31A-1-101. Short title.

This title is known as the "Insurance Code."

Enacted by Chapter 242, 1985 General Session

31A-1-102. Purposes.

The purposes of the Insurance Code are to:

(1) ensure the solidity of insurers doing business in Utah;

(2) ensure that policyholders, claimants, and insurers are treated fairly and equitably;

(3) ensure that Utah has an adequate and healthy insurance market, characterized by competitive conditions, the spirit of innovation, and the exercise of initiative;

(4) provide for an insurance department that is expert in the field of insurance and able to enforce the Insurance Code effectively;

(5) encourage cooperation between the Insurance Department and other Utah regulatory bodies, as well as other federal and state governmental entities;

(6) preserve and improve state regulation of insurance;

(7) maintain freedom of contract and enterprise;

(8) encourage self regulation of the insurance industry;

(9) encourage loss prevention as part of the insurance industry;

(10) keep the public informed on insurance matters; and

(11) achieve other purposes stated elsewhere in the Insurance Code.

Enacted by Chapter 242, 1985 General Session

31A-1-103. Scope and applicability of title.

(1) This title does not apply to:

(a) a retainer contract made by an attorney-at-law:

(i) with an individual client; and

(ii) under which fees are based on estimates of the nature and amount of services to be provided to the specific client;

(b) a contract similar to a contract described in Subsection (1)(a) made with a group of clients involved in the same or closely related legal matters;

(c) an arrangement for providing benefits that do not exceed a limited amount of consultations, advice on simple legal matters, either alone or in combination with referral services, or the promise of fee discounts for handling other legal matters;

(d) limited legal assistance on an informal basis involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, educational, or similar relationship;

(e) legal assistance by employee organizations to their members in matters relating to employment; or

(f) death, accident, health, or disability benefits provided to a person by an organization or its affiliate if:

(i) the organization is tax exempt under Section 501(c)(3) of the Internal Revenue Code and has had its principal place of business in Utah for at least five

years;
(ii) the person is not an employee of the organization; and
(iii) (A) substantially all the person's time in the organization is spent providing voluntary services:
(I) in furtherance of the organization's purposes;
(II) for a designated period of time; and
(III) for which no compensation, other than expenses, is paid; or
(B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more than 18 months.
(2) (a) This title restricts otherwise legitimate business activity.
(b) What this title does not prohibit is permitted unless contrary to other provisions of Utah law.
(3) Except as otherwise expressly provided, this title does not apply to:
(a) those activities of an insurer where state jurisdiction is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended;
(b) ocean marine insurance;
(c) death, accident, health, or disability benefits provided by an organization if the organization:
(i) has as its principal purpose to achieve charitable, educational, social, or religious objectives rather than to provide death, accident, health, or disability benefits;
(ii) does not incur a legal obligation to pay a specified amount; and
(iii) does not create reasonable expectations of receiving a specified amount on the part of an insured person;
(d) other business specified in rules adopted by the commissioner on a finding that:
(i) the transaction of the business in this state does not require regulation for the protection of the interests of the residents of this state; or
(ii) it would be impracticable to require compliance with this title;
(e) except as provided in Subsection (4), a transaction independently procured through negotiations under Section 31A-15-104;
(f) self-insurance;
(g) reinsurance;
(h) subject to Subsection (5), employee and labor union group or blanket insurance covering risks in this state if:
(i) the policyholder exists primarily for purposes other than to procure insurance;
(ii) the policyholder:
(A) is not a resident of this state;
(B) is not a domestic corporation; or
(C) does not have its principal office in this state;
(iii) no more than 25% of the certificate holders or insureds are residents of this state;
(iv) on request of the commissioner, the insurer files with the department a copy of the policy and a copy of each form or certificate; and
(v) (A) the insurer agrees to pay premium taxes on the Utah portion of its business, as if it were authorized to do business in this state; and
(B) the insurer provides the commissioner with the security the commissioner

considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted Insurers;

(i) to the extent provided in Subsection (6):

(i) a manufacturer's or seller's warranty; and

(ii) a manufacturer's or seller's service contract;

(j) except to the extent provided in Subsection (7), a public agency insurance mutual; or

(k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a guaranteed asset protection waiver.

(4) A transaction described in Subsection (3)(e) is subject to taxation under Section 31A-3-301.

(5) (a) After a hearing, the commissioner may order an insurer of certain group or blanket contracts to transfer the Utah portion of the business otherwise exempted under Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized insurer.

(b) If the commissioner finds that the conditions required for the exemption of a group or blanket insurer are not satisfied or that adequate protection to residents of this state is not provided, the commissioner may require:

(i) the insurer to be authorized to do business in this state; or

(ii) that any of the insurer's transactions be subject to this title.

(6) (a) As used in Subsection (3)(i) and this Subsection (6):

(i) "manufacturer's or seller's service contract" means a service contract:

(A) made available by:

(I) a manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) made available:

(I) on one or more specific products; or

(II) on products that are components of a system; and

(C) under which the person described in Subsection (6)(a)(i)(A) is liable for services to be provided under the service contract including, if the manufacturer's or seller's service contract designates, providing parts and labor;

(ii) "manufacturer's or seller's warranty" means the guaranty of:

(A) (I) the manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) (I) on one or more specific products; or

(II) on products that are components of a system; and

(C) under which the person described in Subsection (6)(a)(ii)(A) is liable for services to be provided under the warranty, including, if the manufacturer's or seller's warranty designates, providing parts and labor; and

(iii) "service contract" is as defined in Section 31A-6a-101.

(b) A manufacturer's or seller's warranty may be designated as:

(i) a warranty;

(ii) a guaranty; or

(iii) a term similar to a term described in Subsection (6)(b)(i) or (ii).

(c) This title does not apply to:
(i) a manufacturer's or seller's warranty;
(ii) a manufacturer's or seller's service contract paid for with consideration that is in addition to the consideration paid for the product itself; and
(iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's or seller's service contract if:
(A) the service contract is paid for with consideration that is in addition to the consideration paid for the product itself;
(B) the service contract is for the repair or maintenance of goods;
(C) the cost of the product is equal to an amount determined in accordance with Subsection (6)(e); and
(D) the product is not a motor vehicle.
(d) This title does not apply to a manufacturer's or seller's warranty or service contract paid for with consideration that is in addition to the consideration paid for the product itself regardless of whether the manufacturer's or seller's warranty or service contract is sold:
(i) at the time of the purchase of the product; or
(ii) at a time other than the time of the purchase of the product.
(e) (i) For fiscal year 2001-02, the amount described in Subsection (6)(c)(iii)(C) shall be equal to $3,700 or less.
(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually determine whether the amount described in Subsection (6)(c)(iii)(C) should be adjusted in accordance with changes in the Consumer Price Index published by the United States Bureau of Labor Statistics selected by the commissioner by rule, between:
(A) the Consumer Price Index for the February immediately preceding the adjustment; and
(B) the Consumer Price Index for February 2001.
(iii) If under Subsection (6)(e)(ii) the commissioner determines that an adjustment should be made, the commissioner shall make the adjustment by rule.
(7) (a) For purposes of this Subsection (7), "public agency insurance mutual" means an entity formed by two or more political subdivisions or public agencies of the state:
(i) under Title 11, Chapter 13, Interlocal Cooperation Act; and
(ii) for the purpose of providing for the political subdivisions or public agencies:
(A) subject to Subsection (7)(b), insurance coverage; or
(B) risk management.
(b) Notwithstanding Subsection (7)(a)(ii)(A), a public agency insurance mutual may not provide health insurance unless the public agency insurance mutual provides the health insurance using:
(i) a third party administrator licensed under Chapter 25, Third Party Administrators;
(ii) an admitted insurer; or
(iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.
(c) Except for this Subsection (7), a public agency insurance mutual is exempt

from this title.

(d) A public agency insurance mutual is considered to be a governmental entity and political subdivision of the state with all of the rights, privileges, and immunities of a governmental entity or political subdivision of the state including all the rights and benefits of Title 63G, Chapter 7, Governmental Immunity Act of Utah.

Amended by Chapter 274, 2010 General Session

31A-1-104. Authorization to do insurance business.

A person may not engage in the following without complying with this title:

(1) do an insurance business as defined under Section 31A-1-301;

(2) act as an insurance producer or consultant as defined under Section 31A-1-301; or

(3) engage in insurance adjusting as defined under Section 31A-26-102.

Amended by Chapter 298, 2003 General Session

31A-1-105. Presumption of jurisdiction.

(1) Any insurer, including the Workers' Compensation Fund created under Chapter 33, that provides coverage of a resident of this state, property located in this state, or a business activity conducted in this state, or that engages in any activity described in Subsections 31A-15-102(2)(a) through (h), is:

(a) doing an insurance business in this state; and

(b) subject to the jurisdiction of the insurance commissioner and the courts of this state under Sections 31A-2-309 and 31A-2-310 to the extent of that coverage or activity.

(2) Any person doing or purporting to do an insurance business in this state as defined in Section 31A-1-301 is subject to the jurisdiction of the insurance commissioner and this title, unless the insurer can establish that the exemptions of Section 31A-1-103 apply.

(3) This section does not limit the jurisdiction of the courts of this state under other applicable law.

Amended by Chapter 222, 2000 General Session

31A-1-106. Residual unlicensed domestic insurers.

(1) Every person doing an insurance business in Utah not covered under another section of this title, that does not hold a valid certificate of authority or license under this title shall, by July 1, 1987, complete one of the actions prescribed in Subsections (2) through (5). This section does not apply to an unauthorized foreign insurer doing an insurance business in Utah in full compliance with Section 31A-15-103.

(2) An insurer under Subsection (1) may incorporate and apply, or if already incorporated, may apply for a certificate of authority under Chapter 5, Domestic Stock and Mutual Insurance Corporations, Chapter 7, Nonprofit Health Service Insurance Corporations, Chapter 8, Health Maintenance Organizations and Limited Health Plans, or Chapter 9, Insurance Fraternals. If the commissioner is satisfied that the insurer

substantially complies with the requirements of the appropriate chapter necessary for the protection of insureds and the public, the commissioner shall issue a certificate of authority.

(3) An insurer under Subsection (1) may transfer all its obligations to a corporation authorized under this title to assume them, according to a plan approved by the commissioner. The commissioner may disapprove the plan on a finding, after a hearing, that it is contrary to the interests of insureds, the public, or the law.

(4) An insurer under Subsection (1) may adopt a plan to run off existing obligations without accepting any new policyholders or new obligations. The commissioner may disapprove the plan on a finding, after a hearing, that it is contrary to the interests of insureds, the public, or the law.

(5) The commissioner may, by order, exempt an insurer from the requirements of Subsection (1) or extend the deadline under Subsection (1) on a finding that:

(a) incorporation, licensing, reinsurance, or run off would cause disproportionate expense, loss, or substantial hardship; and

(b) the nature of the existing and prospective business, the assets, or the business plan of the insurer can be reasonably expected to continue to operate in a sound manner and can be subjected to adequate regulatory controls.

(6) Whenever the commissioner grants an exemption under Subsection (5), the commissioner shall issue to the insurer a certificate of authority. The commissioner may amend the certificate at any time, specifying the business that the insurer may transact and specifying in detail the controls to which the insurer shall be subject. These controls shall correspond as nearly as practicable to the controls applicable to corporations transacting a like business.

(7) It is a ground for liquidation under Section 31A-27a-207 if an insurer has not completed action under one of Subsections (2) through (4) and has not applied for and been granted exemption under Subsection (5) before July 1, 1987.

Amended by Chapter 340, 2011 General Session

31A-1-107. Licensees under former Title 31.

Every holder of a license under former Title 31 at the time Title 31A takes effect shall continue to be a licensee of the Insurance Department, subject to the provisions of this title. If a licensee must make changes in its articles, bylaws, or manner of doing business to be in full compliance with this title, and the transition is not specifically provided for under this title, the licensee shall apply for, and the commissioner shall automatically grant, a reasonable, but determinate, time period to enable the licensee to conform to this title.

Amended by Chapter 204, 1986 General Session

31A-1-108. Corporations in the process of organizing.

Corporations in the process of organizing on July 1, 1986, may continue to organize under former Title 31. Any corporation so organizing that does not obtain a certificate of authority by July 1, 1987, shall make appropriate refunds and reimbursements to subscribers, incorporators, and creditors in accordance with a plan

approved by the commissioner. This plan shall specify the date that the legal existence of the corporation terminates.

Enacted by Chapter 242, 1985 General Session

31A-1-109. Name of licensee.

(1) The name of any licensee who is not a natural person may not be the same as or deceptively similar to the name of any licensee existing under the laws of the state or licensee authorized to transact business in this state.

(2) Notwithstanding Subsection (1), the department may authorize the use of a name that is deceptively similar to the name of a licensee described in Subsection (1) if the name requested is not identical with any name already on file and either:

(a) the owner of the other name consents to the use with the department; or

(b) the department is provided a certified copy of the final judgment of a court of competent jurisdiction establishing the applicant's right to use the name in this state.

Enacted by Chapter 344, 1995 General Session

31A-1-110. Scope of a license.

Unless a license is designated as limited, a license authorizes the person holding the license to transact business for all products within a line of authority.

Enacted by Chapter 298, 2003 General Session

31A-1-201. Construction.

(1) This code shall be liberally construed to achieve the purposes stated in Section 31A-1-102 and under other chapters of the Insurance Code. The statements of purpose shall aid and guide interpretation but are not independent sources of power.

(2) A provision of the Insurance Code relating to a particular kind of insurance or a particular type of insurer prevails over a provision relating to insurance or insurers in general if there is inconsistency between them.

Enacted by Chapter 242, 1985 General Session

31A-1-202. Effect of repeal of former provisions.

(1) The repeal of any statute by this title does not affect any right accrued or established, or any liability or penalty incurred under the repealed statute.

(2) An action or proceeding commenced under any law repealed by this title is not affected by the repeal. However, all procedures followed or sanctions imposed after the repeal of Title 31 shall conform to this title as far as possible.

Amended by Chapter 91, 1987 General Session

31A-1-203. Interpretive rules.

References under Section 31A-1-301 to particular sections do not limit application to those sections but merely indicate a place where a term is especially

relevant.

Enacted by Chapter 242, 1985 General Session

31A-1-205. Severability.

If any provision of this title, or the application of any provision of this title to any person or circumstance, is held invalid, the remainder of this title shall be given effect without the invalid provision or application.

Enacted by Chapter 204, 1986 General Session

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

(1) (a) "Accident and health insurance" means insurance to provide protection against economic losses resulting from:

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

(c) "Accident and health insurance" does not include workers' compensation insurance.

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection (163).

(4) "Adult" means an individual who has attained the age of at least 18 years.

(5) "Affiliate" means a person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of individuals manage the corporations.

(6) "Agency" means:

(a) a person other than an individual, including a sole proprietorship by which an individual does business under an assumed name; and

(b) an insurance organization licensed or required to be licensed under Section 31A-23a-301, 31A-25-207, or 31A-26-209.

(7) "Alien insurer" means an insurer domiciled outside the United States.

(8) "Amendment" means an endorsement to an insurance policy or certificate.

(9) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more individuals if the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life.

(10) "Application" means a document:

(a) (i) completed by an applicant to provide information about the risk to be insured; and

(ii) that contains information that is used by the insurer to evaluate risk and decide whether to:

(A) insure the risk under:

(I) the coverage as originally offered; or

(II) a modification of the coverage as originally offered; or

(B) decline to insure the risk; or

(b) used by the insurer to gather information from the applicant before issuance of an annuity contract.

(11) "Articles" or "articles of incorporation" means:

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

(h) another constitutive document for a trust or other entity that is not a corporation; and

(i) an amendment to an item listed in Subsections (11)(a) through (h).

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of a sentence imposed under Subsection 77-20-7(1), as a condition to the release of that person from confinement.

(13) "Binder" is defined in Section 31A-21-102.

(14) "Blanket insurance policy" means a group policy covering a defined class of persons:

(a) without individual underwriting or application; and

(b) that is determined by definition without designating each person covered.

(15) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

(16) "Bona fide office" means a physical office in this state:

(a) that is open to the public;

(b) that is staffed during regular business hours on regular business days; and
(c) at which the public may appear in person to obtain services.
(17) "Business entity" means:
(a) a corporation;
(b) an association;
(c) a partnership;
(d) a limited liability company;
(e) a limited liability partnership; or
(f) another legal entity.
(18) "Business of insurance" is defined in Subsection (88).
(19) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections apply by reference under:
(a) Section 31A-7-201;
(b) Section 31A-8-205; or
(c) Subsection 31A-9-205(2).
(20) (a) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated.
(b) "Bylaws" includes comparable rules for a trust or other entity that is not a corporation.
(21) "Captive insurance company" means:
(a) an insurer:
(i) owned by another organization; and
(ii) whose exclusive purpose is to insure risks of the parent organization and an affiliated company; or
(b) in the case of a group or association, an insurer:
(i) owned by the insureds; and
(ii) whose exclusive purpose is to insure risks of:
(A) a member organization;
(B) a group member; or
(C) an affiliate of:
(I) a member organization; or
(II) a group member.
(22) "Casualty insurance" means liability insurance.
(23) "Certificate" means evidence of insurance given to:
(a) an insured under a group insurance policy; or
(b) a third party.
(24) "Certificate of authority" is included within the term "license."
(25) "Claim," unless the context otherwise requires, means a request or demand on an insurer for payment of a benefit according to the terms of an insurance policy.
(26) "Claims-made coverage" means an insurance contract or provision limiting coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.
(27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.
(b) When appropriate, the terms listed in Subsection (27)(a) apply to the

equivalent supervisory official of another jurisdiction.

(28) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in this Subsection (28)(a) under an agreement effective:

(A) for the life of the insured; or

(B) for a period in excess of one year.

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as a service described in Subsection (28)(a)(ii).

(29) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (29)(a)(i) through (iii).

(b) There is no presumption that an individual holding an official position with another person controls that person solely by reason of the position.

(c) A person having a contract or arrangement giving control is considered to have control despite the illegality or invalidity of the contract or arrangement.

(d) There is a rebuttable presumption of control in a person who directly or indirectly owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting securities of another person.

(30) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

(31) "Controlling person" means a person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(32) "Controlling producer" means a producer who directly or indirectly controls an insurer.

(33) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or
(VIII) an adjuster; and
(B) under:
(I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;
(II) Chapter 25, Third Party Administrators; or
(III) Chapter 26, Insurance Adjusters; or
(ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance Holding Companies.
(b) "Stock corporation" means a stock insurance corporation.
(c) "Mutual" or "mutual corporation" means a mutual insurance corporation.
(34) (a) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.
(b) "Creditable coverage" includes coverage that is offered through a public health plan such as:
(i) the Primary Care Network Program under a Medicaid primary care network demonstration waiver obtained subject to Section 26-18-3;
(ii) the Children's Health Insurance Program under Section 26-40-106; or
(iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.
(35) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor has a disability.
(36) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.
(b) "Credit insurance" includes:
(i) credit accident and health insurance;
(ii) credit life insurance;
(iii) credit property insurance;
(iv) credit unemployment insurance;
(v) guaranteed automobile protection insurance;
(vi) involuntary unemployment insurance;
(vii) mortgage accident and health insurance;
(viii) mortgage guaranty insurance; and
(ix) mortgage life insurance.
(37) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.
(38) "Credit property insurance" means insurance:
(a) offered in connection with an extension of credit; and
(b) that protects the property until the debt is paid.
(39) "Credit unemployment insurance" means insurance:
(a) offered in connection with an extension of credit; and
(b) that provides indemnity if the debtor is unemployed for payments coming due on a:
(i) specific loan; or

(ii) credit transaction.

(40) "Creditor" means a person, including an insured, having a claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(41) (a) "Crop insurance" means insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils that is:

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

(b) "Crop insurance" includes multiperil crop insurance.

(42) (a) "Customer service representative" means a person that provides an insurance service and insurance product information:

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

(ii) to the customer service representative's employer's:

(A) customer;

(B) client; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of the customer service representative's producer, surplus lines producer, or consultant employer.

(43) "Deadline" means a final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

(b) by which a required filing or payment must be received by the department.

(44) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is considered to have taken a specific action. If the statute so provides, a condition precedent may be the commissioner's failure to take a specific action.

(45) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

(46) "Department" means the Insurance Department.

(47) "Director" means a member of the board of directors of a corporation.

(48) "Disability" means a physiological or psychological condition that partially or

totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

(ii) any occupation for which the individual is reasonably suited by education, training, or experience; or

(b) perform two or more of the following basic activities of daily living:

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(49) "Disability income insurance" is defined in Subsection (79).

(50) "Domestic insurer" means an insurer organized under the laws of this state.

(51) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

(c) in the case of an alien insurer, enters into the United States.

(52) (a) "Eligible employee" means:

(i) an employee who:

(A) works on a full-time basis; and

(B) has a normal work week of 30 or more hours; or

(ii) a person described in Subsection (52)(b).

(b) "Eligible employee" includes, if the individual is included under a health benefit plan of a small employer:

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):

(i) an individual who works on a temporary or substitute basis for a small employer;

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(53) "Employee" means an individual employed by an employer.

(54) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

(55) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through a trustee, by:

(A) one or more employers;

(B) one or more labor organizations; or

(C) a combination of employers and labor organizations; and

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of a person employed in this state.

(b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax revenues.

(56) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

(57) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

(b) if there is a waiting period, the first day of the waiting period.

(58) (a) "Escrow" means:

(i) a transaction that effects the sale, transfer, encumbering, or leasing of real property, when a person not a party to the transaction, and neither having nor acquiring an interest in the title, performs, in accordance with the written instructions or terms of the written agreement between the parties to the transaction, any of the following actions:

(A) the explanation, holding, or creation of a document; or

(B) the receipt, deposit, and disbursement of money;

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

(i) the following notarial acts performed by a notary within the state:

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

(ii) the receipt or delivery of a document; or

(iii) the receipt of money for delivery to the escrow agent.

(59) "Escrow agent" means an agency title insurance producer meeting the requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an individual title insurance producer licensed with an escrow subline of authority.

(60) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

(b) The items listed in a list using the term "excludes" are representative examples for use in interpretation of this title.

(61) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

(62) "Expense reimbursement insurance" means insurance:

(a) written to provide a payment for an expense relating to hospital confinement resulting from illness or injury; and

(b) written:
(i) as a daily limit for a specific number of days in a hospital; and
(ii) to have a one or two day waiting period following a hospitalization.
(63) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.
(64) (a) "Filed" means that a filing is:
(i) submitted to the department as required by and in accordance with applicable statute, rule, or filing order;
(ii) received by the department within the time period provided in applicable statute, rule, or filing order; and
(iii) accompanied by the appropriate fee in accordance with:
(A) Section 31A-3-103; or
(B) rule.
(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection (64)(a).
(65) "Filing," when used as a noun, means an item required to be filed with the department including:
(a) a policy;
(b) a rate;
(c) a form;
(d) a document;
(e) a plan;
(f) a manual;
(g) an application;
(h) a report;
(i) a certificate;
(j) an endorsement;
(k) an actuarial certification;
(l) a licensee annual statement;
(m) a licensee renewal application;
(n) an advertisement; or
(o) an outline of coverage.
(66) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.
(67) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.
(68) (a) "Form" means one of the following prepared for general use:
(i) a policy;
(ii) a certificate;
(iii) an application;
(iv) an outline of coverage; or
(v) an endorsement.
(b) "Form" does not include a document specially prepared for use in an individual case.
(69) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in

some way other than through the purchase of insurance.

(70) "General lines of authority" include:

(a) the general lines of insurance in Subsection (71);

(b) title insurance under one of the following sublines of authority:

(i) search, including authority to act as a title marketing representative;

(ii) escrow, including authority to act as a title marketing representative; and

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) any other line of insurance that the commissioner considers necessary to recognize in the public interest.

(71) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

(f) variable contracts, including variable life and annuity.

(72) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

(73) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

(i) to a policyholder on behalf of the group; and

(ii) for the benefit of a member of the group who is selected under a procedure defined in:

(A) the policy; or

(B) an agreement that is collateral to the policy.

(b) A group insurance policy may include a member of the policyholder's family or a dependent.

(74) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

(75) (a) Except as provided in Subsection (75)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

(iii) is offered as a substitute for hospital or medical expense insurance, such as:

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

(b) "Health benefit plan" does not include a policy or certificate that:

(i) provides benefits solely for:
(A) accident;
(B) dental;
(C) income replacement;
(D) long-term care;
(E) a Medicare supplement;
(F) a specified disease;
(G) vision; or
(H) a short-term limited duration; or
(ii) is offered and marketed as supplemental health insurance.

(76) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:
(a) a professional service;
(b) a personal service;
(c) a facility;
(d) equipment;
(e) a device;
(f) supplies; or
(g) medicine.

