan may be offered by a fraternal benefit society.

§432:2-102 Applicability of other laws. (a) Except as herein provided, societies shall be governed by this article and shall be exempt from all other provisions of the insurance laws of this State unless they are expressly designated therein, or unless it is specifically made applicable by this article.

(b) Nothing in this article shall exempt fraternal benefit societies from the provisions and requirements of sections 416-19 and 416-20.

§432:2-103 Definitions. For the purposes of this article:

- (1) Benefit contract shall mean the agreement for provision of benefits authorized by section 432:2-401, as that agreement is described in section 432:2-404(a).
- (2) Benefit member shall mean an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.
- (3) Certificate shall mean the document issued as written evidence of the benefit contract.
- (4) Commissioner means the insurance commissioner of this State.
- (5) Laws shall mean the society's articles of incorporation, constitution and bylaws, however designated.

- (6) Lodge shall mean subordinate member units of the society, known as camps, courts, councils, branches, or by any other designation.
- (7) Premiums shall mean premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.
- (8) Rules shall mean all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.
- (9) Society shall mean fraternal benefit society, unless otherwise indicated.

§432:2-104 Fraternal benefit societies. Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of section 432:2-704(a)(2) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this article, is hereby declared to be a fraternal benefit society.

§432:2-105 Lodge system. (a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(b) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

§432:2-106 Representative form of government. A society has a representative form of government when:

- (1) It has a supreme governing body constituted in one of the following ways:
 - (A) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected, shall meet at least once every four years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.
 - (B) Direct Election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by

mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

- (2) The officers of the society are elected either by the supreme governing body or by the board of directors;
- (3) Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly; and
- (4) Each voting member shall have one vote; no vote may be cast by proxy.

§432:2-107 Purposes and powers. (a) A society shall operate for the benefit of members and their beneficiaries by:

- (1) Providing benefits as specified in section 432:2-401; and
- (2) Operating for one or more lawful, social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(b) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

PART II. MEMBERSHIP

§432:2-201 Qualifications for membership. (a) A society shall specify in its laws or rules:

- (1) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen and not greater than age twenty-one;
- (2) The process for admission to membership for each membership class; and
- (3) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of its insurance affairs.

(c) Membership rights in the society are personal to the member and are not assignable.

§432:2-202 Location of office, meetings, communications to members, grievance procedures. (a) The principal office of any domestic society shall be located in this State. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one subordinate lodge, or in such other location as determined by the supreme governing body. All business transacted at such meetings shall be as valid in all respects as if such meetings were held in this State. The minutes

of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

- (b) (1) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.
- (2) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.
- (c) A society may provide in its laws or rules for grievance or complaint procedures for members.

§432:2-203 No personal liability. (a) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that the person is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which the person served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed:

- (1) In relation to any matter in such action, suit or proceeding as to which the person shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society, or
- (2) In relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement;

unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that the person's conduct was unlawful.

The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in items (1) or (2) may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of the person's heirs and personal representatives.

(c) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by the person in any such capacity or arising out of the person's status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

§432:2-204 Waiver. The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

PART III. GOVERNANCE

§432:2-301 Organization. A domestic society organized on or after the effective date of this article shall be formed as follows:

- (1) Seven or more citizens of the United States, a majority of whom are residents of this State, who desire to form a fraternal benefit society, may make, sign and acknowledge before an officer competent to take acknowledgements of deeds, articles of incorporation, in which shall be stated:
 - (A) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;
 - (B) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this article;
 - (C) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.
- (2) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications and circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the commissioner, who may require such further information as the commissioner deems necessary. The bond with sureties approved by the commissioner shall be in such amount, not less than \$300,000 nor more than \$1,500,000, as required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this article and all provisions of the law have been complied with, the commissioner shall so certify, retain and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

- (3) No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the commissioner upon cause shown, unless the five hundred applicants hereinafter required have been secured and the organization has been completed as herein provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.
- (4) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:
 - (A) Actual bona fide applications for benefits have been secured on not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society;
 - (B) At least ten subordinate lodges have been established into which the five hundred applicants have been admitted;
 - (C) There has been submitted to the commissioner under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and
 - (D) It shall have been shown to the commissioner, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least \$150,000. Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one year, such premiums shall be returned to said applicants.
- (5) The commissioner may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this article. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The commissioner shall cause a record of such certificate of authority to be made. A certified copy of such

record may be given in evidence with like effect as the original certificate of authority.

- (6) Any incorporated society authorized to transact business in this State at the time this article becomes effective shall not be required to reincorporate.

§432:2-302 Amendments to laws. (a) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting, or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

(b) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner who shall approve such amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this State or with the character, objects and purposes of the society. Unless the commissioner shall disapprove any such amendment within sixty days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disapproved such amendment, the reasons therefor shall be stated in such written notice.

(c) Within ninety days from the approval by the commissioner, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society, or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this State shall file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within ninety days after the enactment of same.

