Cal Ins Code § 1063.1

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§ 1063.1. Definitions

As used in this article:

(a) "Member insurer" means an insurer required to be a member of the association in accordance with subdivision (a) of Section 1063, except and to the extent that the insurer is participating in an insolvency program adopted by the United States government.

(b) "Insolvent insurer" means an insurer that was a member insurer of the association, consistent with paragraph (11) of subdivision (c), either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction, or, in the case of the State Compensation Insurance Fund, if a finding of insolvency is made by a duly enacted legislative measure.

(c)

(1) "Covered claims" means the obligations of an insolvent insurer, including the obligation for unearned premiums, that satisfy all of the following requirements:

(A) Imposed by law and within the coverage of an insurance policy of the insolvent insurer.

(B) Which were unpaid by the insolvent insurer.

(C) Which are presented as a claim to the liquidator in the state of domicile of the insolvent insurer or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings.

(D) Which were incurred before the date coverage under the policy terminated and before, on, or within 30 days after the date the liquidator was appointed.

(E) For which the assets of the insolvent insurer are insufficient to discharge in full.

(F) In the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state or under the workers' compensation law of any state if the injured worker is a resident of this state and not otherwise entitled to coverage from an organization similar to the association in any other state.

(G) In the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state.

(2) "Covered claims" also includes the obligations assumed by an assuming insurer from a ceding insurer when the assuming insurer subsequently becomes an insolvent insurer if, at the time of the insolvency of the assuming insurer, the ceding insurer is no longer admitted to transact business in this state. Both the assuming insurer and the ceding insurer shall have been member insurers at the time the assumption was made. "Covered claims" under this paragraph shall satisfy the requirements of subparagraphs (A) to (G), inclusive, of paragraph (1), except for the requirement that the claims be against policies of the insolvent insurer. The association has a right to recover a deposit, bond, or other assets that may have been required to be posted by the ceding company to the extent of covered claim payments and shall be subrogated to any rights the policyholders may have against the ceding insurer.

(3) "Covered claims" does not include obligations arising from the following:

(A) Life, annuity, health, or disability insurance.

(B) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(C) Fidelity or surety insurance including fidelity or surety bonds, or any other bonding obligations.

(D) Credit insurance.

(E) Title insurance.

(F) Ocean marine insurance or ocean marine coverage under an insurance policy, including claims arising from the following: the Jones Act (46 U.S.C. Secs. 30104 and 30105), the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sec. 901 et seq.), or any other similar federal statutory enactment, or an endorsement or policy affording protection and indemnity coverage.

(G) A claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses, except a special excess workers' compensation policy issued pursuant to subdivision (c) of Section 3702.8 of the Labor Code that covers all or any part of workers' compensation liabilities of an employer that is issued, or was previously issued, a certificate of consent to self-insure pursuant to subdivision (b) of Section 3700 of the Labor Code.

(4) "Covered claims" does not include an obligation of the insolvent insurer arising out of a reinsurance contract, an obligation incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured, canceled at the insured's request, or canceled by the liquidator, or an obligation to a state or to the federal government. If the individual has a covered claim that includes medical services provided by a medical facility owned in whole or in part by a state or federal agency, the association may pay that claim directly to the facility, as long as the services provided otherwise qualify as a covered claim and the claim is owned by the medical facility asserting the claim.

(5)

(A) "Covered claims" does not include an obligation to insurers, insurance pools, or underwriting associations, nor their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

(B) An insurer, insurance pool, or underwriting association may not maintain, in its own name or in the name of its insured, a claim or legal action against the insured of the insolvent insurer for contribution, indemnity, or by way of subrogation, except insofar as, and to the extent only, that the claim exceeds the policy limits of the insolvent insurer's policy. In those claims or legal actions, the insured of the insolvent insurer is entitled to a credit or setoff in the amount of the policy limits of the insolvent insurer's policy, or in the amount of the limits remaining, when those limits have been diminished by the payment of other claims.

(6) "Covered claims," except in cases involving a claim for workers' compensation benefits or for unearned premiums, does not include a claim in an amount of one hundred dollars ($100) or less or the portion of a claim that is in excess of the applicable limits provided in the insurance policy issued by the insolvent insurer.

(7)

(A) "Covered claims" does not include that portion of a claim, other than a claim for workers' compensation benefits, that is in excess of five hundred thousand dollars ($500,000).

(B) For purposes of subparagraph (A), with respect to a policy of residential property insurance, each claim for a loss under a different coverage category shall be considered a separate covered claim.