(77) (a) "Health care insurance" or "health insurance" means insurance providing:
(i) a health care benefit; or
(ii) payment of an incurred health care expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:
(i) replacement of income;
(ii) short-term accident;
(iii) fixed indemnity;
(iv) credit accident and health;
(v) supplements to liability;
(vi) workers' compensation;
(vii) automobile medical payment;
(viii) no-fault automobile;
(ix) equivalent self-insurance; or
(x) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

(78) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended.

(79) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

(80) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

(81) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

(82) "Independently procured insurance" means insurance procured under Section 31A-15-104.

(83) "Individual" means a natural person.

(84) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

(b) property in transit over water by means other than boat or ship;

(c) bailee liability;

(d) fixed transportation property such as bridges, electric transmission systems, radio and television transmission towers and tunnels; and

(e) personal and commercial property floaters.

(85) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as the debts and obligations mature;

(b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601(8)(c); or

(c) an insurer is determined to be hazardous under this title.

(86) (a) "Insurance" means:

(i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or

(ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

(b) "Insurance" includes:

(i) a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;

(ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and

(iii) a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk.

(87) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

(88) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance by an organization that is or is required to be licensed under this title;

(b) providing a benefit to an employee in the event of a contingency not within the control of the employee, in which the employee is entitled to the benefit as a right, which benefit may be provided either:

(i) by a single employer or by multiple employer groups; or

(ii) through one or more trusts, associations, or other entities;

(c) providing an annuity:

(i) including an annuity issued in return for a gift; and

(ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of a motor club as outlined in Subsection (116);

(e) providing another person with insurance;

(f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or surety, a contract or policy of title insurance;

(g) transacting or proposing to transact any phase of title insurance, including:

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

(v) transacting matters subsequent to the execution of the contract and arising out of the contract, including reinsurance;

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections (88)(a) through (h) in a manner designed to evade this title.

(89) "Insurance consultant" or "consultant" means a person who:

(a) advises another person about insurance needs and coverages;

(b) is compensated by the person advised on a basis not directly related to the insurance placed; and

(c) except as provided in Section 31A-23a-501, is not compensated directly or indirectly by an insurer or producer for advice given.

(90) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

(91) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) (i) "Producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that insurer.

(ii) "Producer for the insurer" may be referred to as an "agent."

(c) (i) "Producer for the insured" means a producer who:

(A) is compensated directly and only by an insurance customer or an insured; and

(B) receives no compensation directly or indirectly from an insurer for selling, soliciting, or negotiating an insurance product of that insurer to an insurance customer or insured.

(ii) "Producer for the insured" may be referred to as a "broker."

(92) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection (92)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in an insurance policy or certificate.

(93) (a) "Insurer" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;
(ii) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3);
(iii) a motor club;
(iv) an employee welfare plan; and
(v) a person purporting or intending to do an insurance business as a principal on that person's own account.
(b) "Insurer" does not include a governmental entity to the extent the governmental entity is engaged in an activity described in Section 31A-12-107.
(94) "Interinsurance exchange" is defined in Subsection (146).
(95) "Involuntary unemployment insurance" means insurance:
(a) offered in connection with an extension of credit; and
(b) that provides indemnity if the debtor is involuntarily unemployed for payments coming due on a:
(i) specific loan; or
(ii) credit transaction.
(96) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:
(a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and
(b) employs at least two employees on the first day of the plan year.
(97) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.
(98) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:
(a) on the earliest date on which coverage can become effective for the individual under the terms of the plan; or
(b) through special enrollment.
(99) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.
(b) "Legal expense insurance" includes an arrangement that creates a reasonable expectation of an enforceable right.
(c) "Legal expense insurance" does not include the provision of, or reimbursement for, legal services incidental to other insurance coverage.
(100) (a) "Liability insurance" means insurance against liability:
(i) for death, injury, or disability of a human being, or for damage to property, exclusive of the coverages under:
(A) Subsection (110) for medical malpractice insurance;
(B) Subsection (138) for professional liability insurance; and
(C) Subsection (172) for workers' compensation insurance;
(ii) for a medical, hospital, surgical, and funeral benefit to a person other than the insured who is 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 a human being, exclusive of the coverages under:
(A) Subsection (110) for medical malpractice insurance;

(B) Subsection (138) for professional liability insurance; and
(C) Subsection (172) for workers' compensation insurance;
(iii) for loss or damage to property resulting from an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;
(iv) for loss or damage to property caused by:
(A) the breakage or leakage of a sprinkler, water pipe, or water container; or
(B) water entering through a leak or opening in a building; or
(v) for other loss or damage properly the subject of insurance not within another kind of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
(b) "Liability insurance" includes:
(i) vehicle liability insurance;
(ii) residential dwelling liability insurance; and
(iii) making inspection of, and issuing a certificate of inspection upon, an elevator, boiler, machinery, or apparatus of any kind when done in connection with insurance on the elevator, boiler, machinery, or apparatus.
(101) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.
(b) "License" includes a certificate of authority issued to an insurer.
(102) (a) "Life insurance" means:
(i) insurance on a human life; and
(ii) insurance pertaining to or connected with human life.
(b) The business of life insurance includes:
(i) granting a death benefit;
(ii) granting an annuity benefit;
(iii) granting an endowment benefit;
(iv) granting an additional benefit in the event of death by accident;
(v) granting an additional benefit to safeguard the policy against lapse; and
(vi) providing an optional method of settlement of proceeds.
(103) "Limited license" means a license that:
(a) is issued for a specific product of insurance; and
(b) limits an individual or agency to transact only for that product or insurance.
(104) "Limited line credit insurance" includes the following forms of insurance:
(a) credit life;
(b) credit accident and health;
(c) credit property;
(d) credit unemployment;
(e) involuntary unemployment;
(f) mortgage life;
(g) mortgage guaranty;
(h) mortgage accident and health;
(i) guaranteed automobile protection; and
(j) another form of insurance offered in connection with an extension of credit that:
(i) is limited to partially or wholly extinguishing the credit obligation; and
(ii) the commissioner determines by rule should be designated as a form of

limited line credit insurance.

(105) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

(106) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

(k) another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

(107) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection (106); and

(b) a customer service representative.

(108) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

(109) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

(i) in a setting other than an acute care unit of a hospital;

(ii) for not less than 12 consecutive months for a covered person on the basis of:

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

(iii) for one or more necessary or medically necessary services that are:

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

(C) (I) a nonprofit health hospital; and

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections (109)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health

care insurance.

(b) "Long-term care insurance" includes:

(i) any of the following that provide directly or supplement long-term care insurance:

(A) a group or individual annuity or rider; or

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits on the basis of:

(A) cognitive impairment; or

(B) functional capacity; or

(iii) a qualified long-term care insurance contract.

(c) "Long-term care insurance" does not include:

(i) a policy that is offered primarily to provide basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) income replacement or related asset-protection coverage;

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment:

(A) if the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

(B) the coverage is for one or more the following qualifying events:

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

(110) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

(111) "Member" means a person having membership rights in an insurance corporation.

(112) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

(113) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor has a disability.

(114) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

(115) "Mortgage life insurance" means insurance on the life of a debtor in

connection with an extension of credit that pays if the debtor dies.

(116) "Motor club" means a person:

(a) licensed under:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

(b) that promises for an advance consideration to provide for a stated period of time one or more:

(i) legal services under Subsection 31A-11-102(1)(b);

(ii) bail services under Subsection 31A-11-102(1)(c); or

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections (116)(b)(iii)(A) through (D); or

(F) other services given in Subsections 31A-11-102(1)(b) through (f).

(117) "Mutual" means a mutual insurance corporation.

(118) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer, including the financing and delivery of an item paid for as medical care.

(119) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

(120) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

(b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

(c) earnings such as freight, passage money, commissions, or profits derived from transporting goods or people upon or across the oceans or inland waterways; or

(d) a vessel owner or operator as a result of liability to employees, passengers, bailors, owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in connection with maritime activity.

(121) "Order" means an order of the commissioner.

(122) "Outline of coverage" means a summary that explains an accident and health insurance policy.

(123) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

(124) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

(a) has other group health care insurance coverage; or
(b) receives:
(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965; or
(ii) another government health benefit.
(125) "Person" includes:
(a) an individual;
(b) a partnership;
(c) a corporation;
(d) an incorporated or unincorporated association;
(e) a joint stock company;
(f) a trust;
(g) a limited liability company;
(h) a reciprocal;
(i) a syndicate; or
(j) another similar entity or combination of entities acting in concert.
(126) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:
(a) an individual; or
(b) a family.
(127) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).
(128) "Plan year" means:
(a) the year that is designated as the plan year in:
(i) the plan document of a group health plan; or
(ii) a summary plan description of a group health plan;
(b) if the plan document or summary plan description does not designate a plan year or there is no plan document or summary plan description:
(i) the year used to determine deductibles or limits;
(ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis; or
(iii) the employer's taxable year if:
(A) the plan does not impose deductibles or limits on a yearly basis; and
(B) (I) the plan is not insured; or
(II) the insurance policy is not renewed on an annual basis; or
(c) in a case not described in Subsection (128)(a) or (b), the calendar year.
(129) (a) "Policy" means a document, including an attached endorsement or application that:
(i) purports to be an enforceable contract; and
(ii) memorializes in writing some or all of the terms of an insurance contract.
(b) "Policy" includes a service contract issued by:
(i) a motor club under Chapter 11, Motor Clubs;
(ii) a service contract provided under Chapter 6a, Service Contracts; and
(iii) a corporation licensed under:
(A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
(B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
(c) "Policy" does not include:

(i) a certificate under a group insurance contract; or
(ii) a document that does not purport to have legal effect.
(130) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.
(131) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.
(132) "Policy summary" means a synopsis describing the elements of a life insurance policy.
(133) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance.
(134) "Preexisting condition," with respect to a health benefit plan:
(a) means a condition that was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was recommended or received before that day; and
(b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.
(135) (a) "Premium" means the monetary consideration for an insurance policy.
(b) "Premium" includes, however designated:
(i) an assessment;
(ii) a membership fee;
(iii) a required contribution; or
(iv) monetary consideration.
(c) (i) "Premium" does not include consideration paid to a third party administrator for the third party administrator's services.
(ii) "Premium" includes an amount paid by a third party administrator to an insurer for insurance on the risks administered by the third party administrator.
(136) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).
(137) "Proceeding" includes an action or special statutory proceeding.
(138) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.
(139) (a) Except as provided in Subsection (139)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:
(i) from all hazards or causes; and
(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.
(b) "Property insurance" does not include:
(i) inland marine insurance; and
(ii) ocean marine insurance.
(140) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:
(a) an individual or group insurance contract that meets the requirements of Section 7702B(b), Internal Revenue Code; or
(b) the portion of a life insurance contract that provides long-term care

insurance:

(i) (A) by rider; or

(B) as a part of the contract; and

(ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue Code.

(141) "Qualified United States financial institution" means an institution that:

(a) is:

(i) organized under the laws of the United States or any state; or

(ii) in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(b) is regulated, supervised, and examined by a United States federal or state authority having regulatory authority over a bank or trust company; and

(c) meets the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of a financial institution whose letters of credit will be acceptable to the commissioner as determined by:

(i) the commissioner by rule; or

(ii) the Securities Valuation Office of the National Association of Insurance Commissioners.

(142) (a) "Rate" means:

(i) the cost of a given unit of insurance; or

(ii) for property or casualty insurance, that cost of insurance per exposure unit either expressed as:

(A) a single number; or

(B) a pure premium rate, adjusted before the application of individual risk variations based on loss or expense considerations to account for the treatment of:

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

(b) "Rate" does not include a minimum premium.

(143) (a) Except as provided in Subsection (143)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

(i) collecting, compiling, and furnishing loss or expense statistics;

(ii) recommending, making, or filing rates or supplementary rate information; or

(iii) advising about rate questions, except as an attorney giving legal advice.

(b) "Rate service organization" does not mean:

(i) an employee of an insurer;

(ii) a single insurer or group of insurers under common control;

(iii) a joint underwriting group; or

(iv) an individual serving as an actuarial or legal consultant.

(144) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

(d) a rating formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

(145) "Received by the department" means:
(a) the date delivered to and stamped received by the department, if delivered in person;
(b) the post mark date, if delivered by mail;
(c) the delivery service's post mark or pickup date, if delivered by a delivery service;
(d) the received date recorded on an item delivered, if delivered by:
(i) facsimile;
(ii) email; or
(iii) another electronic method; or
(e) a date specified in:
(i) a statute;
(ii) a rule; or
(iii) an order.
(146) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:
(a) operating through an attorney-in-fact common to all of the persons; and
(b) exchanging insurance contracts with one another that provide insurance coverage on each other.
(147) "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 title sometimes refers to:
(a) the insurer transferring the risk as the "ceding insurer"; and
(b) the insurer assuming the risk as the:
(i) "assuming insurer"; or
(ii) "assuming reinsurer."
(148) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.
(149) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.
(150) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.
(b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a liability assumed under a reinsurance contract.
(151) "Rider" means an endorsement to:
(a) an insurance policy; or
(b) an insurance certificate.
(152) (a) "Security" means a:
(i) note;
(ii) stock;
(iii) bond;
(iv) debenture;
(v) evidence of indebtedness;
(vi) certificate of interest or participation in a profit-sharing agreement;
(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;
(ix) transferable share;
(x) investment contract;
(xi) voting trust certificate;
(xii) certificate of deposit for a security;
(xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;
(xiv) commodity contract or commodity option;
(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections (152)(a)(i) through (xiv); or
(xvi) another interest or instrument commonly known as a security.
(b) "Security" does not include:
(i) any of the following under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period:
(A) insurance;
(B) an endowment policy; or
(C) an annuity contract; or
(ii) a burial certificate or burial contract.
(153) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.
(154) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.
(b) Except as provided in this Subsection (154), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.
(c) "Self-insurance" includes:
(i) an arrangement by which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and
(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk that is related to the relationship or employment.
(d) "Self-insurance" does not include an arrangement with an independent contractor.
(155) "Sell" means to exchange a contract of insurance:
(a) by any means;
(b) for money or its equivalent; and
(c) on behalf of an insurance company.
(156) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.
(157) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.
(158) "Small employer," in connection with a health benefit plan, means an

employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(159) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

(160) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

(b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting shares are owned by that person either alone or with its affiliates, except for the minimum number of shares the law of the subsidiary's domicile requires to be owned by directors or others.

(161) Subject to Subsection (86)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from the failure of a principal to pay or perform the principal's obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

(162) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of an insurer or organization that is designated by the insurer or organization as permanent.

(ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require that insurers or organizations doing business in this state maintain specified minimum levels of permanent surplus.

(iii) Except for assessable mutuals, the minimum permanent surplus requirement is the same as the minimum required capital requirement that applies to stock insurers.

(c) "Excess surplus" means:

(i) for a life insurer, accident and health insurer, health organization, or property and casualty insurer as defined in Section 31A-17-601, the lesser of:

(A) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 2.5; and

(II) the sum of the insurer's or health organization's minimum capital or permanent surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

(B) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 3.0; and

(II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

(ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

(A) 1.5; and

(B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

(163) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

(i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;

(ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

(iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under the following, but only for a line of insurance for which the insurer holds a license in this state:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

(iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; or

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt; or

(f) an institution, bank, or financial institution:

(i) that is:

(A) an institution whose deposits and accounts are to any extent insured by a federal deposit insurance agency, including the Federal Deposit Insurance Corporation or National Credit Union Administration; or

(B) a bank or other financial institution that is subject to supervision or examination by a federal or state banking authority; and

(ii) that does not adjust claims without a third party administrator license.

(164) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

(165) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

(a) the statutory accounting applicable to the annual financial statements required to be filed under Section 31A-4-113; and

(b) another item provided by the RBC instructions, as RBC instructions is defined in Section 31A-17-601.

(166) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

(b) "Trustee," when used in reference to an employee welfare fund, means an individual, firm, association, organization, joint stock company, or corporation, whether acting individually or jointly and whether designated by that name or any other, that is charged with or has the overall management of an employee welfare fund.

(167) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

(i) not holding a valid certificate of authority to do an insurance business in this state; or

(ii) transacting business not authorized by a valid certificate.

(b) "Admitted insurer" or "authorized insurer" means an insurer:

(i) holding a valid certificate of authority to do an insurance business in this state; and

(ii) transacting business as authorized by a valid certificate.

(168) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

(169) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection (139).

(170) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

(171) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

(172) "Workers' compensation insurance" means:

(a) insurance for indemnification of an employer against liability for compensation based on:

(i) a compensable accidental injury; and

(ii) occupational disease disability;

(b) employer's liability insurance incidental to workers' compensation insurance and written in connection with workers' compensation insurance; and

(c) insurance assuring to a person entitled to workers' compensation benefits the compensation provided by law.

Amended by Chapter 319, 2013 General Session

31A-2-101. General duties.

The Insurance Department shall administer the Insurance Code, seeking to achieve the purposes in Section 31A-1-102, and shall perform other duties imposed by law.

Enacted by Chapter 242, 1985 General Session

31A-2-102. Appointment, general powers, and duties of commissioner -- Vacancy -- Compensation of commissioner.

(1) The chief officer of the department is the insurance commissioner, who may exercise all powers given to, and shall perform all duties imposed on, the Insurance Department. He shall be appointed by the governor with the consent of the Senate. If the commissioner dies, resigns, or is removed, a successor may be appointed as specified in this subsection. If the Legislature is not then in session, the successor may serve as acting commissioner without consent until the Senate has an opportunity to consent to the successor. The commissioner is subject to removal at the pleasure of the governor.

(2) When the office of the commissioner is vacant, or when the commissioner is unable to perform the duties of the office, the governor shall fill the position as provided in Section 67-1-1.5.

(3) The governor shall establish the commissioner's salary within the salary range approved by the Legislature in Title 67, Chapter 22, State Officer Compensation.

Amended by Chapter 176, 2002 General Session

31A-2-103. Commissioner's appointees.

(1) The commissioner may appoint up to three persons to assist the commissioner. The commissioner may designate a person appointed under this section as a "deputy," "administrative assistant," "secretary," or any other title chosen by the commissioner.

(2) Persons appointed under this section are exempt from career service status under Section 67-19-15 and serve at the pleasure of the commissioner.

Amended by Chapter 128, 1994 General Session

31A-2-104. Other employees -- Insurance fraud investigators.

(1) The department shall employ a chief examiner and such other professional, technical, and clerical employees as necessary to carry out the duties of the department.

(2) An insurance fraud investigator employed pursuant to Subsection (1) may be designated a special function officer, as defined in Section 53-13-105, by the commissioner, but is not eligible for retirement benefits under the Public Safety Employee's Retirement System.

Amended by Chapter 21, 1999 General Session

31A-2-105. Constitutional oath.

Before entering upon the duties of his office, the commissioner shall take, subscribe, and file the constitutional oath. If the commissioner takes action in his office before complying with this section, in good faith and without knowledge of this requirement, and the validity of his action is then challenged, that person may take the oath after the action and the oath shall be given retroactive effect to the date on which he began his duties.

Amended by Chapter 305, 1993 General Session

31A-2-106. Ethical requirements for Insurance Department staff.

(1) No employee of the Insurance Department, including the commissioner, may:

(a) make any solicitation for any partisan political purpose or for anything that is not related to the public interest, as it is affected by insurance; or

(b) continue or initiate a monetary relationship, except as policyholder, with an insurance agency or brokerage firm, insurance service organization, insurance adjuster, insurer or person affiliated with an insurer, except that:

(i) a commissioner may receive renewal commissions or other deferred compensation earned before his appointment if this commission or compensation does not require him to personally perform further service;

(ii) a commissioner may continue to be obligated under the terms of a mortgage entered into prior to his appointment; and

(iii) a commissioner may continue to have the beneficial interest in or own stock in an insurer, noninsurance company with insurance subsidiaries, insurance agency, brokerage firm, or insurance service organization acquired before appointment if the commissioner's ownership or interest is not of such total value that the commissioner might receive a substantial monetary benefit by failing to act impartially towards the organization. A partnership interest shall be treated as if it were shares in a corporation.

(2) If the commissioner has any beneficial interest or ownership in an organization outlined under Subsection (1)(b)(iii), or if it is known to the commissioner that his spouse, parent, sibling, or child has an interest in any organization that, if held by the commissioner, would disqualify him from serving as commissioner, he shall disqualify himself from all actions respecting the particular organization. The commissioner shall then delegate a senior staff member who is not also disqualified to act in his place with regard to that organization. There is a rebuttable presumption that the commissioner or the delegate service staff member knows of any disqualifying holdings. The commissioner shall report a disqualification in each annual report to the governor as long as the disqualification continues.

(3) The commissioner shall give the governor at least 10 days written notice of any solicitation to be made by the commissioner or other member of the department staff.

(4) In addition to any other penalty, an employee violating this section may be removed from office.

Amended by Chapter 91, 1987 General Session

31A-2-108. Legal services.

(1) Except as provided in Subsection (4), the commissioner shall call upon the attorney general for the legal counsel and assistance necessary to enforce this title. Upon the commissioner's request, or upon the attorney general's own initiative, the attorney general may hire special legal counsel under Section 67-5-5 to represent the department.

(2) Upon the commissioner's request, or upon the commissioner's own initiative, the attorney general may aid in any investigation, hearing, or other procedure under this

title and may institute, prosecute, and defend proceedings relating to the enforcement or interpretation of this title, including any proceeding to which the state, or the commissioner or any employee of the department in an official capacity, is a party or is interested.

(3) The commissioner may refer such evidence as is available concerning violations of this title or of any rule or order under this title to the proper county attorney or district attorney, who may, with or without this reference, institute the appropriate criminal proceedings.

(4) For proceedings authorized by Chapter 27a, Insurer Receivership Act, the commissioner may employ on a contract basis legal counsel other than the attorney general, with the fees, costs, and expenses of the counsel and the attorney general being a class one administrative expense under Section 31A-27a-701.

Amended by Chapter 309, 2007 General Session

31A-2-109. Outside consultants.

The department may employ outside consultants on a contract or part-time basis to perform any professional service needed by the department which cannot be performed by regular employees of the department.

Enacted by Chapter 242, 1985 General Session

31A-2-110. Official seal and signature.

(1) Any statutory or common-law requirement that an official seal be affixed is satisfied by the signature of the commissioner. However, the commissioner may adopt and use a seal bearing the words "Commissioner of Insurance for Utah," an impression of which shall be filed with the Division of Archives.

(2) Any signature of the commissioner may be in facsimile unless specifically required to be handwritten.

Amended by Chapter 204, 1986 General Session

31A-2-111. Delegation.

(1) Any power, duty, or function vested in the commissioner by law may be exercised, discharged, or performed by an employee of the Insurance Department acting in the commissioner's name and under his delegated authority.

(2) Any person whose own course of action depends in good faith upon proof of the validity of an alleged delegation is not obligated to act until shown a written delegation of the commissioner with the signature of the commissioner or deputy commissioner.

Enacted by Chapter 242, 1985 General Session

31A-2-112. Advisory councils and committees.

The commissioner may create advisory councils and committees to assist him. He may appoint members and provide by rule for the creation, governance, duties, and

termination of any council or committee established.

Enacted by Chapter 242, 1985 General Session

31A-2-113. Supporting services.

(1) The Department of Administrative Services shall provide suitable offices for the Insurance Department:

(a) in Salt Lake City; and

(b) elsewhere, if approved by the governor as necessary for the efficient operation of the department.

(2) The commissioner shall, in accordance with the rules of the Department of Administrative Services or other applicable laws, procure or obtain access to all materials, supplies, and equipment necessary for the efficient operation of the Insurance Department, including reasonable library facilities and books.

Enacted by Chapter 242, 1985 General Session

31A-2-201. General duties and powers.

(1) The commissioner shall administer and enforce this title.

(2) The commissioner has all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to perform the duties imposed by this title.

(3) (a) The commissioner may make rules to implement the provisions of this title according to the procedures and requirements of Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) In addition to the notice requirements of Section 63G-3-301, the commissioner shall provide notice under Section 31A-2-303 of hearings concerning insurance department rules.

(4) (a) The commissioner shall issue prohibitory, mandatory, and other orders as necessary to secure compliance with this title. An order by the commissioner is not effective unless the order:

(i) is in writing; and

(ii) is signed by the commissioner or under the commissioner's authority.

(b) On request of any person who would be affected by an order under Subsection (4)(a), the commissioner may issue a declaratory order to clarify the person's rights or duties.

(5) (a) The commissioner may hold informal adjudicative proceedings and public meetings, for the purpose of:

(i) investigation;

(ii) ascertainment of public sentiment; or

(iii) informing the public.

(b) An effective rule or order may not result from informal hearings and meetings unless the requirement of a hearing under this section is satisfied.

(6) The commissioner shall inquire into violations of this title and may conduct any examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, that the commissioner considers proper to

determine:
(a) whether or not any person has violated any provision of this title; or
(b) to secure information useful in the lawful administration of this title.

Amended by Chapter 68, 2010 General Session

31A-2-201.1. General filing requirements.