(e) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

§432:2-303 Institutions. A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by section 432:2-107(a)(2). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement.

§432:2-304 Reinsurance. (a) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this State, or if not so authorized, one which is approved by the commissioner. No such society may

reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this article, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Notwithstanding the limitation in subsection (a), a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under section 432:2-305.

§432:2-305 Consolidations and mergers. (a) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner:

- (1) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;
- (2) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner but not earlier than December 31 next preceding the date of the contract;
- (3) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and
- (4) Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(b) If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect, unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the commissioner of this State, or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of insurance of such state or territory and a certificate of such approval filed with the commissioner of this State.

(c) Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument; except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this State in any of the societies consolidated or

merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall be vested absolutely in the society resulting from or remaining after such consolidation or merger.

(d) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be *prima facie* evidence that such notice or document has been furnished the addressees.

§432:2-306 Conversion of fraternal benefit society into mutual life insurance company. Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of chapter 431 pertaining to mutual life insurers. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the commissioner who may give such approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

PART IV. CONTRACTUAL BENEFITS

§432:2-401 Benefits. (a) A society may provide the following contractual benefits in any form:

- (1) Death benefits;
- (2) Endowment benefits;
- (3) Annuity benefits;
- (4) Temporary or permanent disability benefits;
- (5) Hospital, medical or nursing benefits;
- (6) Monument or tombstone benefits to the memory of deceased members; and
- (7) Such other benefits as authorized for life insurers and which are not inconsistent with this article.

(b) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (a), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

§432:2-402 Beneficiaries. (a) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society, unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of \$500.

(c) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid

as provided in subsection (b), shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

§432:2-403 Benefits not attachable. No money or other benefit, charity, relief or aid to be paid, provided or rendered by a society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

§432:2-404 The benefit contract. (a) Every society authorized to do business in this State shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either:

- (1) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or
- (2) In lieu of or in combination with item (1), the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f) No certificate shall be delivered or issued for delivery in this State unless a copy of the form has been filed with the commissioner. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after one year from the effective date of this article shall meet the standard contract provision requirements not inconsistent with this article for like policies, except that a society may provide for a grace

period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(g) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(h) A society may specify the terms and conditions on which benefit contracts may be assigned.

§432:2-405 Nonforfeiture benefits, cash surrender values, certificate loans and other options. (a) For certificates issued prior to one year after the effective date of this article, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to the effective date of this article.

(b) For certificates issued on or after one year from the effective date of this article for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table or the Commissioner's 1958 Standard Ordinary Mortality Table, or the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this State applicable to life insurers issuing policies containing like benefits based upon such tables.

PART V. FINANCIAL

§432:2-501 Investments. A society shall invest its funds only in such investments as are authorized by the laws of this State for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this State which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

§432:2-502 Funds. (a) All assets shall be held, invested and disbursed for the use and benefit of the society. No member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which section 432:2-404(b) and section 432:2-404(d) shall not apply.

§432:2-503 Taxation. Every society organized and operating or licensed under this article shall be, from the time of such organization, exempt from every state, county, and municipal tax, except real property taxes and unemployment compensation taxes; provided that nothing in this section shall be deemed to exempt the association or society from liability to withhold such taxes payable by its employees and pay the same to the proper collection officers, and to keep such records and make such returns and reports, as may be required in the case of other corporations, associations, or societies similarly exempt from the taxes hereinabove first mentioned; provided further, that the exemption hereby granted as to general excise taxes under chapter 237 shall not apply to any activity the primary purpose of which is to produce income.

PART VI. REGULATION

§432:2-601 Valuations. (a) Standards of valuation for certificates issued prior to one year after the effective date of this article shall be those provided by the laws applicable immediately prior to the effective date of this article.

(b) The minimum standards of valuation for certificates issued on or after one year from the effective date of this article shall be based on the following tables:

- (1) For certificates of life insurance the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers.
- (2) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits, such tables as are authorized for use by life insurers in this State.

All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this State applicable to life insurers issuing policies containing like benefits.

(c) The commissioner may, in the commissioner's discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The

commissioner may, in the commissioner's discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by a society authorized to do business in this State.

(d) Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

§432:2-602 Reports. Reports shall be filed in accordance with the provisions of this section.

(a) Every society transacting business in this State shall annually, on or before March 1, unless for cause shown such time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year and pay a fee of \$7.50 for filing same. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(b) As part of the annual statement herein required each society shall, on or before March 1, file with the commissioner a valuation of its certificates in force on December 31 last preceding, provided the commissioner may, in the commissioner's discretion for cause shown, extend the time for filing such valuation for not more than two calendar months. Such valuation shall be done in accordance with the standards specified in section 432:2-601. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(c) A society neglecting to file the annual statement in the form and within the time provided by this section shall be liable for a penalty of \$100 for each day during which such neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this State shall cease while such default continues.