(C) Notwithstanding subparagraph (A), a claim for damage to, or loss of, a dwelling structure under a policy of residential property insurance shall not exceed one million dollars ($1,000,000) or the amount recoverable under the policy, whichever is less.

(8) "Covered claims" does not include an amount awarded as punitive or exemplary damages, or an amount awarded by the Workers' Compensation Appeals Board pursuant to Section 5814 or 5814.5 of the Labor Code because payment of compensation was unreasonably delayed or refused by the insolvent insurer.

(9) "Covered claims" does not include either of the following:

(A) A claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured.

(B) A claim by a person other than the original claimant under the insurance policy in the claimant's own name, the claimant's assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into before insolvency, or the claimant's executor, administrator, guardian, or other personal representative or trustee in bankruptcy, and does not include a claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

(10) "Covered claims" does not include an obligation arising out of the issuance of an insurance policy written by the separate division of the State Compensation Insurance Fund pursuant to Sections 11802 and 11803.

(11) "Covered claims" does not include an obligation of the insolvent insurer arising from a policy or contract of insurance issued or renewed before the insolvent insurer's admission to transact insurance in the State of California.

(12) "Covered claims" does not include surplus deposits of subscribers as defined in Section 1374.1.

(13) "Covered claims" shall also include an obligation arising under an insurance policy written to indemnify a permissibly self-insured employer pursuant to subdivision (b) or (c) of Section 3700 of the Labor Code for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention. However, for purposes of this article, those claims shall not be considered workers' compensation claims and therefore are subject to the per-claim limit in paragraph (7), and any payments and expenses related thereto shall be allocated to category (c) for claims other than workers' compensation, homeowners', and automobile, as provided in Section 1063.5.

These provisions shall apply to obligations arising under a policy as described herein issued to a permissibly self-insured employer or group of self-insured employers pursuant to Section 3700 of the Labor Code and notwithstanding any other provision of this code, those obligations shall be governed by this provision in the event that the Self-Insurers' Security Fund is ordered to assume the liabilities of a permissibly self-insured employer or group of self-insured employers pursuant to Section 3701.5 of the Labor Code. This paragraph applies only to insurance policies written to indemnify a permissibly self-insured employer or group of self-insured employers under subdivision (b) or (c) of Section 3700 of the Labor Code, for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention, and this paragraph does not apply to special excess workers' compensation insurance policies unless issued pursuant to authority granted in subdivision (c) of Section 3702.8 of the Labor Code, and as provided for in subparagraph (G) of paragraph (3). In addition, this paragraph does not apply to a claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses as are excluded in subparagraph (G) of paragraph (3).

A permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall, to the extent required by the Labor Code, be responsible for paying, adjusting, and defending each claim arising under policies of insurance covered under this section, unless the benefits paid on a claim exceed the specific or aggregate retention, in which case:

(A) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy requires the insurer to defend and adjust the claim, the association shall be solely responsible for adjusting and defending the claim, and shall make all payments due under the claim, subject to the limitations and exclusions of this article with regard to covered claims. As to each claim subject to this paragraph, notwithstanding any other provisions of this code or the Labor Code, and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(B) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy does not require the insurer to defend and adjust the claim, the permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall not have any further payment obligations with respect to the claim, but shall

continue defending and adjusting the claim, and shall have the right, but not the obligation, in a proceeding to assert all applicable statutory limitations and exclusions as contained in this article with regard to the covered claim. CIGA shall have the right, but not the obligation, to intervene in a proceeding in which the self-insured employer, group of self-insured employers, or the Self-Insurers' Security Fund is defending a claim and shall be permitted to raise the appropriate statutory limitations and exclusions as contained in this article with respect to covered claims. Regardless of whether the self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, asserts the applicable statutory limitations and exclusions, or whether CIGA intervenes in a proceeding, CIGA shall be solely responsible for paying all benefits due on the claim, subject to the exclusions and limitations of this article with respect to covered claims. As to each claim subject to this paragraph, notwithstanding any other provision of this code or the Labor Code and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund, shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(C) In the event that the benefits paid on the covered claim exceed the per-claim limit in paragraph (7), the responsibility for paying, adjusting, and defending the claim shall be returned to the permissibly self-insured employer or group of employers, or the Self-Insurers' Security Fund.

These provisions shall apply to all pending and future insolvencies. For purposes of this paragraph, a pending insolvency is one involving a company that is currently receiving benefits from the guarantee association.