Except as otherwise provided in this title, the commissioner may set by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific requirements for filing any of the following required by this title:
(1) a form;
(2) a rate; or
(3) a report.

Amended by Chapter 382, 2008 General Session

31A-2-201.2. Evaluation of health insurance market.

(1) Each year the commissioner shall:
(a) conduct an evaluation of the state's health insurance market;
(b) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1 of each year; and
(c) publish the findings of the evaluation on the department website.
(2) The evaluation required by this section shall:
(a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:
(i) the availability and marketing of individual and group products;
(ii) rate changes;
(iii) coverage and demographic changes;
(iv) benefit trends;
(v) market share changes; and
(vi) accessibility;
(b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;
(c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and
(d) include claims loss ratio data for each health insurance company doing business in the state.
(3) When preparing the evaluation required by this section, the commissioner shall include a report of:
(a) the types of health benefit plans sold in the Health Insurance Exchange created in Section 63M-1-2504;
(b) the number of insurers participating in the defined contribution arrangement health benefit plans in the Health Insurance Exchange; and
(c) the number of employers and covered lives in the defined contribution

arrangement market in the Health Insurance Exchange.

(4) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

(5) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section, taking into account the business confidentiality of the insurers.

(6) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 319, 2013 General Session

31A-2-202. Reports and replies.

(1) When relevant, either directly or indirectly, to the performance of the commissioner's duties under this title, the commissioner may require from any person subject to regulation under this title:

(a) in whatever reasonable form and reasonable intervals the commissioner designates:

(i) a statement;

(ii) a report;

(iii) an answer to a questionnaire;

(iv) other information; and

(v) evidence of the information described in Subsections (1)(a)(i) through (iv);

(b) full explanation of the programming of any data storage or communication system in use;

(c) information from books, records, electronic data processing systems, computers, or any other information storage system be made available to the department:

(i) at any reasonable time; and

(ii) in any reasonable manner; and

(d) timely delivery to the National Association of Insurance Commissioners or other entity that gathers insurance industry information, a copy of the statistical data prepared for and submitted to the department, as specified by the commissioner.

(2) (a) Subject to the requirements of this Subsection (2), the commissioner may:

(i) prescribe forms for the information under Subsection (1); and

(ii) specify who shall execute or certify the information under Subsection (1).

(b) The forms prescribed under this Subsection (2) shall be consistent, to the extent practicable, with those prescribed by other jurisdictions.

(c) The commissioner shall use the annual statement forms developed by the National Association of Insurance Commissioners for:

(i) basic financial data; and

(ii) market regulation analysis.

(3) (a) Subject to the requirements of this Subsection (3), the commissioner may prescribe reasonable minimum standards and techniques of accounting and data

handling to ensure that timely and reliable information exists and can be made available.

(b) The standards and techniques prescribed under this Subsection (3) shall be consistent, to the extent practicable, with those prescribed by other states.

(4) (a) A person listed in Subsection (4)(b) shall reply promptly in writing or in other designated form to a reasonable written inquiry from the commissioner.

(b) This Subsection (4) applies to any person with executive authority over or in charge of any segment of the affairs of:

(i) an insurer authorized to do or doing an insurance business in this state;

(ii) the affiliate of an insurer authorized to do or doing an insurance business in this state; and

(iii) any other person licensed under this title.

(5) The commissioner may:

(a) require that any communication made under this section be verified; and

(b) specify by whom a communication shall be verified.

(6) All information submitted to the commissioner shall be accurate and complete.

(7) In the absence of actual malice, no communication to the commissioner required by law or by the commissioner subjects the person making it to an action for damages for defamation.

Amended by Chapter 177, 2006 General Session

31A-2-203. Examinations and alternatives.

(1) (a) When the commissioner determines that information is needed about a matter related to the enforcement of this title, the commissioner may examine the affairs and condition of:

(i) a licensee under this title;

(ii) an applicant for a license under this title;

(iii) a person or organization of persons doing or in process of organizing to do an insurance business in this state; or

(iv) a person who is not, but is required to be, licensed under this title.

(b) When reasonably necessary for an examination under Subsection (1)(a), the commissioner may examine:

(i) so far as it relates to the examinee, an account, record, document, or evidence of a transaction of:

(A) the insurer or other licensee;

(B) an officer or other person who has executive authority over or is in charge of any segment of the examinee's affairs; or

(C) an affiliate of the examinee; or

(ii) a third party model or product used by the examinee.

(c) (i) On demand, an examinee under Subsection (1)(a) shall make available to the commissioner for examination:

(A) the examinee's own account, record, file, document, or evidence of a transaction; and

(B) to the extent reasonably necessary for an examination, an account, record,

file, document, or evidence of a transaction of a person described under Subsection (1)(b).

(ii) Except as provided in Subsection (1)(c)(iii), failure to make an item described in Subsection (1)(c)(i) available is concealment of records under Subsection 31A-27a-207(1)(e).

(iii) If an examinee is unable to obtain an account, record, file, document, or evidence of a transaction from a person described under Subsection (1)(b), that failure is not concealment of records if the examinee immediately terminates the relationship with the other person.

(d) (i) The commissioner or an examiner may not remove an account, record, file, document, evidence of a transaction, or other property of an examinee from the examinee's offices unless:

(A) the examinee consents in writing; or

(B) a court grants permission.

(ii) The commissioner may make and remove a copy or abstract of the following described in Subsection (1)(d)(i):

(A) an account;

(B) a record;

(C) a file;

(D) a document;

(E) evidence of a transaction; or

(F) other property.

(2) (a) Subject to the other provisions of this section, the commissioner shall examine as needed and as otherwise provided by law:

(i) every insurer, both domestic and nondomestic;

(ii) every licensed rate service organization; and

(iii) any other licensee.

(b) The commissioner shall examine an insurer, both domestic and nondomestic, no less frequently than once every five years, but the commissioner may use in lieu an examination under Subsection (4) to satisfy this requirement.

(c) The commissioner shall revoke the certificate of authority of an insurer or the license of a rate service organization that has not been examined, or submitted an acceptable in lieu report under Subsection (4), within the past five years.

(d) (i) Any 25 persons who are policyholders, shareholders, or creditors of a domestic insurer may by verified petition demand a hearing under Section 31A-2-301 to determine whether the commissioner should conduct an unscheduled examination of the insurer.

(ii) Persons demanding the hearing under this Subsection (2)(d) shall be given an opportunity in the hearing to present evidence that an examination of the insurer is necessary.

(iii) If the evidence justifies an examination, the commissioner shall order an examination.

(e) (i) If the board of directors of a domestic insurer requests that the commissioner examine the insurer, the commissioner shall examine the insurer as soon as reasonably possible.

(ii) If the examination requested under this Subsection (2)(e) is conducted within

two years after completion of a comprehensive examination by the commissioner, costs of the requested examination may not be deducted from premium taxes under Section 59-9-102 unless the commissioner's order specifically provides for the deduction.

(f) A bail bond surety company, as defined in Section 31A-35-102, is exempt from:

(i) the five-year examination requirement in Subsection (2)(b);

(ii) the revocation under Subsection (2)(c); and

(iii) Subsections (2)(d) and (2)(e).

(3) (a) The commissioner may order an independent audit or examination by one or more technical experts, including a certified public accountant or actuary:

(i) in lieu of all or part of an examination under Subsection (1) or (2); or

(ii) in addition to an examination under Subsection (1) or (2).

(b) An audit or evaluation under this Subsection (3) is subject to Subsection (5), Section 31A-2-204, and Subsection 31A-2-205(4).

(4) (a) In lieu of all or a part of an examination under this section, the commissioner may accept the report of an examination made by:

(i) the insurance department of another state; or

(ii) another government agency in:

(A) this state;

(B) the federal government; or

(C) another state.

(b) An examination by the commissioner under Subsection (1) or (2) or accepted by the commissioner under this Subsection (4) may use:

(i) an audit completed by a certified public accountant; or

(ii) an actuarial evaluation made by an actuary approved by the commissioner.

(5) (a) An examination may be comprehensive or limited with respect to the examinee's affairs and condition. The commissioner shall determine the nature and scope of an examination, taking into account all relevant factors, including:

(i) the length of time the examinee has been licensed in this state;

(ii) the nature of the business being examined;

(iii) the nature of the accounting or other records available;

(iv) one or more reports from:

(A) independent auditors; and

(B) self-certification entities; and

(v) the nature of examinations performed elsewhere.

(b) The examination of an alien insurer is limited to one or more insurance transactions and assets in the United States, unless the commissioner orders otherwise after finding that extraordinary circumstances necessitate a broader examination.

(6) To effectively administer this section, the commissioner:

(a) shall:

(i) maintain one or more effective financial condition and market regulation surveillance systems including:

(A) financial and market analysis; and

(B) a review of insurance regulatory information system reports;

(ii) employ a priority scheduling method that focuses on insurers and other licensees most in need of examination; and

(iii) use examination management techniques similar to those outlined in the Financial Condition Examination Handbook of the National Association of Insurance Commissioners; and

(b) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, may make rules pertaining to:

(i) a financial condition and market regulation surveillance system; and

(ii) annual financial reporting requirements similar to those outlined in the Annual Financial Reporting Model Regulation of the National Association of Insurance Commissioners.

Amended by Chapter 349, 2009 General Session

31A-2-203.5. Procedures -- Adjudicative proceedings.

The commissioner of insurance shall comply with the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act, in its adjudicative proceedings.

Amended by Chapter 382, 2008 General Session

31A-2-204. Conducting examinations.

(1) (a) For each examination under Section 31A-2-203, the commissioner shall issue an order:

(i) stating the scope of the examination; and

(ii) designating the examiner in charge.

(b) The commissioner need not give advance notice of an examination to an examinee.

(c) The examiner in charge shall give the examinee a copy of the order issued under this Subsection (1).

(d) (i) The commissioner may alter the scope or nature of an examination at any time without advance notice to the examinee.

(ii) If the commissioner amends an order described in this Subsection (1), the commissioner shall provide a copy of any amended order to the examinee.

(e) Statements in the commissioner's examination order concerning examination scope are for the examiner's guidance only.

(f) Examining relevant matters not mentioned in an order issued under this Subsection (1) is not a violation of this title.

(2) The commissioner shall, whenever practicable, cooperate with the insurance regulators of other states by conducting joint examinations of:

(a) multistate insurers doing business in this state; or

(b) other multistate licensees doing business in this state.

(3) An examiner authorized by the commissioner shall, when necessary to the purposes of the examination, have access at all reasonable hours to the premises and to any books, records, files, securities, documents, or property of:

(a) the examinee; and

(b) any of the following if the premises, books, records, files, securities, documents, or property relate to the affairs of the examinee:

(i) an officer of the examinee;
(ii) any other person who:
(A) has executive authority over the examinee; or
(B) is in charge of any segment of the examinee's affairs; or
(iii) any affiliate of the examinee under Subsection 31A-2-203(1)(b).
(4) (a) The officers, employees, and agents of the examinee and of persons under Subsection 31A-2-203(1)(b) shall comply with every reasonable request of the examiners for assistance in any matter relating to the examination.
(b) A person may not obstruct or interfere with the examination except by legal process.
(5) If the commissioner finds the accounts or records to be inadequate for proper examination of the condition and affairs of the examinee or improperly kept or posted, the commissioner may employ experts to rewrite, post, or balance the accounts or records at the expense of the examinee.
(6) (a) The examiner in charge of an examination shall make a report of the examination no later than 60 days after the completion of the examination that shall include:
(i) the information and analysis ordered under Subsection (1); and
(ii) the examiner's recommendations.
(b) At the option of the examiner in charge, preparation of the report may include conferences with the examinee or representatives of the examinee.
(c) The report is confidential until the report becomes a public document under Subsection (7), except the commissioner may use information from the report as a basis for action under Chapter 27a, Insurer Receivership Act.
(7) (a) The commissioner shall serve a copy of the examination report described in Subsection (6) upon the examinee.
(b) Within 20 days after service, the examinee shall:
(i) accept the examination report as written; or
(ii) request agency action to modify the examination report.
(c) The report is considered accepted under this Subsection (7) if the examinee does not file a request for agency action to modify the report within 20 days after service of the report.
(d) If the examination report is accepted:
(i) the examination report immediately becomes a public document; and
(ii) the commissioner shall distribute the examination report to all jurisdictions in which the examinee is authorized to do business.
(e) (i) Any adjudicative proceeding held as a result of the examinee's request for agency action shall, upon the examinee's demand, be closed to the public, except that the commissioner need not exclude any participating examiner from this closed hearing.
(ii) Within 20 days after the hearing held under this Subsection (7)(e), the commissioner shall:
(A) adopt the examination report with any necessary modifications; and
(B) serve a copy of the adopted report upon the examinee.
(iii) Unless the examinee seeks judicial relief, the adopted examination report:
(A) shall become a public document 10 days after service; and
(B) may be distributed as described in this section.

(f) Notwithstanding Title 63G, Chapter 4, Administrative Procedures Act, to the extent that this section is in conflict with Title 63G, Chapter 4, Administrative Procedures Act, this section governs:

(i) a request for agency action under this section; or

(ii) adjudicative proceeding under this section.

(8) The examinee shall promptly furnish copies of the adopted examination report described in Subsection (7) to each member of the examinee's board.

(9) After an examination report becomes a public document under Subsection (7), the commissioner may furnish, without cost or at a reasonable price set under Section 31A-3-103, a copy of the examination report to interested persons, including:

(a) a member of the board of the examinee; or

(b) one or more newspapers in this state.

(10) (a) In a proceeding by or against the examinee, or any officer or agent of the examinee, the examination report as adopted by the commissioner is admissible as evidence of the facts stated in the report.

(b) In any proceeding commenced under Chapter 27a, Insurer Receivership Act, the examination report, whether adopted by the commissioner or not, is admissible as evidence of the facts stated in the examination report.

Amended by Chapter 382, 2008 General Session

31A-2-205. Examination costs.

(1) (a) Except as provided in Subsection (3), an examinee that is one of the following shall reimburse the department for the reasonable costs of examinations made under Sections 31A-2-203 and 31A-2-204:

(i) an insurer;

(ii) a rate service organization;

(iii) a subsidiary of an insurer or rate service organization; or

(iv) a life settlement provider.

(b) The following costs shall be reimbursed under this Subsection (1):

(i) actual travel expenses;

(ii) reasonable living expense allowance;

(iii) compensation at reasonable rates for all professionals reasonably employed for the examination under Subsection (4);

(iv) the administration and supervisory expense of:

(A) the department; and

(B) the attorney general's office; and

(v) an amount necessary to cover fringe benefits authorized by the commissioner or provided by law.

(c) In determining rates, the commissioner shall consider the rates recommended and outlined in the examination manual sponsored by the National Association of Insurance Commissioners.

(d) This Subsection (1) applies to a surplus lines producer to the extent that the examinations are of the surplus line producer's surplus lines business.

(2) An insurer requesting the examination of one of its producers shall pay the cost of the examination. Otherwise, the department shall pay the cost of examining a

licensee other than those specified under Subsection (1).

(3) (a) On the examinee's request or at the commissioner's discretion, the department may pay all or part of the costs of an examination whenever the commissioner finds that because of the frequency of examinations or the financial condition of the examinee, imposition of the costs would place an unreasonable burden on the examinee.

(b) The commissioner shall include in the commissioner's annual report information about any instance in which the commissioner has applied this Subsection (3).

(4) (a) A technical expert employed under Subsection 31A-2-203(3) shall present to the commissioner a statement of all expenses incurred by the technical expert in conjunction with an examination.

(b) The examined insurer shall, at the commissioner's direction, pay to a technical expert:

(i) (A) actual travel expenses;

(B) reasonable living expenses; and

(C) compensation; and

(ii) for expenses necessarily incurred as approved by the commissioner.

(c) The examined insurer shall reimburse the department for:

(i) a department examiner's:

(A) actual travel expenses; and

(B) reasonable living expenses; and

(ii) the compensation of department examiners involved in the examination.

(d) (i) The examined insurer shall certify the consolidated account of all charges and expenses for the examination.

(ii) The examined insurer shall:

(A) retain a copy of the consolidated account; and

(B) file a copy of the consolidated account with the department as a public record.

(e) An annual report of examination charges paid by examined insurers directly to persons employed under Subsection 31A-2-203(3) or to department examiners shall be included with the department's budget request.

(f) Amounts paid directly by examined insurers to persons employed under Subsection 31A-2-203(3) or to department examiners may not be deducted from the department's appropriation.

(5) (a) The amount payable under Subsection (1) is due 10 days after the day on which the examinee is served with a detailed account of the costs.

(b) Payments received by the department under this Subsection (5) shall be handled as provided by Section 31A-3-101.

(6) (a) The commissioner may require an examinee under Subsection (1), or an insurer requesting an examination under Subsection (2), either before or during an examination, to make deposits with the state treasurer to pay the costs of examination.

(b) Any deposit made under this Subsection (6) shall be held in trust by the state treasurer until applied to pay the department the costs payable under this section.

(c) If a deposit made under this Subsection (6) exceeds examination costs, the state treasurer shall refund the surplus.

(7) A domestic insurer may offset the examination expenses paid under this section against premium taxes under Subsection 59-9-102(2).

Amended by Chapter 355, 2009 General Session

31A-2-206. Receipt and handling of deposits.

(1) As used in this chapter:

(a) "Custodian institution" means a financial institution in this state as defined under Section 7-1-103 that:

(i) has authority under Title 7, Chapter 5, Trust Business, to engage in a trust business; and

(ii) is approved by the commissioner to have custody of deposited securities, whether physically, through the Federal Reserve book-entry system, or through a clearing corporation as defined under Subsection 70A-8-101(1).

(b) "Federal Reserve book-entry system" means the computerized system sponsored by the United States Department of the Treasury and certain other agencies and instrumentalities of the United States for holding and transferring securities of the United States government and other agencies and instrumentalities.

(2) Subject to the commissioner's approval and to the requirements of this section, the state treasurer shall accept, and a custodian institution qualified under Subsection (1)(a) may accept:

(a) deposits required or permitted under this title or rules adopted under this title;

(b) deposits of domestic insurers or of alien insurers domiciled in this state if required by the laws of other states as a prerequisite to authority to do an insurance business in other states; and

(c) deposits resulting from application of any retaliatory provisions of this title.

(3) Deposits authorized under Subsection (2) shall be of securities described in Subsection (7).

(4) Unless otherwise provided by the law requiring or permitting the deposit, each deposit shall be held in trust:

(a) first, for administrative costs under Subsection 31A-27a-701(2)(a);

(b) second, for the claimants under Subsection 31A-27a-701(2)(c);

(c) third, for the claimants under Subsection 31A-27a-701(2)(d); and

(d) fourth, for all other creditors in the order of priority established under Section 31A-27a-701.

(5) A claim may be made against the deposit of an alien insurer only if it arises out of a transaction in the United States.

(6) Deposits may be made by:

(a) delivering physical custody and control of the deposited security to the state treasurer or a custodian institution, accompanied by a statement signed by the depositor indicating that the deposit shall be held in trust under the terms of this section and subject to the commissioner's exclusive direction until control is released by the commissioner; or

(b) delivering to the commissioner, on a form adopted by rule, a signed certificate of a custodian institution, describing securities qualifying for deposit under Subsection (7) that are on deposit with a clearing corporation or held in the Federal

Reserve book-entry system in the name of the custodian institution, in trust for the purposes stated under this section, and that these securities are subject to the exclusive direction of the commissioner and may not be withdrawn or transferred by any person, including the insurer owning the securities, without the commissioner's written approval.

(7) (a) Deposits may consist of any securities authorized in Subsection (7)(b) for which there is a ready market if they:

(i) are expressly approved by the commissioner;

(ii) are subject to disposition by the state treasurer or custodian institution only with the concurrence of the commissioner; and

(iii) are not available to any other person except as expressly provided by law.

(b) The authorized securities are:

(i) deposits or certificates of deposit insured by the Federal Deposit Insurance Corporation;

(ii) bonds or other evidences of indebtedness that are guaranteed as to principal and interest by the United States;

(iii) tax anticipation bonds or notes, general obligation bonds, or revenue bonds of this state or of any county, incorporated city or town, school district, or other political subdivision of this state, if the bonds or notes are rated AAA by Standard and Poor's or an equivalent nationally recognized rating agency;

(iv) bonds or other evidences of indebtedness issued or guaranteed by an agency or instrumentality of the United States; and

(v) any other security approved by the commissioner that the commissioner considers an equivalent grade investment to those enumerated under Subsections (7)(b)(i) through (iv) based on tests of the safety of principal and liquidity.

(8) Securities held on deposit shall be valued under Section 31A-17-401 as those investments are valued for life insurers, or at market, whichever is lower. The securities shall be revalued whenever the commissioner requests to ensure continued compliance with the requirements of this title.

(9) (a) The state treasurer or custodian institution shall:

(i) deliver to the depositor a receipt for all securities deposited or held;

(ii) issue a duplicate copy of the receipt to the commissioner; and

(iii) permit the depositor to inspect its physically held securities at any reasonable time.

(b) On application of the depositor or when required by the law of any state or country or by the order of any court of competent jurisdiction, the state treasurer or custodian institution shall certify that the deposit was made and what is on deposit.

(c) Depositors, the state treasurer, any custodian institution, and the commissioner shall each keep a permanent record of securities deposited or held under this section and of any substitutions or withdrawals. They shall compare records at least annually.

(10) A transfer of a deposited security, whether voluntary or by operation of law, is valid only if approved in writing by the commissioner and countersigned by the state treasurer or custodian institution.

(11) Neither a judgment creditor nor other person may levy upon any deposit held under this section.

(12) A depositor that has complied with all provisions of this title intended to preserve its financial solidity is, while solvent and complying with the laws of this state, entitled to:

(a) receive interest and cash dividends accruing on the securities held for its account; and

(b) substitute for deposited securities other eligible securities, as expressly approved by the commissioner.

(13) Within 45 days after the commissioner gives notice to a depositor that a deposit is not an acceptable deposit under Subsection (7), the depositor shall substitute other eligible securities expressly approved by the commissioner and allowed under Subsection (7).

(14) A depositor may voluntarily deposit or transfer control of eligible securities in excess of requirements to absorb fluctuations in value and to facilitate substitution of securities.

(15) Upon the depositor's request and upon approval of the commissioner, any deposit or part of a deposit shall be released to, or on order of, the depositor to the extent not needed to satisfy requirements of this title. On the order of a court of competent jurisdiction, the deposit or appropriate part of the deposit shall be released to the person for whom it is held.

(16) Each depositor shall pay the cost of custody of securities by a custodian institution or by the state treasurer.

(17) The commissioner shall adopt rules to implement this section.

Amended by Chapter 309, 2007 General Session

31A-2-207. Commissioner's records and reports -- Protection from disclosure of certain records.

(1) The commissioner shall maintain all department records that are:

(a) required by law;

(b) necessary for the effective operation of the department; or

(c) necessary to maintain a full record of department activities.

(2) The records of the department may be preserved, managed, stored, and made available for review consistent with:

(a) another Utah statute;

(b) the rules made under Section 63A-12-104;

(c) the decisions of the State Records Committee made under Title 63G, Chapter 2, Government Records Access and Management Act; or

(d) the needs of the public.

(3) A department record may not be destroyed, damaged, or disposed of without:

(a) authorization of the commissioner; and

(b) compliance with all other applicable laws.

(4) The commissioner shall maintain a permanent record of the commissioner's proceedings and important activities, including:

(a) a concise statement of the condition of each insurer examined by the commissioner; and

(b) a record of all certificates of authority and licenses issued by the commissioner.

(5) (a) Prior to October 1 of each year, the commissioner shall prepare an annual report to the governor which shall include, for the preceding calendar year, the information concerning the department and the insurance industry which the commissioner believes will be useful to the governor and the public.

(b) The report required by this Subsection (5) shall include the information required under Chapter 27a, Insurer Receivership Act, and Subsections 31A-2-106(2), 31A-2-205(3), and 31A-2-208(3).

(c) The commissioner shall make the report required by this Subsection (5) available to the public and industry in electronic format.

(6) All department records and reports are open to public inspection unless specifically provided otherwise by statute or by Title 63G, Chapter 2, Government Records Access and Management Act.

(7) On request, the commissioner shall provide to any person certified or uncertified copies of any record in the department that is open to public inspection.

(8) Notwithstanding Subsection (6) and Title 63G, Chapter 2, Government Records Access and Management Act, the commissioner shall protect from disclosure any record, as defined in Section 63G-2-103, or other document received from an insurance regulator of another jurisdiction:

(a) at least to the same extent the record or document is protected from disclosure under the laws applicable to the insurance regulator providing the record or document; or

(b) under the same terms and conditions of confidentiality as the National Association of Insurance Commissioners requires as a condition of participating in any of the National Association of Insurance Commissioners' programs.

Amended by Chapter 382, 2008 General Session

31A-2-208. Publications.