§432:2-603 Annual license. Societies which are now authorized to transact business in this State may continue such business until May 1 next succeeding the effective date of this article. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the succeeding May 1. However, a license so issued shall continue in full force and effect until the new license be issued or specifically refused. For each such license or renewal, the society shall pay the commissioner \$7.50. A duly certified copy or duplicate of such license shall be *prima facie* evidence that the licensee is a fraternal benefit society within the meaning of this article.

§432:2-604 Examination of societies; no adverse publications. (a) The commissioner, or any person the commissioner may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this State in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society

examined or whose certificates are valued, upon statements furnished by the commissioner.

§432:2-605 Foreign or alien society - admission. No foreign or alien society shall transact business in this State without a license issued by the commissioner. Any such society desiring admission to this State shall comply substantially with the requirements and limitations of this article applicable to domestic societies. Any such society may be licensed to transact business in this State upon filing with the commissioner:

- (1) A duly certified copy of its articles of incorporation;
- (2) A copy of its bylaws, certified by its secretary or corresponding officer;
- (3) A power of attorney to the commissioner as prescribed in section 432:2-701;
- (4) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the commissioner of this State;
- (5) Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;
- (6) Copies of its certificate forms; and
- (7) Such other information as the commissioner may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of this article.

§432:2-606 Injunction - liquidation - receivership of domestic society.

- (a) When the commissioner upon investigation finds that a domestic society:
- (1) Has exceeded its powers;
 - (2) Has failed to comply with any provision of this article;
 - (3) Is not fulfilling its contracts in good faith;
 - (4) Has a membership of less than four hundred after an existence of one year or more; or
 - (5) Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for the commissioner's dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty day period in which to comply with the commissioner's request for correction. If the society fails to comply, the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(b) If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the commissioner may present the facts relating thereto to the attorney general who shall, if the attorney general deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so

enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

- (1) The commissioner finds that the violation complained of has been corrected;
- (2) The costs of such action shall have been paid by the society if the court finds that the society was in default as charged;
- (3) The court has dissolved its injunction; and
- (4) The commissioner has reinstated the certificate of authority.

(d) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

(e) No action under this section shall be recognized in any court of this State unless brought by the attorney general upon request of the commissioner. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner as such receiver.

(f) The provisions of this section relating to hearing by the commissioner, action by the attorney general at the request of the commissioner, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

§432:2-607 Suspension, revocation or refusal of license of foreign or alien society. (a) When the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this State:

- (1) Has exceeded its powers;
- (2) Has failed to comply with any of the provisions of this article;
- (3) Is not fulfilling its contracts in good faith; or
- (4) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for the commissioner's dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty day period in which to comply with the commissioner's request for correction. If the society fails to comply the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this State should not be suspended, revoked or refused, the commissioner may suspend or refuse the license of the society to do business in this State until satisfactory evidence is furnished to the commissioner that such suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this State.

(b) Nothing contained in this section shall be taken or construed as preventing any society from continuing in good faith all contracts made in this State during the time the society was legally authorized to transact business in this State.

§432:2-608 Injunction. No application or petition for injunction against any domestic, foreign or alien society, or lodge, shall be recognized in

any court of the State unless made by the attorney general upon request of the commissioner.

§432:2-609 Licensing of agents. (a) Agents of societies shall be licensed in accordance with article 9 of the insurance code; provided that no examination shall be required of any individual licensed to represent a fraternal benefit society prior to the effective date of this chapter.

(b) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of the officer's, employee's or member's services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Any agent, representative or member of a society who devotes, or intends to devote, less than fifty percent of such person's time to the solicitation and procurement of insurance contracts for such society shall be exempt from the requirements of subsection (a). Any person who in the preceding calendar year has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of \$50,000, or, in the case of any other kind or kinds of insurance which the society might write, on the persons of more than twenty-five individuals and who has received or will receive a commission or other compensation therefor, shall be presumed to be devoting, or intending to devote, fifty percent of the person's time to the solicitation or procurement of insurance contracts for such society.

§432:2-610 Unfair methods of competition and unfair and deceptive acts and practices. Every society authorized to do business in this State shall be subject to the provisions of article 13 of the insurance code relating to unfair practices; provided, however, that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members of persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

PART VII. MISCELLANEOUS

§432:2-701 Service of process. (a) Every society authorized to do business in this State shall appoint in writing the commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in such writing that any lawful process against it which is served on said attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this State. Copies of such appointment, certified by the commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the force and effect as the original thereof might be admitted.

(b) Service shall only be made upon the commissioner, or^{f1} if absent, upon the person in charge of the commissioner's office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the commissioner, the commissioner shall forthwith forward one of the duplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty days from the date of mailing the copy of the service to a society. Legal

process shall not be served upon a society except in the manner herein provided. At the time of serving any process upon the commissioner, the plaintiff or complainant in the action shall pay to the commissioner a fee of \$7.50.

§432:2-702 Review. All decisions and findings of the commissioner made under the provisions of this article shall be subject to review by proper proceedings in any court of competent jurisdiction in this State.