(14) "Covered claims" also includes all obligations arising under a policy issued to cover cybersecurity, as long as the association's total liability for all those obligations does not exceed one million dollars ($1,000,000) or the policy limits, whichever is less. Cybersecurity claims shall be covered by the account categorized pursuant to subparagraph (C) of paragraph (2) of subdivision (a) of Section 1063.5, unless the coverage is specifically attached to a policy that would otherwise be covered by an account categorized pursuant to subparagraph (A) or (B) of paragraph (2) of subdivision (a) of Section 1063.5.

(15) Notwithstanding any other provision in this section or Section 1063, if an insurance policy has been allocated to or assumed by a company that did not issue the policy pursuant to a state statute that provides for the division of an insurance company or the statutory assumption of designated policies by a new company, that statute provides a novation has been deemed to have occurred with respect to those policies, and that company is placed in liquidation, then to the extent a claim arising under that allocated or transferred policy would have been a covered claim had the original company been placed in liquidation before the statutory allocation or assumption, any claim arising under that same policy shall be a covered claim regardless of whether the company that allocated or assumed the policy was or was not a member at the time the policy was issued or when the insured event occurred.

(d) "Admitted to transact insurance in this state" means an insurer possessing a valid certificate of authority issued by the department.

(e) "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.

(f) "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 is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by showing that control does not in fact exist.

(g) "Claimant" means an insured making a first party claim or a person instituting a liability claim. However, no person who is an affiliate of the insolvent insurer may be a claimant.

(h) "Net direct written premiums" means the amount of direct written premiums in the annual financial statement on file with the commissioner, adjusted for any premiums written for any lines of insurance or types of coverages not covered by this article, plus premiums written in this state for coverage under a special excess workers' compensation policy.

(i) "Ocean marine insurance" includes marine insurance as defined in Section 103, except for inland marine insurance, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks, that are usually insured against by traditional marine insurance such as hull and machinery, marine builders' risks, and marine protection and indemnity. Those perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of or incident to 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, or death for loss or damage to the property of the insured or another person.

(j) "Unearned premium" means that portion of a premium as calculated by the liquidator that had not been earned because of the cancellation of the insolvent insurer's policy and is that premium remaining for the unexpired term of the insolvent insurer's policy. "Unearned premium" does not include an amount sought as return of a premium under a policy providing retroactive insurance of a known loss or return of a premium under a retrospectively rated policy or a policy subject to a contingent surcharge or a policy in which the final determination of the premium cost is computed after expiration of the policy and is calculated on the basis of actual loss experienced during the policy period.

History

Added Stats 1978 ch 507 § 2, effective August 21, 1978. Amended Stats 1979 ch 384 § 3; Stats 1981 ch 1154 § 1; Stats 1983 ch 308 § 1; Stats 1984 ch 564 § 1; Stats 1987 ch 833 § 1; Stats 1989 ch 1258 § 1; Stats 1991 ch 537 § 1 (SB 1104); Stats 1992 ch 227 § 1 (SB 1581); Stats 1994 ch 6 § 2 (AB 1667), effective February 10, 1994; Stats 1997 ch 372 § 1 (AB 1148), ch 497 § 2.5 (SB 1277); Stats 1999 ch 721 § 5 (AB 1309); Stats 2003 ch 635 § 6 (AB 227); Stats 2005 ch 395 § 1 (AB 817), effective January 1, 2006; Stats 2006 ch 740 § 4 (AB 2125), effective January 1, 2007; Stats 2007 ch 100 § 2 (SB 1038), effective January 1, 2008; Stats 2008 ch 80 § 1 (AB 3055), effective January 1, 2009 (ch 80 prevails); Ch 179 § 166, effective January 1, 2009; Stats 2009 ch 140 § 127 (AB 1164), effective January 1, 2010; Stats 2010 ch 140 § 1 (AB 2781), effective January 1, 2011 (ch 140 prevails), ch 328 § 142 (SB 1330), effective January 1, 2011; Stats 2012 ch 57 § 1 (AB 2301), effective January 1, 2013; Stats 2013 ch 76 § 135 (AB 383), effective January 1, 2014; Stats 2019 ch 833 § 2 (AB 1816), effective October 12, 2019;

Stats 2020 ch 258 § 2 (AB 3012), effective January 1, 2021; Stats 2022 ch 408 § 2 (AB 2154), effective January 1, 2023.

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