(1) The commissioner may prepare and distribute books, pamphlets, and other publications relating to insurance. Except as otherwise provided under this title, the commissioner may charge the cost of producing a publication to those desiring to receive the publication. Money collected from subscription fees charged for a publication shall be deposited into the Relative Value Study Restricted Account, created in Section 59-9-105, to be used as provided in Section 59-9-105.

(2) The commissioner shall have the annual report required in Subsection 31A-2-207(5) printed:

(a) in a form determined by the commissioner; and

(b) in sufficient numbers to meet requests for copies.

(3) The commissioner shall publish in the annual report required in Subsection 31A-2-207(5) an up-to-date chart and explanation of the organization of the commissioner's office, making clear the allocation of responsibility and authority among the staff. This up-to-date chart and explanation shall be printed in sufficient numbers to meet requests for copies.

Amended by Chapter 284, 2011 General Session

31A-2-208.5. Comparison tables.

(1) (a) The commissioner shall annually publish a table comparing the rates charged by insurers for private passenger motor vehicle and homeowners insurance in this state.

(b) The comparison shall list the top 20 insurers writing the greatest volume by premium dollar per calendar year and others requesting inclusion in the comparison.

(c) The commissioner shall develop at least four hypothetical examples of risk in preparing the comparison.

(2) In conjunction with the rate comparison described in Subsection (1), the commissioner shall publish:

(a) a table listing, for each insurer compared, the ratio of justified and questionable complaints received by the department to the premium dollar amount written by the insurer; and

(b) a table listing for each insurer the combined loss and expense ratio for the most current year available.

(3) The department shall make copies of the tables available to the public at minimal or no cost.

Enacted by Chapter 129, 1990 General Session

31A-2-209. Access to state records.

Subject to Title 63G, Chapter 2, Government Records Access and Management Act, the commissioner shall have access to the records of any agency of the state government or of any political subdivision of the state which the commissioner may consult in discharging the commissioner's duties.

Amended by Chapter 382, 2008 General Session

31A-2-210. Participation in organizations.

The commissioner and the Insurance Department shall maintain close relations with the commissioners of other states and shall participate in the activities and affairs of the National Association of Insurance Commissioners and other organizations to the extent, in the commissioner's judgment, these activities will promote the purposes of the Insurance Code. The actual and necessary expenses incurred by this participation shall be paid out of the Insurance Department appropriation. The commissioner may not make any commitments that are not terminable on reasonable notice by the commissioner.

Enacted by Chapter 242, 1985 General Session

31A-2-211. Rules and forms during transition period.

(1) The commissioner's rules adopted under former Title 31 are rescinded unless continued under Subsection (3).

(2) Between May 1, 1985, and July 1, 1986, the commissioner may prepare and

adopt rules to implement or supplement provisions under Title 31A. These rules are effective on July 1, 1986, or on the effective date of the particular provision, if that is later than July 1, 1986.

(3) The commissioner may issue orders declaring that all or part of a rule in effect under former Title 31 remains in effect until a date specified under the order, which date may not be later than June 30, 1989. No rule continued under this subsection may be inconsistent with other provisions under Title 31A. Notice of the order shall be given under Section 31A-2-303.

(4) Every form used, issued, or required by the Insurance Department and approved by the commissioner or otherwise legitimately in use immediately prior to the effective date of this title may continue to be used until replaced in accordance with the provisions of this title.

Amended by Chapter 161, 1987 General Session

31A-2-212. Miscellaneous duties.

(1) Upon issuance of an order limiting, suspending, or revoking a person's authority to do business in Utah, and when the commissioner begins a proceeding against an insurer under Chapter 27a, Insurer Receivership Act, the commissioner:

(a) shall notify by mail the producers of the person or insurer of whom the commissioner has record; and

(b) may publish notice of the order or proceeding in any manner the commissioner considers necessary to protect the rights of the public.

(2) When required for evidence in a legal proceeding, the commissioner shall furnish a certificate of authority of a licensee to transact the business of insurance in Utah on any particular date. The court or other officer shall receive the certificate of authority in lieu of the commissioner's testimony.

(3) (a) On the request of an insurer authorized to do a surety business, the commissioner shall furnish a copy of the insurer's certificate of authority to a designated public officer in this state who requires that certificate of authority before accepting a bond.

(b) The public officer described in Subsection (3)(a) shall file the certificate of authority furnished under Subsection (3)(a).

(c) After a certified copy of a certificate of authority is furnished to a public officer, it is not necessary, while the certificate of authority remains effective, to attach a copy of it to any instrument of suretyship filed with that public officer.

(d) Whenever the commissioner revokes the certificate of authority or begins a proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a surety business, the commissioner shall immediately give notice of that action to each public officer who is sent a certified copy under this Subsection (3).

(4) (a) The commissioner shall immediately notify every judge and clerk of the courts of record in the state when:

(i) an authorized insurer doing a surety business:

(A) files a petition for receivership; or

(B) is in receivership; or

(ii) the commissioner has reason to believe that the authorized insurer doing

surety business:

(A) is in financial difficulty; or

(B) has unreasonably failed to carry out any of its contracts.

(b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the judges and clerks to notify and require a person that files with the court a bond on which the authorized insurer doing surety business is surety to immediately file a new bond with a new surety.

(5) (a) The commissioner shall report to the Legislature in accordance with Section 63M-1-2505.5 prior to adopting a rule authorized by Subsection (5)(b).

(b) The commissioner shall require an insurer that issues, sells, renews, or offers health insurance coverage in this state to comply with the provisions of PPACA and administrative rules adopted by the commissioner related to regulation of health benefit plans, including:

(i) lifetime and annual limits;

(ii) prohibition of rescissions;

(iii) coverage of preventive health services;

(iv) coverage for a child or dependent;

(v) pre-existing condition coverage for children;

(vi) insurer transparency of consumer information including plan disclosures, uniform coverage documents, and standard definitions;

(vii) premium rate reviews;

(viii) essential health benefits;

(ix) provider choice;

(x) waiting periods;

(xi) appeals processes;

(xii) rating restrictions;

(xiii) uniform applications and notice provisions; and

(xiv) certification and regulation of qualified health plans.

(c) The commissioner shall preserve state control over:

(i) the health insurance market in the state;

(ii) qualified health plans offered in the state; and

(iii) the conduct of navigators, producers, and in-person assisters operating in the state.

(d) If the state enters into an agreement with the United States Department of Health and Human Services in which the state operates health insurance plan management, the commissioner may:

(i) for fiscal year 2014, hire one temporary and two permanent full-time employees to be funded through the department's existing budget; and

(ii) for fiscal year 2015, hire two permanent full-time employees funded through the Insurance Department Restricted Account, subject to appropriations from the Legislature and approval by the governor.

Amended by Chapter 341, 2013 General Session

31A-2-213. Immunity.

(1) (a) In the absence of actual malice, a person listed in Subsection (1)(b) is not

subject to any civil liability for any cause of action arising out of any communication, written or oral, made to:

(i) a law enforcement agency;

(ii) a governmental authority; or

(iii) the National Association of Insurance Commissioners.

(b) This section applies to:

(i) the commissioner;

(ii) an authorized representative of the commissioner;

(iii) an examiner appointed by the commissioner; or

(iv) any employee of the department.

(2) This section is not intended to abrogate or modify in any way any common-law or statutory privilege or immunity enjoyed by any person.

Amended by Chapter 320, 2006 General Session

31A-2-214. Market assistance programs -- Joint underwriting associations.

(1) (a) The commissioner may by rule implement a market assistance program whereby all licensed insurers and producers may pool their information as to the available markets if the commissioner finds that in any part of this state:

(i) a line of insurance:

(A) is not generally available in the marketplace; or

(B) is priced in such a manner as to severely limit its availability; and

(ii) the public interest requires availability of the line of insurance described in Subsection (1)(a)(i).

(b) Insurers doing business in this state may, at their own instance or at the request of the commissioner, prepare and submit to the commissioner, for the commissioner's approval and adoption, voluntary plans providing any line of insurance coverage for all or any part of this state in which:

(i) the line of insurance:

(A) is not generally available in the voluntary market; or

(B) is priced in such a manner as to severely limit its availability; and

(ii) the public interest requires the availability of the coverage described in Subsection (1)(b)(i).

(2) (a) If the commissioner finds after notice and hearing that a market assistance program formed under Subsection (1)(a) or (b) has not met the needs it was intended to address, the commissioner may by rule form a joint underwriting association to make available the insurance to applicants who are in good faith entitled to but unable to procure this insurance through ordinary methods.

(b) The commissioner shall allow any market assistance program formed under Subsection (1)(a) or (b) a minimum of 30 days operation before the commissioner forms a joint underwriting association.

(c) The commissioner may not adopt a rule forming a joint underwriting association under Subsection (2)(a) unless the commissioner finds as a result of the hearing that:

(i) a certain coverage is not available or that the price for that coverage is no longer commensurate with the risk in this state; and

(ii) the coverage is:
(A) vital to the economic health of this state;
(B) vital to the quality of life in this state;
(C) vital in maintaining competition in insurance in this state; or
(D) the number of people affected is significant enough to justify its creation.
(d) The commissioner may not adopt a rule forming a joint underwriting association under Subsection (2)(a) on the basis that:
(i) applicants for particular lines of insurance are unable to pay a premium that is commensurate with the risk involved; or
(ii) the number of applicants or people affected is too small to justify its creation.
(e) Each joint underwriting association formed under Subsection (2)(a) shall require participation by all insurers licensed and engaged in writing that line of insurance or any component of that line of insurance within this state.
(f) Each association formed under Subsection (2)(a) shall:
(i) give consideration to:
(A) the need for adequate and readily accessible coverage;
(B) alternative methods of improving the market affected;
(C) the preference of the insurers and producers;
(D) the inherent limitations of the insurance mechanism;
(E) the need for reasonable underwriting standards; and
(F) the requirement of reasonable loss prevention measures;
(ii) establish procedures that will create minimum interference with the voluntary market;
(iii) allocate the burden imposed by the association equitably and efficiently among the insurers doing business in this state;
(iv) establish procedures for applicants and participants to have grievances reviewed by an impartial body;
(v) provide for the method of classifying risks and making and filing applicable rates; and
(vi) specify:
(A) the basis of participation of insurers and producers in the association;
(B) the conditions under which risks must be accepted; and
(C) the commission rates to be paid for insurance business placed with the association.
(g) Any deficit in an association in any year shall be recouped by rate increases for the association, applicable prospectively.
(h) Any surplus in excess of the loss reserves of the association in any year shall be distributed either by rate decreases or by distribution to the members of the association on a pro-rata basis.
(3) Notwithstanding Subsection (2), the commissioner may not create a joint underwriting association under Subsection (2) for:
(a) life insurance;
(b) annuities;
(c) accident and health insurance;
(d) ocean marine insurance;
(e) medical malpractice insurance;

(f) earthquake insurance;
(g) workers' compensation insurance; or
(h) private passenger automobile liability insurance.
(4) Every insurer and producer participating in a joint underwriting association adopted by the commissioner under Subsection (2) shall provide the services prescribed by the association to any person seeking coverage of the kind available in the plan, including full information about the requirements and procedures for obtaining coverage with the association.
(5) If the commissioner finds that the lack of cooperating insurers or producers in an area makes the functioning of the association difficult, the commissioner may order the association to:
(a) establish branch service offices;
(b) make special contracts for provision of the service; or
(c) take other appropriate steps to ensure that service is available.
(6) (a) The association may issue policies for a period of one year.
(b) If, at the end of any one year period, the commissioner determines that the market conditions justify the continued existence of the association, the commissioner may reauthorize its existence.
(c) In reauthorizing the association in accordance with this Subsection (6), the commissioner shall follow the procedure set forth in Subsection (2).

Amended by Chapter 298, 2003 General Session

31A-2-215. Consumer education.
(1) In furtherance of the purposes in Section 31A-1-102, the commissioner may educate consumers about insurance and provide consumer assistance.
(2) Consumer education may include:
(a) outreach activities; and
(b) the production or collection and dissemination of educational materials.
(3) (a) Consumer assistance may include explaining:
(i) the terms of a policy;
(ii) a policy's complaint, grievance, or adverse benefit determination procedure; and
(iii) the fundamentals of self-advocacy.
(b) Notwithstanding Subsection (3)(a), consumer assistance may not include testifying or representing a consumer in any grievance or adverse benefit determination, arbitration, judicial, or related proceeding, unless the proceeding is in connection with an enforcement action brought under Section 31A-2-308.
(4) The commissioner may adopt rules necessary to implement the requirements of this section.

Amended by Chapter 308, 2002 General Session

31A-2-216. Office of Consumer Health Assistance.
(1) The commissioner shall establish:
(a) an Office of Consumer Health Assistance before July 1, 1999; and

(b) a committee to advise the commissioner on consumer assistance rendered under this section.

(2) The office shall:

(a) be a resource for health care consumers concerning health care coverage or the need for such coverage;

(b) help health care consumers understand:

(i) contractual rights and responsibilities;

(ii) statutory protections; and

(iii) available remedies;

(c) educate health care consumers:

(i) by producing or collecting and disseminating educational materials to consumers, health insurers, and health benefit plans; and

(ii) through outreach and other educational activities;

(d) for health care consumers that have difficulty in accessing their health insurance policies because of language, disability, age, or ethnicity, provide services, directly or through referral, such as:

(i) information and referral; and

(ii) adverse benefit determination process initiation;

(e) analyze and monitor federal and state consumer health-related statutes, rules, and regulations; and

(f) summarize information gathered under this section and make the summaries available to the public, government agencies, and the Legislature.

(3) The office may:

(a) obtain data from health care consumers as necessary to further the office's duties under this section;

(b) investigate complaints and attempt to resolve complaints at the lowest possible level; and

(c) assist, but not testify or represent, a consumer in an adverse benefit determination, arbitration, judicial, or related proceeding, unless the proceeding is in connection with an enforcement action brought under Section 31A-2-308.

(4) The commissioner may adopt rules necessary to implement the requirements of this section.

Amended by Chapter 308, 2002 General Session

31A-2-217. Coordination with other states.

(1) (a) Subject to Subsection (1)(b), the commissioner, by rule, may adopt one or more agreements with a state governmental regulatory agency, within and outside of this state, or with the National Association of Insurance Commissioners to address state regulatory issues limited to:

(i) licensing of insurance companies;

(ii) licensing of agents;

(iii) regulation of premium rates and policy forms; and

(iv) regulation of insurer insolvency and insurance receiverships.

(b) An agreement described in Subsection (1)(a), may authorize the commissioner to modify a requirement of this title if the commissioner determines that

the requirements under the agreement provide protections similar to or greater than the requirements under this title.

(2) (a) The commissioner may negotiate an interstate compact that addresses issuing certificates of authority, if the commissioner determines that:

(i) each state participating in the compact has requirements for issuing certificates of authority that provide protections similar to or greater than the requirements of this title; or

(ii) the interstate compact contains requirements for issuing certificates of authority that provide protections similar to or greater than the requirements of this title.

(b) If an interstate compact described in Subsection (2)(a) is adopted by the Legislature, the commissioner may issue certificates of authority to insurers in accordance with the terms of the interstate compact.

(3) If any provision of this title conflicts with a provision of the annual statement instructions or the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, the commissioner may, by rule, resolve the conflict in favor of the annual statement instructions or the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

(4) The commissioner may, by rule, accept the information prescribed by the National Association of Insurance Commissioners instead of the documents required to be filed with an application for a certificate of authority under:

(a) Section 31A-4-103, 31A-5-204, 31A-8-205, or 31A-14-201; or

(b) rules made by the commissioner.

(5) This section shall be repealed in accordance with Section 63I-1-231.

Amended by Chapter 43, 2013 General Session
Amended by Chapter 319, 2013 General Session

31A-2-218. Strategic plan for health system reform.

The commissioner and the department shall:

(1) work with the Governor's Office of Economic Development, the Department of Health, the Department of Workforce Services, and the Legislature to develop health system reform in accordance with the strategic plan described in Title 63M, Chapter 1, Part 25, Health System Reform Act;

(2) work with health insurers in accordance with Section 31A-22-635 to develop standards for health insurance applications and compatible electronic systems;

(3) facilitate a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others by educating employers and insurers about collection services available through private vendors, including financial institutions;

(4) encourage health insurers to develop products that:

(a) encourage health care providers to follow best practice protocols;

(b) incorporate other health care quality improvement mechanisms; and

(c) incorporate rewards and incentives for healthy lifestyles and behaviors as permitted by the Health Insurance Portability and Accountability Act;

(5) involve the Office of Consumer Health Assistance created in Section

31A-2-216, as necessary, to accomplish the requirements of this section; and

(6) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, make rules, as necessary, to implement Subsections (2), (3), and (4).

Enacted by Chapter 383, 2008 General Session

31A-2-301. Special hearing officers -- Witness and mileage fees.

(1) If the commissioner considers it necessary because of the technicality or complexity of the subject, the commissioner may appoint a special hearing officer from outside the department staff and may contract for a reasonable professional fee for the services.

(2) (a) In hearings before the commissioner, witness fees and reimbursement for mileage traveled, if claimed, shall be allowed at the same rate as in district courts.

(b) Witness fees and reimbursement for mileage, together with the actual expense necessarily incurred in securing attendance of witnesses and their testimony, and the hearing officer's fee and reasonable actual expenses, shall be paid by the Insurance Department.

(c) The commissioner shall be reimbursed for these costs as provided in Section 31A-2-205 if:

(i) the hearing is incident to an examination for which costs are payable under Section 31A-2-205; or

(ii) the commissioner orders the persons involved in the hearing to reimburse the department for hearing costs, which the commissioner may do if the commissioner had reasonable cause to believe that the order which issued or might have issued was necessary.

(3) Whenever the commissioner is reimbursed for costs under this section, the expenditures may not be charged against the department budget.

Amended by Chapter 297, 2011 General Session

31A-2-302. Commissioner's disapproval.

(1) When the law requires the commissioner's approval for a certain action without a deemer clause, that approval shall be express. The commissioner's disapproval of an action is assumed if the commissioner does not act within 60 days after receiving the application for approval or give notice of the commissioner's reasonable extension of that time period with the commissioner's reasons for the extension. Assumed disapproval under this subsection entitles the aggrieved person to request agency action under Section 63G-4-201.

(2) When the law provides that a certain action is not effective if disapproved by the commissioner within a certain period, the affirmative approval by the commissioner may make the action effective at a designated earlier date, but not earlier than the date of the commissioner's affirmative approval.

(3) Subsections (1) and (2) do not apply to the extent that the law specifically provides otherwise.

Amended by Chapter 297, 2011 General Session

31A-2-303. Notice.

(1) If the commissioner determines that the number of persons affected by a proposed action is so great as to render it impracticable to serve each person affected with a copy of an order, notice of hearing, or other notice, the commissioner shall:

(a) provide a copy of the order, notice of hearing, or other notice to all persons who have filed with the department a general request to be informed of this type of action, or if fewer than 10 persons have requested this type of notice, provide a copy to those who have and also to others affected by the notice or order so that at least 10 persons receive the notice or order who are collectively representative of the class of persons whose legal status, pecuniary interests, or other substantial interests will be affected by the proposed action; and

(b) publish a copy of the order, notice of hearing, or other notice under Subsection (2).

(2) When this title requires the commissioner to publish an order, notice of hearing, or other document, the commissioner shall cause the notice or order to be published:

(a) at least once during each of the four weeks preceding the hearing, effective date, or other critical event, in at least two newspapers with sufficient circulation and appropriate location to best provide actual notice; and

(b) in accordance with Section 45-1-101 for four weeks preceding the hearing, effective date, or other critical event.

Amended by Chapter 388, 2009 General Session

31A-2-304. Auxiliary procedural powers.

The commissioner, or his delegate authorized for a particular matter over his handwritten signature, may administer oaths, take testimony, issue subpoenas, and take depositions in connection with any hearing, meeting, examination, investigation, or other proceeding that the commissioner may conduct. The subpoena shall have the same effect and shall be served in the same manner as if issued from a court of record. Sections 78B-1-131 and 78B-6-313 apply to the enforcement of the process issued by the commissioner or his delegate.

Amended by Chapter 3, 2008 General Session

31A-2-305. Immunity from prosecution.

(1) If a natural person declines to appear, testify, or produce any record or document in any proceeding instituted by the commissioner or in obedience to the subpoena of the commissioner, the commissioner may apply to a judge of the district court where the proceeding is held for an order to the person to attend, testify, or produce records or documents as requested by the commissioner. In the event a witness asserts a privilege against self-incrimination, testimony and evidence from the witness may be compelled pursuant to Title 77, Chapter 22b, Grants of Immunity.

(2) If a person claims the privilege against self-incrimination and refuses to appear, testify, or produce documents in response to probative evidence against him in a proceeding to revoke or suspend his license, and if the testimony or documents would

have been admissible as evidence in a court of law except for the Fifth Amendment privilege, the refusal to appear, testify, or produce documents is, for noncriminal proceedings only, rebuttable evidence of the facts on which the proceeding is based.

Amended by Chapter 296, 1997 General Session

31A-2-306. Judicial review -- Costs.

(1) A person aggrieved by a rule or order of the commissioner, or aggrieved by the commissioner's failure to act when he has a duty to act, may obtain judicial review.

(2) The court reviewing agency actions governed by this title shall give priority to those actions and shall hear and determine them promptly.

(3) Costs shall be awarded as in civil cases. If the court finds that the appeal from action or inaction stemmed from the bad faith or malice of the commissioner, the court may award reasonable attorney's fees to the prevailing petitioner. Section 63G-7-701 applies to the extent the attorney's fees awarded under this subsection exceed $10,000 for any one appeal.

Amended by Chapter 267, 2004 General Session

31A-2-306.5. Stay of commissioner's decision pending administrative review or judicial appeal.

(1) An order of the commissioner or a designee of the commissioner is not stayed by a petition for:

(a) administrative review;

(b) rehearing; or

(c) judicial review.

(2) A person seeking to stay an order of the commissioner or a designee of the commissioner shall seek a stay in accordance with:

(a) rules made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, pending a petition for:

(i) administrative review; or

(ii) rehearing; or

(b) Section 63G-4-405, pending judicial review.

Amended by Chapter 382, 2008 General Session

31A-2-307. Declaratory interpretation of statutes -- Procedure.

(1) The commissioner or any other person with a substantial interest in the result may petition the Third District Court for Salt Lake County for a declaratory judgment interpreting any provision of this title as applied to stipulated facts.

(2) The court may require that notice be given to persons that may be affected by the judgment. These persons may participate in the proceeding.

(3) The court in its discretion may require the commissioner and any other participating parties to provide testimony and documentary evidence necessary for a fair disposition of the case.

(4) The court may decline to proceed on the petition if it believes the petition is

frivolous, or the declaratory relief is unnecessary or has the possibility of prejudicing persons who cannot practicably be made parties to the proceeding.

(5) The court may declare the meaning of the statute. The declaration has the effect of a final judgment or decree.

(6) Any participating party may obtain judicial review of the decision.

(7) The costs of the proceeding shall be paid by the petitioner unless the commissioner is the petitioner, in which case all parties shall bear their own costs. "Costs" means:

(a) fees of the clerk and marshal;

(b) fees of the court reporter or the transcriber of a tape of the proceedings for all or any part of the transcript necessarily obtained for use in the case;

(c) fees and disbursements for printing and witnesses;

(d) fees for exemplification and copies of papers necessarily obtained for use in the case; and

(e) compensation of court-appointed experts or interpreters. Reimbursements shall be made to the General Fund, and shall be added back to the department's budget, except to the extent the department forwards a reimbursement to the attorney general's office, in which case the attorney general's budget shall be credited with the reimbursement.

Amended by Chapter 101, 1988 General Session

31A-2-308. Enforcement penalties and procedures.

(1) (a) A person who violates any insurance statute or rule or any order issued under Subsection 31A-2-201(4) shall forfeit to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed.

(b) (i) The commissioner may order an individual producer, surplus line producer, limited line producer, managing general agent, reinsurance intermediary, adjuster, or insurance consultant who violates an insurance statute or rule to forfeit to the state not more than $2,500 for each violation.

(ii) The commissioner may order any other person who violates an insurance statute or rule to forfeit to the state not more than $5,000 for each violation.

(c) (i) The commissioner may order an individual producer, surplus line producer, limited line producer, managing general agent, reinsurance intermediary, adjuster, or insurance consultant who violates an order issued under Subsection 31A-2-201(4) to forfeit to the state not more than $2,500 for each violation. Each day the violation continues is a separate violation.

(ii) The commissioner may order any other person who violates an order issued under Subsection 31A-2-201(4) to forfeit to the state not more than $5,000 for each violation. Each day the violation continues is a separate violation.

(d) The commissioner may accept or compromise any forfeiture under this Subsection (1) until after a complaint is filed under Subsection (2). After the filing of the complaint, only the attorney general may compromise the forfeiture.