§432:2-703 Penalties. (a) Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society, shall upon conviction be fined not less than \$100 nor more than \$500 or imprisoned for not less than thirty days nor more than one year, or both.

(b) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this article, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

(c) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this State shall upon conviction be fined not less than \$50 nor more than \$200.

(d) Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this article for which a penalty is not otherwise prescribed, shall upon conviction, be subject to a fine not exceeding \$200.

§432:2-704 Exemption of certain societies. (a) Nothing contained in this article shall be so construed as to affect or apply to:

- (1) Grand or subordinate lodges of societies, orders or associations now doing business in this State which provide benefits exclusively through local or subordinate lodges;
- (2) Orders, societies or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;
- (3) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than \$400 or disability benefits of not more than \$350 to any person in any one year, or both; or
- (4) Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than \$400 or for disability benefits of not more than \$350 to any one person in any one year, or both.

(b) Any such society or association described in subsections (a)(3) or (4) which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subsection (a)(4) which has more than one thousand members, shall not be exempted from the provisions of this article but shall comply with all requirements thereof.

(c) No society which, by the provisions of this section, is exempt from the requirements of this article, except any society described in subsection

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(a)(2), shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

(d) Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this article except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability, shall not apply to such society.

(e) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether such society or association is exempt from the provisions of this article.

(f) Societies, exempted under the provisions of this section, shall also be exempt from all other provisions of the insurance laws of this State.

§432:2-705 Severability. If any provision of this article or the application of such provision to any circumstance is held invalid, the remainder of the article or the application of the provision to other circumstances, shall not be affected thereby."

SECTION 3. The Legislative Reference Bureau shall coordinate the development of an alternative premium tax provision to that found in section 431:7-202. The Legislative Reference Bureau shall seek the cooperation and participation of the Office of the Attorney General, the State Department of Taxation, and the Department of Commerce and Consumer Affairs as well as representatives of the insurance industry in this project. In developing an alternative premium tax provision, the parties shall consider the caselaw regarding the constitutionality of differing tax rates for domestic and alien insurers.

SECTION 4. This Act shall take effect July 1, 1988.

(Approved July 2, 1987.)

Note

1. So in original.

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S.B. NO. 361

A Bill for an Act Relating to Insurance.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:2-214 and to read as follows:

"§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 rate customary for these compensation; 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 a 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) Every rate filing shall be accompanied by a fee as designated in sections 431:14-104 and 431:14-205. This fee shall be credited to the commissioner's education and training fund."

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:3-205 and to read as follows:

"§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 December 31, 1987, 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 the State; and
- (3) Secure the approval of the commissioner before making withdrawals from this designated depository.

Schedule "A"

Class of Insurance	Amount Required
Life	\$ 600,000
Disability	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"

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:3-208 and to read as follows:

"§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

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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."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated as section 431:3-209 and to read as follows:

"§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."

SECTION 5. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:4-303 and to read as follows:

"§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."

SECTION 6. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:4-304 and to read as follows:

- "§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."

SECTION 7. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:4-305 and to read as follows:

- "§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."

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SECTION 8. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:4-306 and to read as follows:

“§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.”

SECTION 9. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:4-307 and to read as follows:

“§431:4-307 Mutual disability insurer. (a) When applying for a certificate of authority, a domestic mutual disability insurer must:

- (1) Have at least five hundred applications from at least five hundred persons for individual disability insurance providing not more than \$1,000 of accidental death benefit and not more than \$25 of weekly indemnity for each applicant; and
- (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.”

SECTION 10. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-201 and to read as follows:

“§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 invest and keep invested its funds aggregating not less than one hundred per cent of its reserves required by this code in cash or premiums in course of collection, or in investments eligible in accordance with this article.”

SECTION 11. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-306 and to read as follows:

"§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 mortgage or deed of trust on real property, located in the United States, which meets 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; or
- (C) The seller's equity in an agreement of sale in any property, covering the entire balance due on a bona fide sale of such property, in an amount not to exceed \$100,000 or the amount permissible under section 431:6-105, whichever is greater, in any one agreement of sale, or 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 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; or
- (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."

SECTION 12. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-309 and to read as follows:

"§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."

SECTION 13. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-311 and to read as follows:

“§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 thirty per cent of its assets in real property including those realty set forth in subsection (a), 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.

(c) Real property acquired pursuant to subsection (b) 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.

(d) 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 (b)(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."

SECTION 14. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:7-206 and to read as follows:

"§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."

SECTION 15. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:8-205 and to read as follows:

"§431:8-205 Insurance independently procured; duty to report and pay tax. (a) Each insured who in this State procures or continues or renews insurance with an unauthorized insurer on a risk located or to be performed in whole or in part in this State, other than insurance procured through a

surplus lines broker pursuant to part III of this article shall, within sixty days after the date the insurance was so procured, continued, or renewed, file a written report of the same with the commissioner, upon 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 amount of premium currently charged therefor; and
- (6) Such additional pertinent information as is reasonably requested by the commissioner.