(2) When a person fails to comply with an order issued under Subsection 31A-2-201(4), including a forfeiture order, the commissioner may file an action in any court of competent jurisdiction or obtain a court order or judgment:

(a) enforcing the commissioner's order;

(b) (i) directing compliance with the commissioner's order and restraining further violation of the order; and

(ii) subjecting the person ordered to the procedures and sanctions available to the court for punishing contempt if the failure to comply continues; or

(c) imposing a forfeiture in an amount the court considers just, up to $10,000 for each day the failure to comply continues after the filing of the complaint until judgment is rendered.

(3) (a) The Utah Rules of Civil Procedure govern actions brought under Subsection (2), except that the commissioner may file a complaint seeking a court-ordered forfeiture under Subsection (2)(c) no sooner than two weeks after giving written notice of the commissioner's intention to proceed under Subsection (2)(c).

(b) The commissioner's order issued under Subsection 31A-2-201(4) may contain a notice of intention to seek a court-ordered forfeiture if the commissioner's order is disobeyed.

(4) If, after a court order is issued under Subsection (2), the person fails to comply with the commissioner's order or judgment:

(a) the commissioner may certify the fact of the failure to the court by affidavit; and

(b) the court may, after a hearing following at least five days written notice to the parties subject to the order or judgment, amend the order or judgment to add the forfeiture or forfeitures, as prescribed in Subsection (2)(c), until the person complies.

(5) (a) The proceeds of the forfeitures under this section, including collection expenses, shall be paid into the General Fund.

(b) The expenses of collection shall be credited to the department's budget.

(c) The attorney general's budget shall be credited to the extent the department reimburses the attorney general's office for its collection expenses under this section.

(6) (a) Forfeitures and judgments under this section bear interest at the rate charged by the United States Internal Revenue Service for past due taxes on the:

(i) date of entry of the commissioner's order under Subsection (1); or

(ii) date of judgment under Subsection (2).

(b) Interest accrues from the later of the dates described in Subsection (6)(a) until the forfeiture and accrued interest are fully paid.

(7) A forfeiture may not be imposed under Subsection (2)(c) if:

(a) at the time the forfeiture action is commenced, the person was in compliance with the commissioner's order; or

(b) the violation of the order occurred during the order's suspension.

(8) The commissioner may seek an injunction as an alternative to issuing an order under Subsection 31A-2-201(4).

(9) (a) A person is guilty of a class B misdemeanor if that person:

(i) intentionally violates:

(A) an insurance statute of this state; or

(B) an order issued under Subsection 31A-2-201(4);

(ii) intentionally permits a person over whom that person has authority to violate:

(A) an insurance statute of this state; or

(B) an order issued under Subsection 31A-2-201(4); or

(iii) intentionally aids any person in violating:
(A) an insurance statute of this state; or
(B) an order issued under Subsection 31A-2-201(4).
(b) Unless a specific criminal penalty is provided elsewhere in this title, the person may be fined not more than:
(i) $10,000 if a corporation; or
(ii) $5,000 if a person other than a corporation.
(c) If the person is an individual, the person may, in addition, be imprisoned for up to one year.
(d) As used in this Subsection (9), "intentionally" has the same meaning as under Subsection 76-2-103(1).
(10) (a) A person who knowingly and intentionally violates Section 31A-4-102, 31A-8a-208, 31A-15-105, 31A-23a-116, or 31A-31-111 is guilty of a felony as provided in this Subsection (10).
(b) When the value of the property, money, or other things obtained or sought to be obtained in violation of Subsection (10)(a):
(i) is less than $5,000, a person is guilty of a third degree felony; or
(ii) is or exceeds $5,000, a person is guilty of a second degree felony.
(11) (a) After a hearing, the commissioner may, in whole or in part, revoke, suspend, place on probation, limit, or refuse to renew the licensee's license or certificate of authority:
(i) when a licensee of the department, other than a domestic insurer:
(A) persistently or substantially violates the insurance law; or
(B) violates an order of the commissioner under Subsection 31A-2-201(4);
(ii) if there are grounds for delinquency proceedings against the licensee under Section 31A-27a-207; or
(iii) if 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 interests of the licensee's customers and the public.
(b) Additional license termination or probation provisions for licensees other than insurers are set forth in Sections 31A-19a-303, 31A-19a-304, 31A-23a-111, 31A-23a-112, 31A-25-208, 31A-25-209, 31A-26-213, 31A-26-214, 31A-35-501, and 31A-35-503.
(12) The enforcement penalties and procedures set forth in this section are not exclusive, but are cumulative of other rights and remedies the commissioner has pursuant to applicable law.

Amended by Chapter 253, 2012 General Session

31A-2-309. Service of process through state officer.
(1) The commissioner, or the lieutenant governor when the subject proceeding is brought by the state, is the agent for receipt of service of a summons, notice, order, pleading, or other legal process relating to a Utah court or administrative agency upon the following:
(a) an insurer authorized to do business in this state, while authorized to do business in this state, and thereafter in a proceeding arising from or related to a

transaction having a connection with this state;

(b) a surplus lines insurer for a proceeding arising out of a contract of insurance that is subject to the surplus lines law, or out of a certificate, cover note, or other confirmation of that type of insurance;

(c) an unauthorized insurer or other person assisting an unauthorized insurer under Subsection 31A-15-102(1) by doing an act specified in Subsection 31A-15-102(2), for a proceeding arising out of a transaction that is subject to the unauthorized insurance law;

(d) a nonresident producer, consultant, adjuster, or third party administrator, while authorized to do business in this state, and thereafter in a proceeding arising from or related to a transaction having a connection with this state; and

(e) a reinsurer submitting to the commissioner's jurisdiction under Subsection 31A-17-404(8).

(2) The following is considered to have irrevocably appointed the commissioner and lieutenant governor as that person's agents in accordance with Subsection (1):

(a) a licensed insurer by applying for and receiving a certificate of authority;

(b) a surplus lines insurer by entering into a contract subject to the surplus lines law;

(c) an unauthorized insurer by doing in this state an act prohibited by Section 31A-15-103; and

(d) a nonresident producer, consultant, adjuster, and third party administrator.

(3) The commissioner and lieutenant governor are also agents for an executor, administrator, personal representative, receiver, trustee, or other successor in interest of a person specified under Subsection (1).

(4) A litigant serving process on the commissioner or lieutenant governor under this section shall pay the fee applicable under Section 31A-3-103.

(5) The right to substituted service under this section does not limit the right to serve a summons, notice, order, pleading, demand, or other process upon a person in another manner provided by law.

Amended by Chapter 257, 2008 General Session

31A-2-310. Procedure for service of process through state officer.

(1) Service upon the commissioner or lieutenant governor under Section 31A-2-309 is service on the principal, if:

(a) two copies of the process are delivered personally or to the office of the official designated in Section 31A-2-309, and

(b) that official mails a copy of the process to the person to be served according to Subsection (2)(b).

(2) (a) The commissioner and the lieutenant governor shall give receipts for and keep records of all process served through them.

(b) The commissioner or the lieutenant governor shall immediately send by certified mail one copy of the process received to the person to be served at that person's last known principal place of business, residence, or post-office address. The commissioner or the lieutenant governor shall retain the other copy for his files.

(c) No plaintiff or complainant may take a judgment by default in any proceeding

in which process is served under this section and Section 31A-2-309 until the expiration of 40 days from the date of service of process under Subsection (2)(b).

(3) Proof of service shall be evidenced by a certificate by the official designated in Section 31A-2-309, showing service made upon him and mailing by him, and attached to a copy of the process presented to him for that purpose.

(4) When process is served under this section, the words "twenty days" in the first sentence of Rule 12(a) of the Utah Rules of Civil Procedure shall be changed to read "forty days."

Amended by Chapter 20, 1995 General Session

31A-2-311. Reciprocal enforcement of foreign decrees.

(1) As used in this section:

(a) "Reciprocal state" means a state whose laws contain procedures substantially similar to those specified in this section for the enforcement of decrees or orders issued by courts located in other states against an insurer authorized to do business in the reciprocal state, and which recognizes Utah as a reciprocal state under its law.

(b) "Foreign decree" means a decree or order of a court located in a reciprocal state, including a United States court located in a reciprocal state against an insurer authorized to do business in Utah.

(2) The commissioner shall determine which states qualify as reciprocal states and shall maintain a list of them.

(3) The attorney general, upon request of the commissioner, may proceed in the courts of Utah or any other state to enforce an order or decision issued in Utah in any court proceeding or in any administrative proceeding before the insurance commissioner.

(4) (a) A copy of any foreign court decree authenticated under Utah statutes or court rules may be filed in the office of the clerk of the Third District Court for Salt Lake County. The clerk, upon verifying with the commissioner that the decree or order qualifies as a foreign court decree, shall treat it in the same manner and give it the same effect as a decree of a district court of Utah.

(b) (i) When filing the foreign decree, the filer shall deposit with the clerk of the court an affidavit setting forth the name and last-known post-office address of the defendant in Utah.

(ii) When the foreign decree and the affidavit are filed, the clerk shall immediately mail notice of the filing of the foreign decree to the defendant at the address given by the filer and to the commissioner, and shall note the mailing in the docket. In addition, the attorney general may mail a notice of the filing of the foreign decree to the defendant and to the commissioner. Alternatively, the commissioner may mail a notice of the filing of the foreign decree to the defendant, and either the attorney general or the commissioner may file proof of this mailing with the clerk. The clerk's failure to mail notice of the filing does not affect the enforcement proceedings if the attorney general or the commissioner has filed a proof of mailing.

(iii) No execution or other process for enforcement of a foreign decree may issue until 30 days after the foreign decree is filed.

(c) (i) If the defendant shows the court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof by the defendant that he has furnished the security for the satisfaction of the decree required by the state in which it was rendered.

(ii) If the defendant shows the court any ground upon which enforcement of a similar decree of any district court of Utah would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon proof by the defendant that he has furnished the same security for satisfaction of the decree as is required in Utah.

(d) A person filing a foreign decree shall pay to the clerk of the court the same fee for an enforcement proceeding as is required for enforcing a decree of the district court.

Enacted by Chapter 242, 1985 General Session

31A-2-401. Title.

This part is known as the "Title and Escrow Commission Act."

Enacted by Chapter 185, 2005 General Session

31A-2-402. Definitions.

As used in this part:

(1) "Commission" means the Title and Escrow Commission created in Section 31A-2-403.

(2) "Concurrence" means the entities given a concurring role must jointly agree for the action to be taken.

(3) "Dual licensed title licensee" means a title licensee who holds:

(a) an individual title insurance producer license as a title licensee; and

(b) a license or certificate under:

(i) Title 61, Chapter 2c, Utah Residential Mortgage Practices and Licensing Act;

(ii) Title 61, Chapter 2f, Real Estate Licensing and Practices Act; or

(iii) Title 61, Chapter 2g, Real Estate Appraiser Licensing and Certification Act.

(4) "Real Estate Commission" means the Real Estate Commission created in Section 61-2f-103.

(5) "Title licensee" means a person licensed under this title as:

(a) an agency title insurance producer with a title insurance line of authority;

(b) an individual title insurance producer with:

(i) a general title insurance line of authority; or

(ii) a specific category of authority for title insurance; or

(c) a title insurance adjuster.

Amended by Chapter 319, 2013 General Session

31A-2-403. Title and Escrow Commission created.

(1) (a) Subject to Subsection (1)(b), there is created within the department the Title and Escrow Commission that is comprised of five members appointed by the governor with the consent of the Senate as follows beginning July 1, 2013:

(i) two members shall be employees of a title insurer;

(ii) two members shall:

(A) be employees of a Utah agency title insurance producer;

(B) be or have been licensed under the title insurance line of authority;

(C) as of the day on which the member is appointed, be or have been licensed with the search or escrow subline of authority for at least five years; and

(D) as of the day on which the member is appointed, not be from the same county as another member appointed under this Subsection (1)(a)(ii); and

(iii) one member shall be a member of the general public from any county in the state.

(b) No more than one commission member may be appointed from a single company or an affiliate or subsidiary of the company.

(2) (a) Subject to Subsection (2)(c), a commission member shall file with the commissioner a disclosure of any position of employment or ownership interest that the commission member has with respect to a person that is subject to the jurisdiction of the commissioner.

(b) The disclosure statement required by this Subsection (2) shall be:

(i) filed by no later than the day on which the person begins that person's appointment; and

(ii) amended when a significant change occurs in any matter required to be disclosed under this Subsection (2).

(c) A commission member is not required to disclose an ownership interest that the commission member has if the ownership interest is in a publicly traded company or held as part of a mutual fund, trust, or similar investment.

(3) (a) Except as required by Subsection (3)(b), as terms of current commission members expire, the governor shall appoint each new commission member to a four-year term ending on June 30.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment, adjust the length of terms to ensure that the terms of the commission members are staggered so that approximately half of the members appointed under Subsection (1)(a)(i) and half of the members appointed under Subsection (1)(a)(ii) are appointed every two years.

(c) A commission member may not serve more than one consecutive term.

(d) When a vacancy occurs in the membership for any reason, the governor, with the consent of the Senate, shall appoint a replacement for the unexpired term.

(e) Notwithstanding the other provisions of this Subsection (3), a commission member serves until a successor is appointed by the governor with the consent of the Senate.

(4) A commission member may not receive compensation or benefits for the commission member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

(5) Members of the commission shall annually select one commission member to serve as chair.

(6) (a) The commission shall meet at least monthly. Notwithstanding Section 52-4-207, a commission member shall physically attend a regularly scheduled monthly meeting of the commission and may not attend through electronic means. A commission member may attend subcommittee meetings, emergency meetings, or other not regularly scheduled meetings electronically in accordance with Section 52-4-207.

(b) The commissioner may call additional meetings:

(i) at the commissioner's discretion;

(ii) upon the request of the chair of the commission; or

(iii) upon the written request of three or more commission members.

(c) (i) Three commission members constitute a quorum for the transaction of business.

(ii) The action of a majority of the commission members when a quorum is present is the action of the commission.

(7) The commissioner shall staff the commission.

Amended by Chapter 319, 2013 General Session

31A-2-404. Duties of the commissioner and Title and Escrow Commission.

(1) Notwithstanding the other provisions of this chapter, to the extent provided in this part, the commissioner shall administer and enforce the provisions in this title related to:

(a) title insurance; and

(b) escrow conducted by a title licensee or title insurer.

(2) The commission shall:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and subject to Subsection (4), make rules for the administration of the provisions in this title related to title insurance including rules related to:

(i) rating standards and rating methods for a title licensee, as provided in Section 31A-19a-209;

(ii) the licensing for a title licensee, including the licensing requirements of Section 31A-23a-204;

(iii) continuing education requirements of Section 31A-23a-202; and

(iv) standards of conduct for a title licensee;

(b) concur in the issuance and renewal of a license in accordance with Section 31A-23a-105 or 31A-26-203;

(c) in accordance with Section 31A-3-103, establish, with the concurrence of the commissioner, the fees imposed by this title on a title licensee;

(d) in accordance with Section 31A-23a-415 determine, after consulting with the commissioner, the assessment on a title insurer as defined in Section 31A-23a-415;

(e) conduct an administrative hearing not delegated by the commission to an administrative law judge related to the:

(i) licensing of an applicant;
(ii) conduct of a title licensee; or
(iii) approval of a continuing education program required by Section 31A-23a-202;
(f) with the concurrence of the commissioner, approve a continuing education program required by Section 31A-23a-202;
(g) with the concurrence of the commissioner, impose a penalty:
(i) under this title related to:
(A) title insurance; or
(B) escrow conducted by a title licensee;
(ii) after investigation by the commissioner in accordance with Part 3, Procedures and Enforcement; and
(iii) that is enforced by the commissioner;
(h) advise the commissioner on the administration and enforcement of any matter affecting the title insurance industry;
(i) advise the commissioner on matters affecting the commissioner's budget related to title insurance; and
(j) perform other duties as provided in this title.
(3) The commission may make rules establishing an examination for a license that will satisfy Section 31A-23a-204:
(a) after consultation with the commissioner and the commissioner's test administrator;
(b) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
(c) subject to Subsection (4).
(4) The commission may make a rule under this title only if at the time the commission files its proposed rule and rule analysis with the Division of Administrative Rules in accordance with Section 63G-3-301, the commission provides the Real Estate Commission that same information.
(5) (a) The commissioner shall annually report the information described in Subsection (5)(b) in writing to the commission.
(b) The information required to be reported under this Subsection (5):
(i) may not identify a person; and
(ii) shall include:
(A) the number of complaints the commissioner receives with regard to transactions involving title insurance or a title licensee during the calendar year immediately proceeding the report;
(B) the type of complaints described in Subsection (5)(b)(ii)(A); and
(C) for each complaint described in Subsection (5)(b)(ii)(A):
(I) any action taken by the commissioner with regard to the complaint; and
(II) the time-period beginning the day on which a complaint is made and ending the day on which the commissioner determines it will take no further action with regard to the complaint.
(6) The commission may not impose a penalty in a manner inconsistent with Subsection (2)(g) or make a rule that conflicts with Subsection (2)(g).

Amended by Chapter 43, 2013 General Session
Amended by Chapter 319, 2013 General Session

31A-2-405. Dual licensing.

(1) A dual licensed title licensee may provide a title insurance product or service under this title only if before providing that title insurance product or service the dual licensed title licensee obtains approval as provided in this section.

(2) (a) Except as provided in Subsection (3), a dual licensed title licensee shall obtain approval from the commissioner by filing under penalty of perjury with the department:

(i) a statement that includes:

(A) a description of the title insurance product or service to be provided;

(B) the names of the principals anticipated to be involved in the provision or receipt of the title insurance product or service;

(C) a legal description of the property to be involved in the provision or receipt of the title insurance product or service;

(D) whether or not the dual licensed title licensee received any consideration from a person described in Subsection (2)(a)(i)(B) within 18 months prior to the day on which the dual licensed title licensee files the statement; and

(E) any other information the commission requires by rule made in accordance with this section and Section 31A-2-404; and

(ii) the fee applicable under Section 31A-3-103.

(b) The commissioner shall approve the provision of a title insurance product or service under this section if the commissioner finds that the dual licensed title licensee:

(i) completed the filing required by Subsection (2)(a);

(ii) is acting in good faith; and

(iii) has not received consideration from a person described in Subsection (2)(a)(i)(B) within the 18-month period described in Subsection (2)(a)(i)(D).

(c) If the commissioner does not deny approval under this section, the commissioner is considered to have approved the provision of the title insurance product or service the earlier of:

(i) the day on which the commissioner issues the commissioner's approval in writing; or

(ii) 15 days after the day on which the dual licensed title licensee completes the filing under Subsection (2)(a).

(3) Notwithstanding Subsection (2), a dual licensed title licensee may obtain approval from the chair of the commission if:

(a) the dual licensed title licensee completes the filing under Subsection (2)(a);

(b) the dual licensed title licensee establishes a need for expedited approval; and

(c) the chair of the commission issues approval in writing after making the findings described in Subsection (2)(b).

(4) The commissioner shall revoke the license under this title of a dual licensed title licensee if the dual licensed title licensee:

(a) provides a title insurance product or service without the approval required by this section; or

(b) knowingly provides false or misleading information in the statement required by Subsection (2).

(5) The commission may make rules, subject to Section 31A-2-404, to implement the filing requirements under Subsection (2), including the definition of terms.

Enacted by Chapter 325, 2007 General Session

31A-3-101. General finance provisions.

Department expenditures shall conform to the Legislature's appropriation adopted under Title 63J, Chapter 1, Budgetary Procedures Act.

Amended by Chapter 284, 2011 General Session

31A-3-102. Exclusive fees and taxes.

(1) The taxes and fees under this chapter, the premium taxes under Sections 59-9-101 through 59-9-104, the fees under Section 31A-31-108, and the examination costs under Section 31A-2-205 are in place of all other license fees or assessments that might otherwise be levied by the state or any other taxing body within the state.

(2) An insurer that pays premium taxes under Sections 59-9-101 through 59-9-104 is not subject to corporate franchise taxes.

(3) Unless otherwise exempt, a licensee under this title is subject to real and personal property taxes.

Amended by Chapter 243, 1994 General Session

31A-3-103. Fees.

(1) For purposes of this section, "services" means functions that are reasonable and necessary to enable the commissioner to perform the duties imposed by this title including:

(a) issuing or renewing a license or certificate of authority;

(b) filing a policy form;

(c) reporting a producer appointment or termination; and

(d) filing an annual statement.

(2) Except as otherwise provided by this title:

(a) the commissioner may set and collect a fee for services provided by the commissioner;

(b) a fee related to the renewal of a license may be imposed no more frequently than once each year; and

(c) a fee charged by the commissioner shall be set in accordance with Section 63J-1-504.

(3) (a) The commissioner shall publish a schedule of fees established pursuant to this section.

(b) The commissioner shall, by rule, establish the deadlines for payment of a fee established pursuant to this section.

(4) (a) Beginning July 1, 2011, there is created in the General Fund a restricted

account known as the "Insurance Department Restricted Account."

(b) Except as provided in Subsection (4)(c), the Insurance Department Restricted Account shall consist of:

(i) fees authorized by this section; and

(ii) other money received by the department, including:

(A) reimbursements for examination costs incurred by the department; and

(B) forfeitures collected under this title.

(c) The department shall deposit money it receives that is subject to a restricted account or enterprise fund created by this title into the restricted account or enterprise fund in accordance with the statute creating the restricted account or enterprise fund, and the department may not deposit the money into the Insurance Department Restricted Account.

(d) Subject to appropriation by the Legislature, the department may expend money in the Insurance Department Restricted Account to fund the operations of the department.

(e) At the end of each fiscal year, the director of the Division of Finance shall transfer into the General Fund any money deposited into the Insurance Department Restricted Account under Subsection (4)(b) that exceeds the legislative appropriations from the Insurance Department Restricted Account for that year.

Amended by Chapter 284, 2011 General Session

31A-3-104. Technology fees -- Restricted account.

(1) The commissioner may impose a fee for requests for information:

(a) that is obtained from an electronic database of the commissioner; or

(b) derived from data that is generated by electronic means.

(2) In addition to any fee authorized in this title, the commissioner shall impose a supplemental fee on the issuance or renewal of any of the following issued by the department:

(a) a license;

(b) a registration; or

(c) a certificate of authority.

(3) A fee imposed under this section shall be:

(a) established in accordance with Section 31A-3-103; and

(b) deposited into the Technology Development Restricted Account.

(4) (a) There is created in the General Fund a restricted account known as the "Technology Development Restricted Account."

(b) The Technology Development Restricted Account shall consist of the fees imposed by the commissioner in accordance with this section.

(c) The commissioner shall administer the Technology Development Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Technology Development Restricted Account to provide services through use of electronic commerce or other similar technology.

(d) An appropriation from the Technology Development Restricted Account is nonlapsing.

Amended by Chapter 10, 2010 General Session
Amended by Chapter 265, 2010 General Session, (Coordination Clause)

31A-3-105. Criminal Background Check Restricted Account.

(1) There is created in the General Fund a restricted account known as the "Criminal Background Check Restricted Account."

(2) The Criminal Background Check Restricted Account shall consist of the fees imposed by the commissioner in accordance with:

(a) Subsection 31A-16-103(3);

(b) Subsection 31A-23a-105(3);

(c) Subsection 31A-25-203(3); and

(d) Subsection 31A-26-203(3).

(3) The commissioner shall administer the Criminal Background Check Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Criminal Background Check Restricted Account to pay the costs the department is required to pay related to obtaining criminal background information in accordance with the provisions listed in Subsection (2)(a).

(4) An appropriation from the Criminal Background Check Restricted Account is nonlapsing.

Enacted by Chapter 10, 2010 General Session
Amended by Chapter 265, 2010 General Session, (Coordination Clause)

31A-3-205. Taxation of insurance companies.

An admitted insurer shall pay to the State Tax Commission taxes imposed on the admitted insurer by Title 59, Revenue and Taxation.

Enacted by Chapter 123, 2005 General Session

31A-3-301. Tax imposed on surplus lines insurance transactions.

(1) (a) An insurance transaction under Section 31A-15-103 is subject to a tax of 4-1/4% of gross premiums, less 4-1/4% of return premiums paid to insureds by reason of policy cancellations or premium reductions.

(b) "Gross premium," for a surplus lines insurance transaction, means the monetary consideration for an insurance policy including the fees charged to the insured, however designated.

(2) The tax imposed by this section does not apply to:

(a) ocean marine insurance;

(b) insurance premiums paid by institutions within the state system of higher education as specified in Section 53B-1-102; or

(c) annuities.

(3) The department shall deposit a tax imposed by this section in the General Fund.

(4) (a) A county, city, or municipality within the state may not impose an occupation tax or other tax or fee on a surplus lines insurance transaction.

(b) Notwithstanding Subsection (4)(a), an insurer, producer, or policyholder may

be subject to other taxes not described in Subsection (4)(a).

Amended by Chapter 275, 2011 General Session

31A-3-302. Tax on illegal transactions.

An insurance transaction under Chapter 15 which violates the restrictions placed on transactions by that chapter shall be taxed at a rate four percentage points higher than the applicable rate under Section 59-9-101.