(b) Gross premiums charged for the insurance, 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 (a), the insured shall pay the tax to the commissioner.

(c) 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.

(d) Delinquent taxes hereunder shall bear interest at the rate of ten per cent per annum.

(e) 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.

(f) This section shall not apply to life insurance, accident and sickness insurance, or annuities."

SECTION 16. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:10B-108 and to read as follows:

"§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. 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 any 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 which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the coverage, or are contrary to any provision of the 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. In the determination of the reasonableness of the relation of benefits and premiums consistent with a sixty per cent loss ratio, the commissioner may establish a common authorized premium rate for similar or substantially

similar coverage by class of creditor. The commissioner may approve a higher rate than the common rate where a creditor's experience under a specific policy form reasonably indicates an ultimate loss ratio higher than sixty per cent, but the commissioner shall limit the use of the higher rate to those creditors whose experience was the basis of the approval of the higher rates. The commissioner shall require insurers to file the information as the commissioner deems necessary to determine that this standard is met every two years, or more often in the commissioner's discretion, on forms recommended by the National Association of Insurance Commissioners for that purpose. Upon giving notice as is required by law, the commissioner may withdraw approval of any form including the rate set forth therein, on the ground that a reasonable relation of benefits to premiums no longer exists, or may approve a higher or lower rate if justified by experience.

The commissioner shall adopt a rate that shall be deemed acceptable as satisfying this standard without any actuarial or statistical filing.

(d) The commissioner shall adopt by rules *prima facie* acceptable premium rates, except as set forth below, which shall be usable without statistical justification when filed together with an otherwise acceptable policy form submission. The rates shall produce or shall reasonably be expected to produce a ratio of losses incurred to premiums earned of at least sixty per cent. The rules shall specify the plans of benefits to which the premium rates apply.

(e) 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 established rate and shall base the commissioner's determination on the sixty per cent loss ratio standard. Except where the deviated rate exceeds sixty cents per \$100 initial insurance per year 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.

(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 thirty 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.

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(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."

SECTION 17. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:10C-203 and to read as follows:

"§431:10C-203 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 motor vehicle insurance at least thirty days before the proposed effective date of the filing.

(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 public inspection upon filing with the commissioner."

SECTION 18. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:10C-503 and to read as follows:

"§431:10C-503 Required motorcycles and motor scooters policy coverage. (a) An insurance policy covering a motorcycle or motor scooter shall provide insurance to pay, on behalf of the owner or any operator of the insured vehicle, sums which 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 the charge of the insured which arise out of the ownership, operation, maintenance, or use of the vehicle:

- (1) Liability coverage of not less than \$35,000 for all damages arising out of accidental harm sustained by any one person as a result of any one accident applicable to each person sustaining accidental harm; and

- (2) Liability coverage of not less than \$10,000 for all damages arising out of injury 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.
- (b) At the option of the owner, each insurer shall:
 - (1) Offer medical payment coverage up to \$15,000 to pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical and dental services, and necessary ambulance, hospital, professional nursing, and funeral services; and
 - (2) Offer an income disability plan.”

SECTION 19. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated as section 431:14-104 and to read as follows:

“§431:14-104 Rate filings. (a) Every insurer shall file in triplicate with the commissioner, except as to specific inland marine risks which by general custom of the business are not written according to manual rate or rating plans, every manual of classifications, rules, and rates, every rating plan, and every other rating rule, and every modification of any of the foregoing which it proposes to use. Every filing shall state its proposed effective date, and shall indicate the character and extent of the coverage contemplated. The filing also shall include a report on investment income.

(b) 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.

(c) 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 the event, the waiting period shall commence as of the date the information is furnished. The information furnished in support of a filing may include:

- (1) The experience or judgment of the insurer or rating organization making the filing,
- (2) Its interpretation of any statistical data it relies upon,
- (3) The experience of other insurers or rating organizations, or
- (4) Any other relevant factors.

(d) A filing and any supporting information shall be open to public inspection upon filing with the commissioner.

(e) Specific inland marine rates on risks specially rated, made by a rating organization, shall be filed with the commissioner.

(f) An insurer may satisfy its obligation to make the filings by becoming a member of, or a subscriber to, a licensed rating organization which makes the filings, and by authorizing the commissioner to accept the filings on its behalf; provided that nothing contained in this article shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(g) The commissioner shall review filings as soon as reasonably possible after they have been made in order 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.

(h) Subject to the exception specified in subsection (i), 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 or rating organization which made the filing that the commissioner needs the additional time for the consideration of the filing. Upon written application by the insurer or rating 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.

(i) The following rates shall become effective when filed:

- (1) Specific inland marine rates on risks specially rated by a rating organization; and
- (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.

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.

(j) 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 and rating 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)(7).

(k) 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.