Amended by Chapter 2, 1987 General Session

31A-3-303. Payment of tax.

(1) (a) An insurer, the producers involved in the transaction, and the policyholder are jointly and severally liable for the payment of the taxes required under Section 31A-3-301.

(b) The policyholder's liability for payment of the premium tax under Section 31A-3-301 ends when the policyholder pays the tax to a producer or an insurer.

(c) The insurer and the producers involved in the transaction are jointly and severally liable for the payment of the additional tax required under Section 31A-3-302.

(d) Except for the tax under Section 31A-3-302, the policyholder shall pay a tax under this part and shall be billed specifically for the tax when billed for the premium.

(e) Except for the tax imposed under Section 31A-3-302, absorption of the tax by the producer or insurer is an unfair method of competition under Sections 31A-23a-402 and 31A-23a-402.5.

(2) (a) The commissioner shall by rule prescribe accounting and reporting forms and procedures for insurers, producers, and policyholders to use in determining the amount of taxes owed under this part, and the manner and time of payment.

(b) If a tax is not paid within the time prescribed under the commissioner's rule, a penalty shall be imposed of 25% of the tax due, plus 1-1/2% per month from the time of default until full payment of the tax.

(3) Upon making a record of its actions, and upon reasonable cause shown, the commissioner may waive, reduce, or compromise any of the penalties or interest imposed under this part.

(4) Subject to Section 31A-3-305, if a policy covers risks that are only partially located in this state, for computation of tax under this part the premium shall be reasonably allocated among the states on the basis of risk locations. However, the premiums with respect to surplus lines insurance received in this state by a surplus lines producer or charged on policies written or negotiated in or from this state are taxable in full under this part, subject to a credit for any tax actually paid in another state to the extent of a reasonable allocation on the basis of risk locations.

(5) Subject to Section 31A-3-305, the premium taxes collected under this part by a producer or by an insurer are the property of this state.

(6) If the property of a producer is seized under any process in a court in this state, or if a producer's business is suspended by the action of creditors or put into the hands of an assignee, receiver, or trustee, the taxes and penalties due this state under this part are preferred claims and the state is to that extent a preferred creditor.

Amended by Chapter 62, 2011 General Session
Amended by Chapter 275, 2011 General Session

31A-3-304 (Superseded 07/01/15). Annual fees -- Other taxes or fees prohibited -- Captive Insurance Restricted Account.

(1) (a) A captive insurance company shall pay an annual fee imposed under this section to obtain or renew a certificate of authority.

(b) The commissioner shall:

(i) determine the annual fee pursuant to Section 31A-3-103; and

(ii) consider whether the annual fee is competitive with fees imposed by other states on captive insurance companies.

(2) A captive insurance company that fails to pay the fee required by this section is subject to the relevant sanctions of this title.

(3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under the laws of this state that may be levied or assessed on a captive insurance company:

(i) a fee under this section;

(ii) a fee under Chapter 37, Captive Insurance Companies Act; and

(iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company Act.

(b) The state or a county, city, or town within the state may not levy or collect an occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii) against a captive insurance company.

(c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115 against a captive insurance company.

(d) A captive insurance company is subject to real and personal property taxes.

(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June 20 of each year.

(5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be deposited into the Captive Insurance Restricted Account.

(b) There is created in the General Fund a restricted account known as the "Captive Insurance Restricted Account."

(c) The Captive Insurance Restricted Account shall consist of the fees described in Subsection (3)(a).

(d) The commissioner shall administer the Captive Insurance Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Captive Insurance Restricted Account to:

(i) administer and enforce:

(A) Chapter 37, Captive Insurance Companies Act; and

(B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

(ii) promote the captive insurance industry in Utah.

(e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the

commissioner in excess of $950,000 shall be treated as free revenue in the General Fund.

Amended by Chapter 284, 2011 General Session

31A-3-305. Agreement related to nonadmitted insurance taxes.

(1) As used in this section:

(a) "Agreement" means a cooperative agreement, reciprocal agreement, or compact with one or more other states.

(b) (i) "Home state," except as provided in Subsections (1)(b)(ii) and (iii), with respect to an insured, means:

(A) the state in which the insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(B) if 100% of the insured risk is located out of the state described in Subsection (1)(b)(i)(A), the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(ii) If more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, "home state" means the home state determined under Subsection (1)(b)(i) of the member of the affiliated group that has the largest percentage of premium attributed to it under the nonadmitted insurance contract.

(iii) (A) When a group policyholder pays 100% of the premium from its own money, "home state" means the home state determined under Subsection (1)(b)(i) of the group policy holder.

(B) When a group policyholder does not pay 100% of the premium from its own money, "home state" means the home state determined under Subsection (1)(b)(i) of the group member.

(c) "Principal place of business," for purposes of determining the home state of an insured, means:

(i) the state where the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities;

(ii) if the insured's high-level officers direct, control, and coordinate the business activities in more than one state, the state in which the greatest percentage of the insured's taxable premium for that insurance contract is allocated; or

(iii) if the insured maintains its headquarters or the insured's high-level officers direct, control, and coordinate the business activities outside any state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(d) "Principal residence," with respect to determining the home state of an insured, means:

(i) the state where the insured resides for the greatest number of days during a calendar year; or

(ii) if the insured's principal residence is located outside any state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(2) The commissioner may enter into an agreement to:

(a) facilitate the collection, allocation, and disbursement of premium taxes

attributable to the placement of nonadmitted insurance;

(b) provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications; and

(c) share information among states relating to nonadmitted insurance premium taxes.

(3) If the commissioner enters into an agreement under Subsection (2), the following apply:

(a) In addition to the full amount of gross premiums charged by the insurer for the insurance, a surplus lines producer shall collect and pay to the commissioner a sum based on the total gross premiums charged, less any return premiums, for surplus lines insurance provided by the surplus lines producer.

(b) When surplus lines insurance covers property, risks, or exposures located or to be performed in and out of this state, the sum payable is calculated as follows:

(i) calculate an amount equal to the applicable tax rates under this part on that portion of the gross premiums allocated to this state pursuant to the agreement;

(ii) add to the amount under Subsection (3)(b)(i) an amount equal to the portion of the premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks, or exposures located or to be performed outside of this state pursuant to the agreement; and

(iii) subtract from the amount under Subsection (3)(b)(ii) the amount of gross premiums allocated to this state and returned to the insured.

(c) The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines producer. A surplus lines producer may not absorb or rebate, for any reason, any part of the tax.

(4) The commissioner may participate in a clearinghouse established through an agreement described in Subsection (2) for the purpose of collecting or disbursing to reciprocal states any money collected pursuant to Subsection (3) applicable to properties, risks, or exposures located or to be performed outside of this state. To the extent that other states where portions of the properties, risks, or exposures reside have failed to enter into an agreement with this state, the state shall retain the net premium tax collected.

(5) The commissioner may adopt an allocation schedule included in an agreement described in Subsection (2) for the purpose of allocating risk and computing the tax due on the portion of premium attributable to each risk classification and to each state where properties, risks, or exposures reside.

(6) The commissioner may apply the definition of "home state" in Subsection (1) when implementing an agreement described in Subsection (2).

(7) The commissioner shall report to the Business and Labor Interim Committee regarding the nature and status of any agreement into which the commissioner enters under Subsection (2).

Enacted by Chapter 275, 2011 General Session

31A-3-401. Retaliation against insurers of foreign state or country.

(1) Except as provided in Section 31A-3-402, when, under the laws of another

state or foreign country any taxes, licenses, other fees, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed on Utah insurers, or on the agents or representatives of Utah insurers, that are in excess of the taxes, licenses, other fees, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon the agents or representatives of those insurers, of that other state or country under the statutes of this state, as long as the laws of that other state or country continue in force or are so applied, the same taxes, licenses, other fees, deposit requirements, or other material obligations, prohibitions, or restrictions of any kind shall be imposed, collected, and enforced by the State Tax Commission, with the assistance of the commissioner, upon the insurers, or upon the agents or representatives of those insurers, of that other state or country doing business or seeking to do business in this state.

(2) Any tax, license, or other obligation imposed by any city, county, or other political subdivision or agency of another state or country on Utah insurers, their agents, or representatives is considered as being imposed by that state or country within the meaning of this section.

(3) The commissioner may by rule waive the retaliatory requirements for a person that is:

(a) doing business in this state; or

(b) seeking to do business in this state.

Amended by Chapter 308, 2002 General Session

31A-3-402. Obligations to which retaliation inapplicable.

Section 31A-3-401 does not apply to personal income taxes, ad valorem taxes on real or personal property, nor special purpose obligations or assessments in connection with particular kinds of insurance, except that deductions from premium taxes or other taxes otherwise payable, allowed on account of real estate or personal property taxes paid, are taken into consideration by the commissioner in determining the propriety and extent of retaliatory action under this part.

Enacted by Chapter 242, 1985 General Session

31A-3-403. Domicile of alien insurers.

(1) The domicile of an insurer formed under the laws of Canada, or a province of Canada, is considered to be that province in which its head office is situated.

(2) For the purposes of this part, the domicile of an alien insurer, other than insurers formed under the laws of Canada or a province thereof, is the state where the insurer's principal place of business is located in the United States, except that alien insurers may designate in a writing filed with the commissioner at time of admission to Utah or by January 1, 1987, whichever date is later, any one of the following states as the alien insurer's state of domicile:

(a) the state where the insurer was first authorized to transact insurance;

(b) the state which is the insurer's principal place of business in the United States; or

(c) the state where the largest deposit of trusteed assets of the insurer for the

protection of its policyholders and creditors in the United States is held.

Enacted by Chapter 242, 1985 General Session

31A-4-101. Solicitation permit.

(1) No person may advertise for or solicit or receive any funds, subscriptions for securities, or membership fees, dues, or contributions in Utah or from any person present in Utah for the purpose of forming or financing the formation or enlargement of an insurer, holding company to form or acquire one or more insurers, or any corporation or unincorporated association to do or facilitate the doing of an insurance business in Utah or elsewhere, unless the person has obtained the appropriate organization or solicitation permit under Chapter 5, Domestic Stock and Mutual Insurance Corporations, Chapter 6a, Service Contracts, Chapter 7, Nonprofit Health Service Insurance Corporations, Chapter 8, Health Maintenance Organizations and Limited Health Plans, or Chapter 9, Insurance Fraternals, and filed any required statement under Chapter 16, Insurance Holding Companies.

(2) Any person obtaining the appropriate organization or solicitation permit under this code is exempt from compliance with Title 61, Securities Division - Real Estate Division.

Amended by Chapter 340, 2011 General Session

31A-4-102. Qualified insurers.

(1) A person may not conduct an insurance business in Utah in person, through an agent, through a broker, through the mail, or through another method of communication, except:

(a) an insurer:

(i) authorized to do business in Utah under Chapter 5, 7, 8, 9, 10, 11, 13, or 14; and

(ii) within the limits of its certificate of authority;

(b) a joint underwriting group under Section 31A-2-214 or 31A-20-102;

(c) an insurer doing business under Section 31A-15-103;

(d) a person who submits to the commissioner a certificate from the United States Department of Labor, or such other evidence as satisfies the commissioner, that the laws of Utah are preempted with respect to specified activities of that person by Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law; or

(e) a person exempt from this title under Section 31A-1-103 or another applicable statute.

(2) As used in this section, "insurer" includes a bail bond surety company, as defined in Section 31A-35-102.

Amended by Chapter 345, 2008 General Session

31A-4-103. Certificate of authority.

(1) Each certificate of authority issued by the commissioner shall specify:

(a) the name of the insurer;
(b) the kinds of insurance the insurer is authorized to transact in Utah; and
(c) any other information the commissioner requires.
(2) A certificate of authority issued under this chapter remains in force until:
(a) the certificate is not renewed; or
(b) under Subsection (3), the certificate of authority is:
(i) revoked; or
(ii) suspended.
(3) (a) After an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, if the commissioner makes a finding described in Subsection (3)(b), the commissioner may:
(i) revoke a certificate of authority;
(ii) suspend a certificate of authority for a period not to exceed 12 months; or
(iii) limit a certificate of authority.
(b) The commissioner may take any action described in Subsection (3)(a) if the commissioner finds the insurer has:
(i) failed to pay when due any fee due under Section 31A-3-103;
(ii) violated or failed to comply with:
(A) this title;
(B) a rule made under Subsection 31A-2-201(3); or
(C) an order issued under Subsection 31A-2-201(4); or
(iii) engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.
(c) An order suspending a certificate of authority shall specify:
(i) the conditions and terms imposed on the insurer during the suspension; and
(ii) the conditions and procedures for reinstatement from suspension.
(d) The commissioner may place limitations on a certificate of authority at the time the certificate of authority is issued based on information contained in the application for the certificate of authority.
(e) An order limiting a certificate of authority that is issued under Subsection (3)(a) or (3)(d) shall specify:
(i) the period of the limitation;
(ii) the conditions of the limitation; and
(iii) the procedures for removing the limitation.
(4) Subject to the requirements of this section and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may by rule prescribe procedures to renew or reinstate a certificate of authority.
(5) An insurer under this chapter whose certificate of authority is suspended or revoked, but that continues to act as an authorized insurer, is subject to the penalties for acting as an insurer without a certificate of authority.
(6) Any insurer holding a certificate of authority in this state shall immediately report to the commissioner a suspension or revocation of that insurer's certificate of authority in any:
(a) state;
(b) the District of Columbia; or
(c) a territory of the United States.

(7) (a) An order revoking a certificate of authority under Subsection (3) may specify a time within which the former authorized insurer may not apply for a new certificate of authority, except that the time may not exceed five years from the date on which the certificate of authority is revoked.

(b) If no time is specified in an order revoking a certificate of authority under Subsection (3), the former authorized insurer may not apply for a new certificate of authority for five years from the date on which the certificate of authority is revoked without express approval by the commissioner.

(8) (a) Subject to Subsection (8)(b), the insurer shall pay all fees under Section 31A-3-103 that would have been payable if the certificate of authority had not been suspended or revoked, unless the commissioner, in accordance with rule, waives the payment of the fees by no later than the day on which:

(i) a suspension under Subsection (3) of an insurer's certificate of authority ends; or

(ii) a new certificate of authority is issued to an insurer whose certificate of authority is revoked under Subsection (3).

(b) If a new certificate of authority is issued more than three years after the day on which a similar certificate of authority was revoked, this Subsection (8) applies only to the fees that would have accrued during the three years immediately following the revocation.

Amended by Chapter 382, 2008 General Session

31A-4-104. Bar on local activity by persons not authorized.

A person not qualified under Section 31A-4-102 to do an insurance business may not, from offices or by personnel or facilities located in Utah, solicit insurance applications or transact insurance business in another jurisdiction.

Enacted by Chapter 242, 1985 General Session

31A-4-105. Deposit required from domestic insurers.

Domestic insurers organized or operating under Chapter 5, 7, or 9 shall maintain a deposit under Section 31A-2-206 in the amount of the insurer's required capital for stock insurers, or minimum permanent surplus for mutuals. The commissioner may not issue a certificate of authority to an insurer operating under one of these chapters until the insurer complies with this section.

Amended by Chapter 20, 1995 General Session

31A-4-105.5. Deposit required from foreign insurers.

(1) (a) Foreign insurers operating under Chapter 14 shall maintain a deposit in the amount of the insurer's minimum required capital for stock insurers, or minimum required permanent surplus for mutual insurers.

(b) The deposit shall be held for the benefit of all policyholders and may be maintained with an official of some other state designated by law to accept the deposit.

(2) The commissioner may not issue or renew a certificate of authority to an

insurer until the insurer complies with this section.

Enacted by Chapter 316, 1994 General Session

31A-4-106. Provision of health care.

(1) As used in this section, "health care provider" has the same definition as in Section 78B-3-403.

(2) Except under Subsection (3) or (4), unless authorized to do so or employed by someone authorized to do so under Chapter 5, 7, 8, 9, or 14, a person may not:

(a) directly or indirectly provide health care;

(b) arrange for health care;

(c) manage or administer the provision or arrangement of health care;

(d) collect advance payments for health care; or

(e) compensate a provider of health care.

(3) Subsection (2) does not apply to:

(a) a natural person or professional corporation that alone or with others professionally associated with the natural person or professional corporation, and except as provided in Subsection (3)(f), without receiving consideration for services in advance of the need for a particular service, provides the service personally with the aid of nonprofessional assistants;

(b) a health care facility as defined in Section 26-21-2 that:

(i) is licensed or exempt from licensing under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and

(ii) does not engage in health care insurance as defined under Section 31A-1-301;

(c) a person who files with the commissioner a certificate from the United States Department of Labor, or other evidence satisfactory to the commissioner, showing that the laws of Utah are preempted under Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law;

(d) a person licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, who:

(i) arranges for the insurance of all services under:

(A) Subsection (2) by an insurer authorized to do business in Utah; or

(B) Section 31A-15-103; or

(ii) works for an uninsured employer that complies with Chapter 13, Employee Welfare Funds and Plans;

(e) an employer that self-funds its obligations to provide health care services or indemnity for its employees if the employer complies with Chapter 13, Employee Welfare Funds and Plans; or

(f) notwithstanding the provisions of Subsection (3)(a), a natural person or professional corporation that alone or with others professionally associated with the natural person or professional corporation enters into a medical retainer agreement in accordance with Section 31A-4-106.5.

(4) A person may not provide administrative or management services for another person subject to Subsection (2) and not exempt under Subsection (3) unless the person:

(a) is an authorized insurer under Chapter 5, 7, 8, 9, or 14; or
(b) complies with Chapter 25, Third Party Administrators.
(5) An insurer or person who provides, administers, or manages health care insurance under Chapter 5, 7, 8, 9, or 14 may not enter into a contract that limits a health care provider's ability to advise the health care provider's patients or clients fully about treatment options or other issues that affect the health care of the health care provider's patients or clients.

Amended by Chapter 50, 2012 General Session

31A-4-106.5. Medical retainer agreements.
(1) For purposes of this section:
(a) "Medical retainer agreement" means a written contract:
(i) between:
(A) except as provided in Subsection (1)(b)(iii)(B), a natural person or a professional corporation, alone or with others professionally associated with the natural person or professional corporation; and
(B) an individual patient or a patient's representative; and
(ii) in which:
(A) the person described in Subsection (1)(a)(i)(A) agrees to provide routine health care services to the individual patient for an agreed upon fee and period of time; and
(B) either party to the contract may terminate the agreement upon written notice to the other party.
(b) "Routine health care services" include:
(i) screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury;
(ii) supplies and prescription drugs that are dispensed in a health care provider's office; and
(iii) laboratory work, such as routine blood screening or routine pathology screening performed by a laboratory that:
(A) is associated with the health care provider entering into the medical retainer agreement; or
(B) if not associated with the health care provider, has entered into an agreement with the health care provider to provide the laboratory work without charging a fee to the patient for the laboratory work.
(2) A medical retainer agreement exempt from the provisions of Subsection 31A-4-106(2) shall:
(a) describe the specific routine health care services that are included in the contract;
(b) prominently state in writing that the retainer agreement is not health insurance; and
(c) prohibit the health care provider, but not the patient, from billing an insurer for the services provided under the medical retainer agreement.

Enacted by Chapter 50, 2012 General Session

31A-4-107. Other business.

(1) As used in this section, "business reasonably incidental to insurance business" includes:

(a) in the case of an insurer authorized to transact title insurance:

(i) preparing or selling abstracts of title and related documents; and

(ii) providing escrow services in connection with real estate transactions, or other services incidental to the sale or transfer of insurance related to the sale or transfer of real property, except the sale of other kinds of insurance related to the sale or transfer of real property; and

(b) the business that could be done through subsidiaries authorized under Subsection 31A-5-218(3) or, in the case of a nondomestic insurer, through corporations that would be authorized under Subsection 31A-5-218(3) if the insurer were a domestic insurer.

(2) No domestic insurer may engage, directly or indirectly, in any business other than insurance and business reasonably incidental to its insurance business, except as specifically authorized by Section 31A-5-218 or other law in this state.

(3) No nondomestic insurer may engage in this state in any business forbidden to a domestic insurer, nor may the insurer engage in that type of business elsewhere if the commissioner orders the nondomestic insurer to cease doing that type of business upon finding that doing that business is not consistent with the interests of its insureds, creditors, or the public in this state.

Amended by Chapter 308, 2002 General Session

31A-4-107.5. Penalty for failure of a regulated health insurance entity to fulfill duties related to state claims for Medicaid payment or recovery.

(1) For purposes of this section, "regulated health insurance entity" means a health insurance entity, as defined in Section 26-19-2, that is subject to regulation by the department.

(2) If a regulated health insurance entity fails to comply with the provisions of Section 26-19-4.7:

(a) the commissioner may revoke or suspend, in whole or in part, a license, certificate of authority, registration, or other authority that is granted by the commissioner to the regulated health insurance entity; and

(b) the regulated health insurance entity is subject to the penalties and procedures provided for in Section 31A-2-308.

Enacted by Chapter 64, 2007 General Session

31A-4-108. Power to hold property in other than own name.

(1) An insurer shall hold all investments and deposits of its funds in its own name except:

(a) securities:

(i) kept under a custodial agreement or trust arrangement with one of the following approved by the commissioner:

(A) a bank;

(B) a securities firm's trust company;
(C) a trust company; or
(D) a brokerage firm; and
(ii) that may be issued in the name of a nominee of the:
(A) bank;
(B) securities firm's trust company;
(C) trust company; or
(D) brokerage firm; and
(b) securities that may be acquired and held in bearer form.
(2) An insurer shall take steps which the commissioner reasonably prescribes by rule or order to:
(a) safeguard the securities described in Subsection (1); and
(b) ensure that the securities are not loaned to other insurers, affiliated or not, to mislead the commissioner about the true financial condition of either the lending or the borrowing insurer.
(3) (a) If the department finds that an insurer is in violation of this section, the insurer is subject to:
(i) a fine;
(ii) suspension of a license;
(iii) revocation of a license;
(iv) another penalty permitted by Section 31A-2-308; or
(v) any combination of Subsections (3)(a)(i) through (iv).
(b) An insurer may not provide for the custody of the insurer's securities except as granted by this section.
(c) Securities of an insurer kept under a custodial agreement or trust arrangement in violation of this section shall be disregarded in:
(i) determining the financial condition of the insurer; or
(ii) reporting the financial condition of the insurer.

Amended by Chapter 176, 2006 General Session

31A-4-109. Insurers as fundholders.

All of an insurer's assets shall be held, invested, and disbursed for the use and benefit of the insurer. No policyholder, member, or beneficiary may have or acquire individual rights in these assets or become entitled to an apportionment or the surrender of any part of these assets, except as provided in this title or by contract. An insurer may create, maintain, invest, disburse, and apply any special funds necessary to carry out any purpose permitted by the laws of this state and the articles and bylaws of the insurer.

Amended by Chapter 204, 1986 General Session

31A-4-110. Duty of insurers to report abandoned property.

All insurers doing business in Utah shall report under Section 67-4a-301 any property presumed abandoned under Title 67, Chapter 4a, Part 2.

Amended by Chapter 198, 1995 General Session

31A-4-111. Authority to insure with certain insurers.

A person, government, governmental agency, state, political subdivision of the state, public or private corporation, board, association, estate, trustee, or fiduciary may purchase nonassessable policies of insurance issued by an insurer under Chapter 5, 7, 8, or 14, which is authorized to write that type of insurance under this code. These authorized insurers may issue that type of insurance to any of the persons named above.

Amended by Chapter 20, 1995 General Session

31A-4-112. Political activities.

(1) Title 36, Chapter 11, Lobbyist Disclosure and Regulation Act, applies to the lobbying efforts of every person subject to regulation under this title.

(2) Except insurers with excess surplus, an insurer doing business in Utah may not directly or indirectly pay or use, or offer or agree to pay or use any money or thing of value:

(a) for or in aid of any political office;

(b) for the nomination for the political office; or

(c) for reimbursement or indemnification of any person for money or property used to aid any political office.

Amended by Chapter 9, 1996 Special Session 2

31A-4-113. Annual statements.

(1) (a) Each authorized insurer shall annually, on or before March 1, file with the commissioner a true statement of the authorized insurer's financial condition, transactions, and affairs as of December 31 of the preceding year.

(b) The statement required by Subsection (1)(a) shall be:

(i) verified by the oaths of at least two of the insurer's principal officers; and

(ii) in the general form and provide the information as prescribed by the commissioner by rule.

(c) The commissioner may, for good cause shown, extend the date for filing the statement required by Subsection (1)(a).

(2) The annual statement of an alien insurer shall:

(a) relate only to the alien insurer's transactions and affairs in the United States unless the commissioner requires otherwise; and

(b) be verified by:

(i) the insurer's United States manager; or

(ii) the insurer's authorized officers.

Amended by Chapter 2, 2004 General Session

31A-4-113.5. Filing requirements -- National Association of Insurance Commissioners.