(l) 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 (j) or (k). This subsection shall not apply to contracts or policies for inland marine risks as to which filings are not required."

SECTION 20. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated as section 431:16-108 and to read as follows:

"§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 determination of insolvency, which the insolvent insurer would have been legally obligated to pay but for its insolvency, and arising within thirty days after the determination of insolvency, or before the policy expiration date if less than thirty days after the determination, or before the insured replaces the policy or causes its cancellation, if the insurer does so within thirty days of the determination, but the obligation shall include only that amount of each covered claim which is less than \$300,000, except that the association shall pay the full amount of any

- covered claim arising out of a workers' compensation policy. 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;
- (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;
 - (3) Assess insurers amounts necessary to pay the obligations of the association under subsection (a)(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under section 431:16-113, 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 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. 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 such settlements, releases, and judgments may be properly contested;
 - (5) Notify the persons as the commissioner directs under section 431:16-110(b)(1);
 - (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 shall pay the other expenses of the association authorized by this code; and

- (8) Have the authority, notwithstanding sections 431:10C-110 and 431:10C-111, to cancel all policies issued by an insolvent insurer. All claims under these policies shall be covered by the association in an amount not to exceed the state policy limit of the insolvent insurer under the policy from which the claim arises.
- (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."

SECTION 21. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated as section 431:20-107 and to read as follows:

"§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."

SECTION 22. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated as section 431:20-108 and to read as follows:

"§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."

SECTION 23. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated as section 431:20-114 and to read as follows:

"§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 the effective date of this code; 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 the effective date of this code.

(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 the effective date of this Act shall be released in accordance with the law in effect before the effective date of this code."

SECTION 24. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:20-116 and to read as follows:

"§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.

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(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."

SECTION 25. New statutory material is underscored¹.

SECTION 26. This Act shall take effect on July 1, 1988 only if H.B. No. 410, H.D. 1, S.D. 1, C.D. 1, in any form passed by the legislature, Regular Session of 1987, becomes an Act.

(Approved July 2, 1987.)

Note

1. Edited pursuant to HRS §23G-16.5.

ACT 349

S.B. NO. 1525

A Bill for an Act Relating to Insurance.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:1-216 and to read as follows:

"§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."

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:3-217 and to read as follows:

"§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."

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-321 and to read as follows:

"§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."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-322 and to read as follows:

"§431:6-322 Common trust funds, mutual funds. An insurer may invest in:

- (1) A bank's common trust fund as defined in the United States Internal Revenue Code of 1954, Section 584; and

- (2) The securities of any open-end management type investment company or investment trust registered with the federal Securities and Exchange Commission under the Investment Company Act of 1940, as amended, if the investment company or trust, other than one of which as a subsidiary of the insurer is investment adviser or principal underwriter, has a new value of not less than \$25,000,000 as of the date of investment by the insurer."

SECTION 5. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-323 and to read as follows:

"§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 subsection (b), 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 which can readily be determined in the market place. 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."

SECTION 6. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:6-324 and to read as follows:

"§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 which do not exceed the lesser of five 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, there shall be included:
 - (A) Total net monies 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) 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 item (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."

SECTION 7. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:10C-202 and to read as follows:

"§431:10C-202 Making of motor vehicle insurance rates. (a) All premium rates for motor vehicle 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 in 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) Reasonable margin for profit from and contingencies in the administration of motor vehicle insurance sold;
 - (C) Past and prospective expenses in the sale and administration of motor vehicle insurance;
 - (D) Investment income from reserves, unearned insurance premiums, and other unearned proceeds received on account of motor vehicle insurance sold, and all other factors that may be deemed relevant, such as but not limited to types of vehicles, occupations, and involvement in past accidents, provided they are established to have a probable effect upon losses or expense, or rates; and
 - (E) Optionally, to past or prospective loss, sales, and administrative costs experience in the nation or regionally, whenever the consideration will serve to reduce rates;

- (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) The commissioner shall be prohibited from setting, maintaining, or in any way fixing the rates charged by motor vehicle insurers for motor vehicle insurance issued in conformity with this article as either no-fault insurance or as optional additional insurance except as provided in part IV of this article. Each insurer licensed to underwrite no-fault insurance in the State shall establish its own rate schedule. The commissioner, however, shall monitor and survey the several companies' rate making methods and systems. The commissioner shall require of each insurer and of each self-insurer any and all information, data, internal memoranda, studies, and audits the commissioner deems desirable for the purpose of evaluation, comparison, and study of the methods and schedules.

(d) Notwithstanding subsection (c), commencing on December 16, 1985 and ending on December 31, 1988, all insurers of any motor vehicle shall provide a ten per cent reduction off premium charges each insurer assesses for each new and renewal policy for no-fault benefits and medical payment coverage for any motor vehicle which is equipped with seat belt assemblies as required under any federal motor vehicle safety standard issued pursuant to Public Law 89-563, the federal National Traffic and Motor Vehicle Safety Act of 1966, as amended, or which is so equipped even if not required to be under any federal motor vehicle standard.