(1) (a) Each domestic, foreign, and alien insurer who is authorized to transact insurance business in this state shall annually, on or before March 1, file with the National Association of Insurance Commissioners a copy of the insurer's:

(i) annual statement convention blank; and

(ii) any additional filings required by the commissioner for the preceding year.

(b) The information filed with the National Association of Insurance Commissioners under Subsection (1)(a) shall:

(i) be in the format and scope required by the commissioner; and

(ii) include:

(A) the signed jurat page; and

(B) the actuarial certification.

(c) Any amendments and addendums to an annual statement that are filed with the commissioner shall be filed by the insurer with the National Association of Insurance Commissioners.

(d) At the time an insurer makes a filing under this Subsection (1), the insurer shall pay any filing fees assessed by the National Association of Insurance Commissioners.

(e) A foreign insurer that is domiciled in a state that has a law substantially similar to this section shall be considered to be in compliance with this section.

(2) All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the Insurance Regulatory Information System are confidential and may not be disclosed by the department.

(3) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to:

(a) file the annual statement as required by Subsection (1)(a) when due or within any extension of time granted for good cause by:

(i) the commissioner; or

(ii) the National Association of Insurance Commissioners; or

(b) pay by the time specified in Subsection (3)(a) a fee the insurer is required to pay under this section to:

(i) the commissioner; or

(ii) the National Association of Insurance Commissioners.

Amended by Chapter 252, 2003 General Session

31A-4-114. Powers of a reciprocal insurer and interinsurance exchange.

(1) Every reciprocal insurer or interinsurance exchange may:

(a) purchase, receive, own, hold, and lease its property;

(b) mortgage, pledge, or encumber its property by deed of trust or otherwise; and

(c) manage and sell real property to fulfill its purposes, including:

(i) making investments for the production of income; or

(ii) transacting its business in a convenient manner.

(2) The attorney-in-fact designated by the subscribers of the reciprocal or interinsurance exchange shall execute any contract, which includes deeds, leases, mortgages, deeds of trust, purchase or sale agreements, or any other contract, in the

name of the reciprocal insurer or interinsurance exchange.

Enacted by Chapter 327, 1990 General Session

31A-4-115. Plan of orderly withdrawal.

(1) (a) When an insurer intends to withdraw from writing a line of insurance in this state or to reduce its total annual premium volume by 75% or more, the insurer shall file with the commissioner a plan of orderly withdrawal.

(b) For purposes of this section, a discontinuance of a health benefit plan pursuant to one of the following provisions is a withdrawal from a line of insurance:

(i) Subsection 31A-30-107(3)(e); or

(ii) Subsection 31A-30-107.1(3)(e).

(2) An insurer's plan of orderly withdrawal shall:

(a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

(b) include provisions for:

(i) meeting the insurer's contractual obligations;

(ii) providing services to its Utah policyholders and claimants;

(iii) meeting any applicable statutory obligations; and

(iv) (A) the payment of a withdrawal fee of $50,000 to the Utah Comprehensive Health Insurance Pool if:

(I) the insurer is an accident and health insurer; and

(II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner; or

(B) the payment of a withdrawal fee of $50,000 to the department if:

(I) the insurer is not an accident and health insurer; and

(II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner.

(3) The commissioner shall approve a plan of orderly withdrawal if the plan adequately demonstrates that the insurer will:

(a) protect the interests of the people of the state;

(b) meet the insurer's contractual obligations;

(c) provide service to the insurer's Utah policyholders and claimants; and

(d) meet any applicable statutory obligations.

(4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for orderly withdrawal.

(5) The commissioner may require an insurer to increase the deposit maintained in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the name of the commissioner upon finding, after an adjudicative proceeding that:

(a) there is reasonable cause to conclude that the interests of the people of the state are best served by such action; and

(b) the insurer:

(i) has filed a plan of orderly withdrawal; or

(ii) intends to:

(A) withdraw from writing a line of insurance in this state; or

(B) reduce the insurer's total annual premium volume by 75% or more.

(6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

(a) withdraws from writing insurance in this state; or

(b) reduces its total annual premium volume by 75% or more in any year without having submitted a plan or receiving the commissioner's approval.

(7) An insurer that withdraws from writing all lines of insurance in this state may not resume writing insurance in this state for five years unless:

(a) the commissioner finds that the prohibition should be waived because the waiver is:

(i) in the public interest to promote competition; or

(ii) to resolve inequity in the marketplace; and

(b) the insurer complies with Subsection 31A-30-108(5), if applicable.

(8) The commissioner shall adopt rules necessary to implement this section.

Amended by Chapter 308, 2002 General Session

31A-4-116. Adverse benefit determination procedures.

(1) If an insurer has established a complaint resolution body or grievance appeal board, the body or board shall include at least one consumer representative.

(2) Adverse benefit determination procedures for health insurance policies and health maintenance organization contracts shall be established in accordance Section 31A-22-629.

Amended by Chapter 308, 2002 General Session

31A-4-117. Closing or settlement protection.

(1) A title insurer may issue closing or settlement protection in the form of a closing protection letter filed with the department to a person who is a party to a transaction in which a title insurance policy is issued.

(2) Closing or settlement protection may indemnify a person who is a party to a transaction referred to in Subsection (1) against loss that the title insurer approves for the closing or settlement protection, under the terms and conditions of the closing protection letter issued by the title insurer, because of one or more of the following acts of a title insurance policy issuing individual title insurance producer or agency title insurance producer or other settlement service provider:

(a) theft or misappropriation of settlement funds in connection with a transaction in which one or more title insurance policies are issued by or on behalf of the title insurer issuing the closing or settlement protection, but only to the extent that the theft or misappropriation relates to the status of the title to that interest in land or to the validity, enforceability, and priority of the lien of the mortgage on that interest in land; or

(b) failure to comply with the written closing instructions when agreed to by the settlement agent, title agent, or employee of the title insurer, but only to the extent that the failure to follow the written closing instructions relates to the status of the title to that interest in land or the validity, enforceability, and priority of the lien of the mortgage on that interest in land.

(3) A title insurer may not make the fee charged by a title insurer for each party receiving closing or settlement protection coverage subject to any agreement requiring a division of fees or premiums collected on behalf of the title insurer. The fee charged for a closing or settlement coverage protection letter will be filed by the title insurer with the department 30 days before use.

(4) A title insurer may not provide any other protection that purports to contractually indemnify against improper acts or omissions of a person who is a party to a transaction referred to in Subsection (1) with regard to settlement or closing services.

Enacted by Chapter 319, 2013 General Session

31A-5-101. Definitions.

In this chapter, unless the context requires otherwise:

(1) The definitions of the following terms applicable to the Utah Revised Business Corporation Act in Section 16-10a-102 apply to stock corporations:

(a) "affiliate";

(b) "mail"; and

(c) "notice."

(2) The definitions to the following terms applicable to nonprofit corporations in Section 16-6a-102 apply to mutuals:

(a) "articles of incorporation";

(b) "bylaws"; and

(c) "member."

(3) "Promoter securities" are securities issued by a stock insurer to the incorporators, directors, officers, or their families or nominees at any time prior to, and up to one year following, the issuance of a certificate of authority to the stock insurer.

Amended by Chapter 386, 2009 General Session

31A-5-102. Scope and purposes.

(1) (a) Except as expressly provided otherwise in this title, this chapter applies to all corporations organized under Utah law and doing an insurance business as defined under Section 31A-1-301, except those expressly governed by other chapters of this title. This chapter applies to corporations doing a reinsurance business, whether or not they do other insurance business.

(b) Except as expressly provided otherwise, this chapter does not apply to nondomestic insurers.

(c) Except as provided otherwise in this title, Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, apply to corporations under this chapter.

(d) If Title 16, Chapter 6a, or Title 16, Chapter 10a, conflict with this title, this title governs.

(2) The purposes of this chapter include:

(a) to provide a procedure for the formation of insurance corporations;

(b) to assure the solidity of insurance corporations by providing an organizational framework to facilitate sound management, sound operation, and sound

regulation;

(c) to provide fair means of corporate transformation; and

(d) where feasible, to strengthen internal corporate democracy through enhancing shareholder and policyholder participation.

Amended by Chapter 300, 2000 General Session

31A-5-103. Orders imposing and relaxing restrictions.

(1) The commissioner may by order subject an individual corporation not otherwise subject to some or all of the restrictions of Subsections 31A-5-304(4), 31A-5-305(1)(a), 31A-5-305(2)(a)(i) and (ii), and 31A-5-410(1)(b) if he finds after a hearing that the individual corporation's financial condition, management, and other circumstances require additional regulation for the protection of the interests of insureds or the public. The commissioner shall detail in writing the grounds for his order.

(2) The commissioner may by order free a new corporation from any or all of the restrictions generally applicable to new corporations under the provisions listed in Subsection (1), if he is satisfied that the corporation's financial condition, management, and other circumstances give assurance that the interests of insureds and the public will not be endangered by doing so.

Amended by Chapter 1, 2000 General Session

31A-5-104. General corporate powers and procedures.

(1) (a) Subject to other provisions of this code, Section 16-10a-302 applies to stock and mutual insurance corporations.

(b) Subject to other specific provisions of this title, a domestic insurance corporation may participate in any activity permitted as a promoter, partner, member, associate, or manager of any partnership, joint venture, trust, or other enterprise.

(2) Subsections 16-10a-303(2)(a) and (b) apply to stock corporations, and Section 16-10a-622 applies to mutuals.

(3) Whenever a seal is required on a corporate document, writing or printing the word "Seal" constitutes a valid seal.

(4) In waiving notice and in informal actions by shareholders, members, or directors, Sections 16-10a-704, 16-10a-706, and 16-10a-823 apply to stock corporations, and Sections 16-6a-705 and 16-6a-707 apply to mutuals.

(5) A life insurance corporation may hold assets under Section 31A-22-410 as general corporate assets or as trustee.

Amended by Chapter 300, 2000 General Session

31A-5-105. Documents as evidence.

A certificate issued by the commissioner under a provision of this chapter is prima facie evidence of the facts stated in the certificate.

Enacted by Chapter 242, 1985 General Session

31A-5-106. Unauthorized assumption of corporate power.

All persons who presume to act as a corporation under this chapter without authority to do so are jointly and severally liable for all debts and liabilities incurred or arising as a result.

Enacted by Chapter 242, 1985 General Session

31A-5-108. Transition provision for former mutual benefit associations, cooperative associations, county mutuals, and reciprocal insurers.

(1) Except as otherwise provided in this code, a domestic stock or mutual insurance corporation, including an incorporated mutual benefit association, a county mutual, a reciprocal insurer, or an incorporated cooperative association, holding a valid certificate of authority on July 1, 1986, continues to be authorized within the limits of its certificate of authority. Incorporated mutual benefit associations, county mutuals, reciprocal insurers, and cooperative associations become Chapter 5 mutuals by operation of law on July 1, 1986.

(2) If timely adjustment to the requirements of Chapter 5 would cause an existing stock or mutual insurance corporation hardship, disproportionate expense, or serious inconvenience, the commissioner may, upon the corporation's request, grant an extension for compliance with specified requirements, if the interests of insureds and the public are not endangered. The extension may not be beyond July 1, 1988.

Enacted by Chapter 242, 1985 General Session

31A-5-109. Compliance extension.

If timely adjustment to a particular requirement applicable to a Chapter 5 mutual would cause a former county mutual, reciprocal insurer, cooperative association, or mutual benefit association hardship, disproportionate expense, or serious inconvenience, the commissioner may, upon the insurer's request, grant an extension for compliance if the interests of insureds and the public are not endangered. This extension may not be beyond July 1, 1988. The requirement of payment of taxes and fees is not considered a hardship or a disproportionate expense.

Enacted by Chapter 242, 1985 General Session

31A-5-201. Reservation and registration of corporate name.

The reservation, registration, and renewal of the corporate name of stock corporations and mutuals is governed by Sections 16-10a-402, 16-10a-403, and 31A-1-109. The reservation and registration fees provided in Section 31A-3-103 apply.

Amended by Chapter 344, 1995 General Session

31A-5-202. Incorporators.

(1) One or more adult natural persons may organize and act as incorporators of a corporation under Section 31A-5-204.

(2) One to 15 adult natural persons may organize and act as incorporators of a

corporation under the accelerated organization procedure of Section 31A-5-213.

(3) This section does not apply to stock and mutual insurance corporations already in existence on July 1, 1986.

Amended by Chapter 71, 2002 General Session

31A-5-203. Articles and bylaws.

(1) The articles of incorporation requirements in Section 16-10a-202 apply to the articles of a stock corporation, except that:

(a) the name of the corporation shall comply with Sections 16-10a-401 and 31A-1-109 and the name of any new or renamed corporation shall include the word "insurance" or a term of equivalent meaning;

(b) authorized shares shall conform to Subsection 31A-5-305(1) and the capital provided for shall conform to Section 31A-5-211; and

(c) beginning on July 1, 1988, the purposes of the corporation are limited to those permitted by Section 31A-4-107.

(2) The articles of incorporation requirements in Section 16-6a-202, except Subsections 16-6a-202(1) (f) and (g), apply to the articles of a mutual except that:

(a) The name of the corporation shall comply with Sections 16-6a-401 and 31A-1-109 and the name of any new or renamed corporation shall include the words "mutual" and "insurance" or terms of equivalent meaning.

(b) If any mutual bonds are authorized, they shall comply with Subsection 31A-5-305(2)(a).

(c) The purposes of the corporation may not include doing a title insurance business, and shall be limited to those purposes permitted by Section 31A-4-107.

(d) If assessable policies are permitted, the articles shall contain provisions giving assessment liabilities and procedures, including a provision specifying the classes of business on which assessment may be separately levied.

(e) The articles may specify those classes of persons who may be policyholders, or prescribe the procedure for establishing or removing restrictions on the classes of persons who may be policyholders. The articles shall also state that each policyholder is a member of the corporation.

(3) Sections 16-10a-830 and 16-10a-831 apply to stock corporations and Section 16-6a-818 applies to mutuals. The articles or bylaws shall designate three or more principal offices the principal officers of the corporation shall hold. The principal offices shall be held by at least three separate natural persons.

(4) The bylaws of a domestic corporation shall comply with this chapter. A copy of the bylaws, and any amendments to them, shall be filed with the commissioner within 60 days after their adoption. Subject to this Subsection (4), Subsections 31A-5-204(2)(c) and (5), Subsection 31A-5-213(4), and Section 16-10a-206 apply to stock corporations and Section 16-6a-206 applies to mutuals.

Amended by Chapter 364, 2008 General Session

31A-5-204. Organization permit -- Certificate of incorporation.

(1) Subject to Section 31A-5-213, a person, including a stock insurance

corporation, insurance holding company, stock corporation to finance an insurer or insurance production for an insurer, corporation to provide management or administrative services for any of the entities named above, or mutual insurer, may not solicit subscriptions for its securities, or in the case of a mutual insurance corporation, solicit applications for qualifying insurance policies or subscriptions for mutual bonds or contribution notes, until the commissioner has issued an organization permit.

(2) The application for an organization permit shall give the name of the insurer to be formed and shall be signed and acknowledged by or on behalf of each incorporator. The application shall include or have attached:

(a) the names, and for the preceding 10 years all addresses, and all occupations of the incorporators and the proposed directors and officers;

(b) for all persons planned by the incorporators to own 10% or more of the capital stock of the corporation, their annual financial statements and reports for the three most recent years, and if the planned shareholders are corporations, their articles and bylaws, and a list of the names, addresses, and occupations of all their directors and principal officers;

(c) the proposed articles, which shall be signed and acknowledged by or on behalf of each incorporator, and the proposed bylaws;

(d) all agreements relating to the corporation to which any incorporator, proposed director, or officer is a party;

(e) the amount and sources of the funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other persons;

(f) the plan for solicitation of applications for qualifying insurance policies and for the corporation's securities;

(g) the forms to be used for stock subscriptions, certificates for shares, applications for qualifying insurance policies, subscriptions for mutual bonds and contribution notes, and the forms for bonds and notes;

(h) the capital and initial paid in surplus in the case of a stock insurer, or the minimum permanent surplus and the additional surplus in the case of a mutual insurer;

(i) the plan for conducting the insurance business, including:

(i) the geographical area in which business is intended to be done in the first two years;

(ii) the types of insurance intended to be written in the first two years;

(iii) the proposed marketing methods;

(iv) when requested by the commissioner, the proposed method for establishing premium rates; and

(v) the proposed aggregate compensation of the five highest compensated officers, directors, and employees;

(j) a projection certified by a member of the American Academy of Actuaries of the anticipated operating results of the corporation at the end of each of the first two years of operation, based on reasonable assumptions of loss experience, premium and other income, operating expenses, and acquisition costs; and

(k) any other relevant document or information the commissioner reasonably requires.

(3) The commissioner shall issue an organization permit if:

(a) all the requirements of law have been met, including the payment of fees;

(b) all the incorporators, persons listed in Subsection (2)(b), and the proposed directors and officers of the corporation being formed, are trustworthy and collectively have the competence and experience to engage in the particular insurance business proposed;

(c) the business plan is consistent with the interests of the corporation's potential insureds and the public; and

(d) the bond required by Section 31A-5-205 is filed.

(4) If the commissioner denies the application for a permit, the commissioner shall state the reasons for the denial.

(5) (a) The organization permit shall:

(i) specify the minimum capital or minimum permanent surplus required under Section 31A-5-211; and

(ii) describe the securities or policies to be solicited under the permit.

(b) The organization permit may contain any other information the commissioner considers necessary.

(6) The director of the Division of Corporations and Commercial Code shall accept the filing of the corporation's articles of incorporation upon notice from the insurance commissioner that all the applicable requirements of law have been met, including the payment of fees.

(7) (a) When the director of the Division of Corporations and Commercial Code accepts the articles of incorporation:

(i) the legal existence of the corporation begins;

(ii) the articles and bylaws become effective; and

(iii) the proposed directors and officers take office.

(b) The certificate is conclusive evidence of compliance with this section, except in a proceeding by the state against the corporation.

(8) Notwithstanding Title 63G, Chapter 2, Government Records Access and Management Act, the permit applicant may request that any part of the information supplied under Subsection (2) be kept confidential. The information shall then be kept confidential unless the commissioner expressly finds, after a hearing, that the interest of the corporation or the public requires that the information be open to the public.

Amended by Chapter 382, 2008 General Session

31A-5-205. Bond.

(1) No organization permit may be issued until the commissioner receives from the applicants a bond of an authorized corporate surety, or a deposit of cash or approved securities under Section 31A-2-206. This bond or deposit shall be in an amount the commissioner determines is sufficient, but in no event may it be less than $20,000, nor more than $100,000. The bond or deposit shall be in favor of the state of Utah and of any subscribers and creditors of the applicant, for the payment of costs incurred by the state by reason of dissolution of the corporation before the issuance of a certificate of authority and for the payment of other debts incurred in the organizational period. The bond shall be discharged or the deposit returned upon issuance of the certificate of authority under Section 31A-5-212.

(2) This section does not apply to stock or mutual insurance corporations already in existence on July 1, 1986.

Enacted by Chapter 242, 1985 General Session

31A-5-206. Sale of securities by authorized insurer.

A domestic insurer that has already received a certificate of authority may issue additional securities to obtain further financing, after obtaining a solicitation permit from the commissioner. The organizational permit requirements in Section 31A-5-204 apply if the commissioner prescribes its application. The phrase "organization permit" in Section 31A-5-204 means "solicitation permit" when being applied to this section. The solicitation permit terminates one year from the date of its issuance. However, this permit may be extended for not more than one additional year by the commissioner on terms he considers sufficient to protect the policyholders, the shareholders, and the public.

Amended by Chapter 95, 1987 General Session

31A-5-207. Powers under organization permit.

(1) While its organization permit is in effect a stock corporation may:

(a) register stock under Section 31A-5-302, solicit subscriptions subject to Section 16-10a-620, accept payment for the subscriptions in cash or, with the approval of the commissioner, in other property constituting a permitted investment under Chapter 18, and issue receipts for payments made at values approved by the commissioner, but no certificates for shares may be issued until a certificate of authority has been issued; and

(b) transact all other business necessary and appropriate in the organization of the planned insurance enterprise.

(2) While its organization permit is in effect a mutual may:

(a) register mutual bonds under Section 31A-5-302, solicit applications for qualifying insurance policies under Subsection 31A-5-211(5), solicit subscriptions for mutual bonds and contribution notes and accept payment for the subscriptions in cash or, with the approval of the commissioner, in property constituting a permitted investment under Chapter 18, and issue receipts for payments made at values approved by the commissioner, but no policies or bonds are effective or may be issued until a certificate of authority has been issued; and

(b) transact all other business necessary and appropriate in the organization of the planned insurance enterprise.

(3) (a) The existence of the organization permit may not be used as an inducement in any solicitation.

(b) No person may knowingly, with intent to deceive, exhibit any false document or account regarding the affairs of any organization under Section 31A-5-204 or make any misrepresentation about its affairs.

(4) Solicitations under this section may be made for stock or bond subscriptions only by persons registered under Title 61, Chapter 1, as broker-dealers or agents. Solicitations under this section may be made for qualifying insurance policies only by

persons licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, as insurance producers. Before any solicitation, the solicitor shall obtain from the commissioner a license to solicit, after paying the fee applicable under Section 31A-3-103.

(5) This section does not apply to stock or mutual insurance corporations already in existence on July 1, 1986.

Amended by Chapter 298, 2003 General Session

31A-5-208. Deposit of proceeds of subscriptions.

(1) All funds, and the securities and documents representing interests in property, received by a stock corporation for stock subscriptions or by a mutual for applications for insurance policies or for mutual bond or contribution note subscriptions, shall be deposited in the name of the corporation with a custodian financial institution qualified under Subsection 31A-2-206(1). This deposit is subject to an escrow agreement approved by the commissioner under which withdrawals may be made only in accordance with conditions specified in the agreement, and with the commissioner's approval. Securities may be held as authorized in Subsection 31A-2-206(2) and are required to be approved by the commissioner.

(2) This section does not apply to stock or mutual insurance corporations already in existence on July 1, 1986.

Amended by Chapter 297, 2011 General Session

31A-5-209. Termination and revocation of organization permit and payment of organization expenses.

(1) The organization permit terminates upon:

(a) issuance of a certificate of authority under Section 31A-5-212;

(b) revocation of the organization permit under Subsection (2); or

(c) expiration of one year after issuance, except that

(i) filing with the commissioner a good-faith application for a certificate of authority tolls the running of the expiration period for 30 days or until the commissioner rejects the application, whichever is earlier; and

(ii) on application before expiration of the year the commissioner may grant a reasonable extension if he states that he expects the corporation to be able to satisfy the requirements for a certificate of authority within the extended period.

(2) The commissioner may revoke an organization permit if:

(a) he finds, after a hearing, that because of changes in circumstances, or because the facts are not as represented in the application, the conditions for issuance of a permit are not satisfied; or

(b) he denies an application for a certificate of authority and finds that the corporation cannot reasonably be expected to satisfy the requirements for a certificate of authority within the remaining term of the organization permit or extension allowable under Subsection (1)(c).

(3) (a) Except in cases under Subsections (3)(b) and (3)(c), if the organization permit is revoked or expires before a certificate of authority is granted, after payment of

the expenses of the state and payments to creditors under Section 31A-5-205, incorporators who have advanced money for the reasonable and authorized expenses of organization, including underwriting expenses, may be reimbursed in cash from the proceeds of share, mutual bond, or contribution note subscriptions under the organization permit, on itemized receipts audited by the commissioner. The total reimbursement may not exceed 5% of the amount received from subscribers. The remainder in the escrow account shall then be distributed among the subscribers in proportion to their contributions, valued as of the time the contributions were made. The bond under Section 31A-5-205 shall be discharged or the deposits under Section 31A-5-205 shall be released to the extent they are not needed for other purposes.

(b) Reimbursement may be refused to any incorporator under Subsection (3), if the commissioner finds that in connection with the organization of the corporation, the incorporator has wilfully or negligently violated in a material way any provision of this chapter.

(c) No reimbursement may be made under Subsection (3)(a) to an incorporator of an assessable mutual until all advance premiums collected under Subsection 31A-5-211(5) have been repaid in full.

(4) The legal existence of the corporation terminates upon completion of the payments under Subsection (3).

(5) This section does not apply to stock or mutual insurance corporations already in existence on July 1, 1986.

Enacted by Chapter 242, 1985 General Session

31A-5-210. Incorporators' liability and organization expenses.

(1) The incorporators are jointly and severally liable for all organizational and promotional expenses and obligations incurred prior to the issuance of the certificate of authority. Upon issuance of the certificate, the insurer may pay those outstanding expenses and obligations lawfully incurred.

(2) (a) (i) After issuance of the certificate of authority, incorporators of a stock corporation who have advanced money or incurred obligations for the reasonable and authorized expenses of organization, including underwriting of securities, may be reimbursed in cash from the proceeds of shares subscribed to under the organization permit, or in shares at the public offering price, on itemized receipts audited by the commissioner.