(e) Notwithstanding subsection (c), and in addition to all other premium reductions required under this section, commencing on October 1, 1986 and ending on September 30, 1989, all insurers of any motor vehicle shall provide a 1.5 per cent reduction for bodily injury liability, property damage liability, no-fault benefits, uninsured motorist, and underinsured motorist coverages, and a 0.75 per cent reduction for collision coverage off premium charges each insurer assesses for each new and renewal policy, based on the anticipated effects of section 281-78. Commencing on October 1, 1989 and ending on September 30, 1990, at the discretion of and as determined by the commissioner, based on the difference between the actual and anticipated effects of section 281-78, all insurers of any motor vehicle shall provide a refund or credit to each insured at the time of renewal of a no-fault policy.

(f) 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 subsection shall not apply to advisory organizations referred to in section 431:14-111 which are not involved in rate making under this article."

SECTION 8. Chapter 431, Hawaii Revised Statutes, is amended by adding a new article to be designated Article 11 and to read as follows:

"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 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.

§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(i) that control does not exist in fact.
- (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.

"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 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.

"Subsidiary of a specified person" means an affiliate controlled by the person directly or indirectly through one or more intermediaries.

"Voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

§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 broker or as an insurance agent 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, agents, 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 under article 6, 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 monies 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 item (1) or in article 6. 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.

§431:11-104 Acquisition of control or merger with domestic insurer. (a) No person other than the issuer shall make a tender offer or request or invitation for tenders, or enter into any agreement to exchange securities, or 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. 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 any 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 subsection (b) and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner hereinafter prescribed.

(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 such person, or who perform or will perform functions appropriate to the positions. The list shall include for each individual the information required by subsection (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 which 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) which 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) which 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 such acquiring party;
 - (10) Copies of all tender offers, requests, or invitation for tenders, or 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; and
- (12) Any additional information as the commissioner may by rule or regulation 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 items (1) through (12) 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 items (1) through (12) 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;
 - (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 which 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 and 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 and of the public to permit the merger or other acquisition of control; or

- (F) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.
- (2) The public hearing referred to in item (1) shall be held within thirty days after the statement required by subsection (a) is filed, and at least twenty days notice thereof 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 thirty days after the conclusion of the hearing. 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) 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 subsection 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, or merger with, a domestic insurer unless approval is given by the commissioner.
 - (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.

§431:11-105 Registration of insurers. (a) Every insurer who is authorized to do business in this State and who 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 which are substantially similar to those contained in this section and section 431:11-106(a)(1). The insurer shall file a copy of the registration statement and summary of its registration statement as required by subsections (b) and (c) with the National Association of Insurance Commissioners. The insurer also 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 who 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 who is a member of a holding company system who 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 domiciliary jurisdiction.

(b) Every insurer subject to registration shall file the registration statement on a form 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 which have occurred during the last calendar year between such 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 which 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, 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; and
- (5) 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.
- (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 31st day of December 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 which 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 who is authorized to do business in this State and who is part of an insurance holding company system to register on behalf of any affiliated insurer who 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. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section which may arise out of the insurer's relationship with the person unless and until the commissioner disallows the disclaimer. The commissioner shall disallow a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance.

(l) The failure to file a registration statement or any summary of the registration statement required by this section within the time specified for such filing shall be a violation of this section.

§431:11-106 Standards and management of an insurer within a holding company system.

- (a) (1) Transactions within a 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) Charges or fees for services performed shall be reasonable;
 - (C) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;
 - (D) The books, accounts, and records of each party to all transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including the accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and
 - (E) 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 holding company system may 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 thereto, or a shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period:
 - (A) Sales, purchases, exchanges, loans, or extensions of credit, guarantees, 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 each as of the 31st day of December next preceding; or
 - (ii) with respect to life insurers, three per cent of the insurer's admitted assets as of the 31st day of December 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 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 each as of the 31st day of December next preceding; or
 - (ii) with respect to life insurers, three per cent of the insurer's admitted assets as of the 31st day of December next preceding;
 - (C) Reinsurance agreements or modifications thereto in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five per cent of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which 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 and all cost-sharing arrangements; and
- (E) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this section shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same holding company system, would be otherwise contrary to law.

- (3) A domestic insurer may not enter into transactions, which are part of a plan or series of like transactions with persons within the 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. If 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 subsection (a)(2), shall consider whether the transactions comply with the standards set forth in subsection (a)(1) and whether they may adversely affect the interests of policyholders.
- (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 shall have 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:
 - (A) Ten per cent of such insurer's surplus as regards policyholders as of the 31st 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 31st 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 may carry forward income from the previous two calendar years that has not already been paid out as dividends.

Notwithstanding any other provisions of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and the declaration shall confer no rights upon shareholders until:

- (i) The commissioner has approved the payment of the dividend or distribution; or
 - (ii) The commissioner 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 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 herein 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) Not less than one-third of the directors of a domestic insurer and not less than 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 any such entity. At least one of these persons must 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 comprised 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 similar entity. The committee or committees shall have responsibility for recommending the selection of independent certified public accountants, reviewing the insurer's financial condition, the scope and results of the independent audit, and any internal audit, nominating candidates for director for election by shareholders or policyholders, and 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) The provisions of subsections (c)(3) and (c)(4) shall not apply to a domestic insurer if the person controlling the insurer is an insurer having a board of directors and committees thereof that meet the requirements of subsections (c)(3) and (c)(4).
- (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.

§431:11-107 Examination. (a) Subject to the limitation contained in this section and in addition to the powers which the commissioner has under article 2 relating to the examination of insurers, the commissioner shall also have the power to order any insurer registered under section 431:11-105 to produce records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to ascertain the financial condition of the insurer or to determine compliance with this article. In the event the insurer fails to comply with the order, the commissioner shall have the power to examine the insurer's affiliates to obtain the information.

(b) 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 subsection (a). Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(c) Each registered insurer producing for examination records, books and papers pursuant to subsection (a) shall be liable for and shall pay the expense of the examination in accordance with article 2.

§431:11-108 Confidential treatment. All information, documents, and copies thereof 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 section 431:11-105 and section 431:11-106, shall be given confidential treatment, shall not be subject to subpoena, and shall not be made public by the commissioner, the National Association of Insurance Commissioners, or any other person, except to insurance departments of other states, without the 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 thereof in such manner as the commissioner may deem appropriate.

§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.

§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.

§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 penalty of \$100 for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the general fund of this State. The maximum penalty under this subsection is \$5,000. 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 shall permit any of the officers or agents of the insurer to engage in any transactions or make investments which have not been properly reported or submitted pursuant to sections 431:11-105(a), 431:11-106(a)(2), or 431:11-106(b) or who violates this article, shall pay, in their individual capacity, a civil forfeiture of not more than \$5,000 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 forfeiture with respect to the gravity of the violation, the history of previous violations, and such 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 which is subject to section 431:11-106 and which 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 willful 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 who willfully violates this article may be fined not more than \$5,000. Any individual who willfully violates this article may be fined in the individual's capacity not more than \$5,000, or be imprisoned for not more than one year.

(e) Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes, or causes to be made, any false statements or 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 their individual capacity.

§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.

§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.

§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.

§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.

§431:11-116 Conflict with other laws. All laws and parts of laws of this State inconsistent with this article are hereby superceded with respect to matters covered by this article.

§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."

SECTION 9. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:14-105 and to read as follows:

"§431:14-105 Policy revisions which alter coverage. All policy revisions which 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 policy revision must be submitted in accordance with section 431:14-104."

SECTION 10. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:15-324 and to read as follows:

"§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 marshalled 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 health 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 health 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)."

SECTION 11. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:15-332 and to read as follows:

"§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:

(a) Class 1. The costs and expenses of administration, including but not limited to the following:

- (1) The actual and necessary costs of preserving or recovering the assets of the insurer;
- (2) Compensation for all services rendered in the liquidation;
- (3) Any necessary filing fees;
- (4) The fees and mileage payable to witnesses; and
- (5) Reasonable attorney's fees.

(b) Class 2. The reasonable expenses of a guaranty fund or association, or foreign guaranty association in handling claims.

(c) Class 3. 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.

(d) Class 4. 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, 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.

(e) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(f) Class 6. Claims of the federal or 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 subsection (h).

(g) Class 7. Claims filed late or any other claims other than claims under subsections (h) and (i).

(h) 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 law.

(i) Class 9. The claims of shareholders or other owners."

SECTION 12. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated section 431:16-109 and to read as follows:

"§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 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Establish the amount and method of reimbursing members of the board of directors under section 431:16-107(c);
 - (4) 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;
 - (5) Establish regular places and times for meetings of the board of directors;
 - (6) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;
 - (7) 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;
 - (8) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner; and
 - (9) 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."

SECTION 13. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to be designated as section 431:20-115 and to read as follows:

"§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, where 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."

SECTION 15. New statutory material is underscored.¹

SECTION 16. This Act shall take effect on July 1, 1988 only if H.B. No. 410, H.D. 1, S.D. 1, C.D. 1, in any form passed by the legislature, Regular Session of 1987, becomes an Act.

(Approved July 2, 1987.)

Note

1. Edited pursuant to HRS §23G-16.5.

INSURANCE INDEX

This special index is limited to the new HRS provisions in Acts 347, 348, and 349, SLH 1987. It is constructed as a concise search aid to serve until the insurance provisions in the main index of the HRS are updated. Generally, while the word "insurance" is not used, headings and entries should be read as if it were included as a descriptive term. For example, read "commissioner" as "insurance commissioner" and "life" as "life insurance". Cross references are to main headings but only a subentry under a heading may be the applicable subject matter.

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