(ii) Promotional securities in connection with the financing of a stock corporation which is in the promotional, exploratory, or developmental stage may be issued in an amount and for a consideration which is not unreasonable. In this regard, the commissioner may adopt rules setting forth standards with respect to promotional securities allowed to be issued and the considerations to be received for them. The reimbursement for expenses under Subsection (2)(a)(i) has priority over the issuance of promotional securities under Subsection (2)(a)(ii).

(iii) In no event may securities issued under Subsection (2)(a)(i) or promotional securities issued under Subsection (2)(a)(ii) be issued in a manner which would, in the aggregate, cause the dilution in the net tangible asset value of the insurer's securities proposed to be issued to the public to exceed 25%.

(b) After issuance of the certificate of authority, incorporators of a mutual who have advanced money or incurred obligations for the reasonable and authorized expenses of organization may be reimbursed in cash from the proceeds of subscriptions for mutual bonds and contribution notes, on itemized receipts audited by the commissioner. The total reimbursement may not exceed 15% of the amount received for the bonds and notes.

(3) This section does not apply to stock or mutual insurance corporations already in existence on July 1, 1986.

Enacted by Chapter 242, 1985 General Session

31A-5-211. Minimum capital or permanent surplus requirements.

(1) (a) Except as provided in Subsections (4) and (5), insurers being organized or operating under this chapter shall maintain minimum capital or permanent surplus for a mutual, in amounts specified in Subsection (2).

(b) The certificate of authority issued under Section 31A-5-212 does not permit an insurer to transact types of insurance for which the insurer does not have the required minimum capital or permanent surplus for a mutual, in at least the amounts specified under Subsection (2).

(c) Minimum capital and permanent surplus requirements under this section are based upon all types of insurance transacted by the insurer in any and all areas which it operates, whether or not only a portion of those types of insurance is or is to be transacted in this state.

(2) The minimum capital, or permanent surplus for a nonassessable mutual, is as follows for the indicated types of insurance:

(a) life, annuity, accident and health, or any combination of these.....$400,000

(b) subject to an aggregate maximum of $1,000,000 for more than one of the following types of coverages:

(i) property insurance.....200,000

(ii) surety insurance.....300,000

(iii) bail bonds insurance only.....100,000

(iv) marine and transportation insurance.....200,000

(v) vehicle liability insurance, residential dwelling liability insurance, or both.....400,000

(vi) liability insurance.....600,000

(vii) workers' compensation insurance.....300,000

(c) title insurance.....200,000

(d) professional liability insurance, excluding medical

malpractice.....700,000

(e) professional liability, including medical malpractice.....
.....1,000,000

(f) all types of insurance, except life, annuity, or
title.....2,000,000

(3) Prior to beginning operations, an insurer licensed under this chapter shall have total adjusted capital in excess of the company action level RBC as defined in Subsection 31A-17-601(8)(b).

(4) (a) Subject to Subsections (4)(b) and (4)(c), an insurer holding a valid certificate of authority to transact insurance in this state prior to July 1, 1986, continues to be authorized to transact the same kinds of insurance as permitted by that certificate of authority, if the insurer maintains not less than the amount of minimum capital or permanent surplus required for that authority under the laws of this state in force immediately prior to July 1, 1986.

(b) If, after July 1, 1986, an insurer ever has minimum capital or permanent surplus that meets or exceeds the requirements of Subsections (2) and (3), then Subsection (4)(a) is inapplicable to that insurer and it shall comply with Subsections (2) and (3).

(c) Any insurer satisfying the minimum capital or permanent surplus requirement through application of Subsection (4)(a) shall comply with Subsections (2) and (3) by July 1, 1990.

(d) Beginning July 1, 1987, former county mutuals shall comply with the capital and surplus requirements of this section.

(5) (a) (i) An assessable mutual may be organized under this chapter, but it may not issue life insurance or annuities.

(ii) An assessable mutual need not have a permanent surplus if the assessment liability of its policyholders is unlimited and all insurance policies clearly state that.

(iii) If assessments are limited to a specified amount or a specified multiple of annual advance premiums, the minimum permanent surplus is the amount that would be required under Subsections (2) and (3) if the corporation were not assessable, reduced by an amount that reasonably reflects the value of the policyholders' assessment liability in satisfying the financial needs of the corporation.

(iv) The liability of members in an assessable mutual is joint and several up to the limits provided by:

(A) the articles of incorporation of the assessable mutual; or

(B) this title.

(b) (i) Except as provided in Subsections (5)(c) and (d), a certificate of authority may not be issued to an assessable mutual until it has at least 400 bona fide applications for insurance from not less than 400 separate applicants, on separate risks located in this state, in each of the classes of business upon which assessments may be separately levied. A full year's premium shall be paid with each application and the aggregate premium is at least $50,000 for each class.

(ii) If at any time while the corporation is an assessable mutual, the business plan is amended to include an additional class of business on which assessments may be separately levied, identical requirements of Subsection (5)(b)(i) are applicable to each additional class.

(c) Five or more employers may join in the formation of an assessable mutual to write only workers' compensation insurance if, instead of the requirements of Subsection (5)(b), policies are simultaneously put into effect that cover at least 1,500 employees, with no single employer having more than 1/5 of the employees insured by the assessable mutual. A full year's premium shall be paid by each employer, aggregating at least $200,000.

(d) (i) The number and amount of required initial applications and premium payments may be reduced by substituting surplus for the applications or premium payments.

(ii) The commissioner shall determine the reduction in required initial applications and premium payments that is appropriate for a given amount of surplus.

(iii) The insurer shall continue to be assessable until conversion under Subsection 31A-5-507(1) to a nonassessable mutual.

(6) (a) The capital or permanent surplus requirements of Subsection (2) apply to persons seeking certificates of authority under this chapter to write reinsurance.

(b) This Subsection (6) may not be construed as requiring reinsurers to obtain a certificate of authority.

(c) Section 31A-17-404 imposes alternate safety prerequisites to reserve credit being granted for reinsurance ceded to a reinsurer without a certificate of authority.

Amended by Chapter 123, 2005 General Session

31A-5-212. Certificate of authority.

(1) The corporation may apply for a certificate of authority at any time prior to the expiration of its organization permit. The application shall include a detailed statement by a principal officer about any material changes that have taken place or are likely to take place in the facts on which the issuance of the organization permit was based, and if any material changes are proposed in the business plan, the information about the changes that would be required if an organization permit were being applied for.

(2) (a) The commissioner shall issue a certificate of authority if the commissioner finds:

(i) enough cash or property authorized under Subsection 31A-5-207(1)(a) or (2)(a) has been received to satisfy the requirements of Section 31A-5-211;

(ii) there is no basis for revoking the organization permit under Subsection 31A-5-209(2); and

(iii) all other applicable requirements of the law have been met.

(b) The certificate of authority shall specify any limits placed on the insurance business the corporation may carry on and may, within the powers given the commissioner under this title, specify limits on the corporation's methods of operation.

(3) After the issuance of the certificate of authority the following action shall take place:

(a) The board shall authorize and direct the issuance of certificates for shares, bonds, or notes subscribed to under the organization permit, and of insurance policies upon qualifying applications obtained under the organization permit.

(b) The commissioner shall authorize the release to the corporation of all funds

held in escrow under Section 31A-5-208.

(4) (a) A corporation may apply to the commissioner for a new or amended certificate of authority altering limits on its business or methods of operation. The application shall contain or be accompanied by information in Subsection 31A-5-204(2) as the commissioner reasonably requires. The commissioner shall issue the new certificate if the commissioner finds:

(i) the corporation's capital and surplus satisfy the requirements of Section 31A-5-211 as to the operations proposed under the new certificate of authority; and

(ii) the proposed business would not be contrary to law or to the interests of insureds or the public.

(b) If the commissioner issues an order under Chapter 27, Part 5, Administrative Actions, against a corporation, the commissioner may also revoke the corporation's certificate and issue a new one with any limitation the commissioner considers necessary.

(5) Except as to Subsection (4), this section does not apply to stock or mutual insurance corporations already in existence on July 1, 1986.

Amended by Chapter 309, 2007 General Session

31A-5-213. Accelerated organization procedure.

(1) The incorporators may apply for a certificate of authority without first obtaining an organization permit if:

(a) their number is not more than 15;

(b) no compensation is paid directly or indirectly for soliciting any of them;

(c) they purchase for their own accounts all the shares proposed to be issued in the case of a stock corporation, or in the case of a mutual, they supply all the minimum permanent surplus and initial expendable surplus by contribution notes or otherwise; and

(d) the shares are promotional securities and are subject to Subsection 31A-5-304(3) and (4).

(2) The application for a certificate of authority shall include:

(a) proof that the purchase price for the shares or the proceeds of contribution notes have been deposited on behalf of the proposed corporation;

(b) a statement concerning whether and what property other than money is held in trust for the proposed corporation; and

(c) the information which the commissioner reasonably requires under Subsection 31A-5-204(2).

(3) The commissioner shall issue a certificate of authority if he finds that:

(a) all requirements of law have been met;

(b) all natural persons who are incorporators, the directors and principal officers of corporate incorporators, and the proposed directors and officers of the corporation being formed are trustworthy and collectively have the competence and experience to engage in the particular insurance business proposed; and

(c) the business plan is consistent with the interests of the corporation's potential insureds and of the public.

(4) The director of the Division of Corporations and Commercial Code shall

issue a certificate of incorporation upon notice from the insurance commissioner that all the applicable requirements of law have been met, including the payment of fees.

(5) When the certificate of incorporation is issued, the corporation's legal existence begins, the articles and bylaws become effective, and the proposed directors and officers take office. The certificate is conclusive evidence of compliance with this section, except in a proceeding by the state against the corporation.

(6) This section does not apply to stock or mutual insurance corporations already in existence on July 1, 1986.

Amended by Chapter 95, 1987 General Session

31A-5-216. Change of domicile.

(1) A foreign insurance corporation may become a Utah insurance corporation if it submits an application which evidences that the corporation complies with all of the requirements imposed on domestic Utah corporations. The commissioner may, by order after a hearing, relax the requirements of this chapter applicable to corporations in the process of organization that, because of the developed status of the insurer, he finds unnecessary to protect policyholders and the public. The commissioner shall simultaneously issue a certificate of organization under Subsection 31A-5-204(3) and a certificate of authority under Subsection 31A-5-212(2) when the conditions for both have been satisfied.

(2) Upon approval by the commissioner, a domestic insurer may transfer its domicile to any other state in which it is admitted. The commissioner shall approve the transfer of domicile unless he finds that the transfer will prejudice the interests of policyholders, creditors, or the public in Utah. The commissioner may require a special deposit, reinsurance, or other protective measures as an alternative to rejecting the insurer's application to move. After or simultaneous with the removal of the corporation, it may seek entry into this state as a foreign corporation under Chapter 14.

(3) The transfer of domicile of an insurance corporation under either Subsection (1) or Subsection (2) does not affect the obligations of the corporation under its existing insurance contracts or any other existing contracts.

Enacted by Chapter 242, 1985 General Session

31A-5-217. Separate accounts for variable contracts.

(1) Separate accounts under this section may be designated by any appropriate name the corporation wishes to use, except that the commissioner may by rule provide guidelines for the naming of separate accounts.

(2) With the approval of the commissioner, any corporation may establish, or at the direction of the commissioner shall establish, one or more separate accounts and allocate to them any amounts paid or remitted to, or held by, the corporation under designated contracts or classes of contracts. These amounts are to be applied to provide benefits payable partly or wholly in variable dollar amounts, and to provide benefits in fixed and guaranteed dollar amounts and other incidental benefits.

(3) To the extent necessary to comply with the federal Investment Company Act of 1940, 15 U.S.C. Sec. 80a-1 et seq., or its interpretive rules, the corporation may:

(a) adopt special procedures for the conduct of the business and affairs of a separate account; and

(b) for persons having beneficial interests in a separate account, provide special voting and other rights, including special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee, the members of which need not be otherwise affiliated with the corporation, to manage the business and affairs of the account.

(4) The commissioner may specify in the certificate of authority of a newly organized corporation the minimum required capital or the minimum required permanent surplus to be provided for each separate account. If a separate account is established after a certificate of authority has been issued, the commissioner shall require the corporation to allocate an adequate amount of capital and surplus to the separate account. An insurer may not be required to allocate more capital and surplus to a separate account than would be required of a separate insurer under Section 31A-5-211 and Chapter 17, Part 6, Risk-Based Capital.

(5) The income and assets attributable to a separate account shall always remain identified with the particular account, but unless the commissioner so orders, the assets need not be kept physically separate from other assets of the corporation. The income and gains and losses, whether or not realized, from assets attributable to a separate account shall be credited to or charged against the account without regard to other income, gains, or losses of the corporation.

(6) Except as provided in Subsection (7), liabilities arising out of any other business of the corporation are not to be allocated to a separate account, nor are any liabilities arising out of a separate account to be allocated to any other account of the corporation, except as provided in Subsection (11).

(7) (a) Each separate account shall be considered as an insurer within the meaning of Subsection 31A-27a-102(23).

(b) A liquidation order under Section 31A-27a-401 for the general account or for any separate account shall have effect as a rehabilitation order under Section 31A-27a-301 for all other accounts of the corporation. Claims remaining unpaid after completion of the liquidation under Chapter 27a, Insurer Receivership Act, shall be liens on the interests of shareholders, if any, but not on any other interests, in all of the corporation's assets that are not liquidated. The rehabilitator may transform these liens into ownership interests under Section 31A-27a-302.

(8) Assets in excess of the liabilities allocated to separate accounts are the property of the corporation.

(9) A corporation may own a particular asset in determinate proportions for separate accounts, for its general account, or as a trustee when acting as such within its legal powers.

(10) The corporation may by an identifiable act transfer assets among the separate accounts, the general account, and any trust accounts of the corporation, for fair consideration as defined in Section 31A-27a-102.

(11) The general account of the corporation, or any separate account, may, for a fair consideration as defined in Section 31A-27a-102, provide guarantees in connection with, perform services for, or reinsure other accounts, subject to rules adopted by the commissioner. The determination of a fair consideration shall be made by applying

generally accepted accounting principles and realistic actuarial tables.

(12) Section 31A-18-102 deals with separate account investments. Section 31A-20-106 requires the commissioner's approval before delivery of certain variable contracts. Section 31A-22-411 and Subsection 31A-21-301(1)(d) deal with policy provisions in separate account contracts.

Amended by Chapter 309, 2007 General Session

31A-5-217.5. Variable contract law.

(1) This section applies to a separate account that is used to support one or more of the following:

(a) a variable life insurance policy that satisfies the requirements of Section 817, Internal Revenue Code;

(b) a variable annuity policy, including a modified guaranteed annuity; or

(c) benefits under a plan governed by the Employee Retirement Income Security Act of 1974.

(2) If there is a conflict between this section and another section of this title as it relates to a separate account described in Subsection (1), this section prevails.

(3) (a) Subject to the other provisions of this Subsection (3), a domestic life insurer may:

(i) establish one or more separate accounts; and

(ii) allocate to those separate accounts amounts, which include:

(A) proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance or annuities; and

(B) benefits incidental to life insurance or annuities, payable in fixed, variable, or both fixed and variable amounts.

(b) An insurer shall credit to or charge against a separate account the income, gains, and losses, realized or unrealized, from assets allocated to the separate account, without regard to other income, gains, or losses of the insurer.

(c) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in Subsection (3)(d):

(i) an insurer may invest or reinvest amounts allocated to a separate account and accumulations on those amounts without regard to the requirements or limitations prescribed by the laws of this state governing the investments of a life insurer; and

(ii) an insurer may not take into account the investments in a separate account in applying the investment limitations that otherwise apply to the investments of the insurer.

(d) Except with the approval of the commissioner and under any condition the commissioner prescribes as to investments and other matters, which shall recognize the guaranteed nature of the benefits provided, an insurer may not maintain in a separate account reserves for:

(i) benefits guaranteed as to dollar amount and duration; and

(ii) funds guaranteed as to principal amount or stated rate of interest.

(e) (i) Except as provided in Subsection (3)(e)(ii) and unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued:

(A) at their market value on the date of valuation; or

(B) if there is no readily available market, then as provided under the terms of the contract, rules, or other written agreement that applies to the separate account.

(ii) Unless otherwise approved by the commissioner, the portion of the assets of a separate account that are equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in Subsection (3)(d) shall be valued in accordance with the rules that otherwise apply to the company's assets.

(f)(i) An insurer owns the amounts it allocates to a separate account in the exercise of the power granted by this section, and the insurer may not be, nor hold itself out to be, a trustee with respect to those amounts.

(ii) To the extent provided under the applicable insurance policy, an insurer may not charge the portion of the assets of a separate account that is equal to the reserves and other insurance liabilities with respect to the separate account with liabilities arising out of any other business the insurer may conduct.

(g) (i) A sale, exchange, or other transfer of assets may not be made by an insurer between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(A) in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the insurance policies with respect to the separate account to which the transfer is made; and

(B) the transfer, whether into or from a separate account, is made by:

(I) a transfer of cash; or

(II) if the transfer of securities is approved by the commissioner, a transfer of securities having a readily determinable market value.

(ii) The commissioner may approve a transfer not described in Subsection (2)(g)(i) among the accounts described in Subsection (2)(g)(i) if, in the commissioner's opinion, the transfer would not be inequitable.

(h) To the extent an insurer considers it necessary to comply with an applicable federal or state law, the insurer with respect to a separate account, including a separate account which is a management investment company or a unit investment trust, may provide for a person having an interest in the separate account to have appropriate voting and other rights and special procedures for the conduct of the business of the separate account, including:

(i) special rights and procedures relating to investment policy;

(ii) investment advisory services;

(iii) selection of independent public accountants; and

(iv) the selection of a committee, the members of which need not be otherwise affiliated with the insurer, to manage the business of the separate account.

Amended by Chapter 10, 2010 General Session
Amended by Chapter 324, 2010 General Session

31A-5-218. Subsidiaries.

(1) Subject to the limitations under Subsection 31A-18-106(1)(k), an insurance corporation may form or acquire subsidiaries to do any lawful insurance business.

(2) An insurance corporation may form or acquire subsidiaries to hold or manage any assets that it might hold or manage directly.

(3) (a) An insurance corporation may form or acquire subsidiaries to perform functions or provide services that are ancillary to its insurance operations.

(b) A subsidiary is an ancillary subsidiary if it is engaged principally in one or more of the following:

(i) acting as an insurance producer;

(ii) investing, reinvesting, or trading in securities, or acting as a securities broker, dealer, or marketing representative;

(iii) managing investment companies registered under the federal Investment Company Act of 1940, as amended, including related sales and services;

(iv) providing investment advice and services;

(v) acting as administrative agent for a government instrumentality performing an insurance, public assistance, or related function;

(vi) providing services related to insurance operations, including accounting, actuarial, pension administration, appraisal, auditing, claims adjusting, collection, data processing, communications, loss prevention, premium financing, safety engineering, and underwriting services;

(vii) holding or managing property used by the corporation, alone or with its affiliates for the convenient transaction of its business;

(viii) engaging in the motor club business under Chapter 11, Motor Clubs;

(ix) engaging in the business of any institution subject to the jurisdiction of the Department of Financial Institutions under Title 7, Financial Institutions;

(x) providing similar services or performing similar activities which the commissioner declares ancillary by rule; and

(xi) owning corporations that would be authorized as subsidiaries under Subsections (3)(b)(i) through (3)(b)(ix) and under Subsections (1) and (2).

(4) An insurance corporation may form or acquire subsidiaries other than those under Subsections (1) through (3), but only to the extent the insurer has excess surplus as defined under Section 31A-1-301.

(5) (a) An insurance corporation shall notify the commissioner immediately following the formation or acquisition of a subsidiary under this section.

(b) Chapter 16 provides additional requirements that are applicable to the acquisition of certain subsidiaries.

Amended by Chapter 298, 2003 General Session

31A-5-219. Amendment of articles.

(1) Subject to Subsection (3) and to the requirements of the Insurance Code, a stock corporation may amend its articles under Sections 16-10a-1001 through 16-10a-1009 and a mutual may amend its articles under Sections 16-6a-1001 through 16-6a-1005 in any manner, including substantial changes of its original purposes. No amendment may be made contrary to Subsections 31A-5-203(1) through (3).

(2) An amendment becomes effective when the properly adopted and filed articles of amendment are approved by the commissioner.

(3) Section 16-10a-1009 applies to stock corporations and the second paragraph of Section 16-6a-1009 applies to mutuals.

Amended by Chapter 300, 2000 General Session

31A-5-301. Securities regulation.

(1) (a) Except as provided in Subsections (1)(b) and (c), no security issued by a domestic or nondomestic insurance corporation may be sold in this state by or for the corporation or any other person unless it is registered under Section 31A-5-302 and otherwise complies with this chapter. Securities that comply with this chapter are not subject to Title 61, Chapter 1.

(b) Securities and transactions exempt under Section 61-1-14 are also exempt under this chapter.

(c) Any exemption under Section 61-1-14 may be revoked by the commissioner for a particular insurance corporation by an order after a hearing. The order shall explain the reasons for the revocation.

(2) (a) No person which is organizing or is acquiring additional funds in this state or elsewhere solely or partly for the purpose of organizing a corporation under this chapter, may register or sell its securities in this state, directly or indirectly, unless it obtains an organization permit under Section 31A-5-204.

(b) No security may be registered or sold in this state if the person registering or selling the security, or any person affiliated with the person, represents that an insurer will be organized or purchased in this state with the proceeds of the sale, unless the issuer first obtains an organization permit under Section 31A-5-204.

(3) If a security is issued or sold in violation of this chapter, the transaction is valid and enforceable by an outsider against the corporation or against an insider, and is valid and enforceable by the corporation against an insider.

(4) This section does not apply to securities issued prior to July 1, 1986.

Amended by Chapter 204, 1986 General Session

31A-5-302. Registration of securities.

(1) (a) An insurance security shall be registered with the commissioner:

(i) by coordination under Section 61-1-9; or

(ii) by qualification under Section 61-1-10.

(b) A registration statement under this Subsection (1) shall conform to Section 61-1-11.

(2) The commissioner has the powers specified in Sections 61-1-12, 61-1-15, 61-1-19, 61-1-20, and 61-1-24.

(3) Sections 61-1-16, 61-1-17, 61-1-18.3, and 61-1-25 apply to the regulation of securities under this part.

(4) As used in this chapter, the words "commission" or "division" under Title 61, Chapter 1, Utah Uniform Securities Act, mean the insurance commissioner.

Amended by Chapter 351, 2009 General Session

31A-5-303. Insider trading of securities.

(1) Every person who is directly or indirectly the beneficial owner of more than 10% of any class of any equity security of a domestic stock insurance corporation, or

who is a director or officer of a domestic stock corporation, shall file with the commissioner within 10 days after he becomes a beneficial owner, director, or officer, and within 10 days after the close of any following calendar month in which there has been a change in his ownership or office, a statement in a form prescribed by the commissioner, of his office and of all the equity securities of the company which he beneficially owns, and of all the changes in either. The commissioner may accept a copy of a similar statement filed with another regulatory authority in satisfaction of this subsection's requirement.

(2) To prevent the unfair use of information which may have been obtained by a beneficial owner, director, or officer because of his relationship to the corporation, any profit realized by him from the purchase and sale or sale and purchase of any equity security of the corporation within any period of less than six months, unless the security was acquired in good faith in connection with a debt previously contracted, is recoverable by the corporation. This recovery may be made in spite of any intention by the beneficial owner, director, or officer in entering into the transaction to hold the security purchased or not to repurchase the security sold for a period exceeding six months. A suit to recover the profit may be instituted in any court of competent jurisdiction by the corporation. If the corporation fails to bring suit within 60 days after request by the owner of a security of the corporation or if the corporation fails to prosecute it diligently, the owner of any security of the corporation may bring suit or prosecute the action in the name and on behalf of the corporation. This suit may not be brought more than two years after the date the profit was realized. This subsection does not apply to any transaction where the beneficial owner was not a beneficial owner both at the time of the purchase and sale, or the sale and purchase, of the security involved, nor does it apply to any transaction which the commissioner, by rule, exempts as not within the purpose of this subsection.

(3) (a) A dealer in the ordinary course of his business and incident to his establishment or maintenance of a primary or secondary market for the security other than on an exchange as defined in the federal Securities Exchange Act of 1934, is not governed by Subsection (2) regarding a purchase and sale or sale and purchase. The commissioner may by rule define terms and prescribe conditions regarding 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.

(b) Subsections (1) and (2) do not apply to foreign or domestic arbitrage transactions unless made in contravention of rules the commissioner adopts to carry out this section.

(c) Subsections (1) and (2) do not apply to equity securities of a corporation if:

(i) the securities are registered, or are required to be registered, under Section 12 of the federal Securities Exchange Act of 1934, as amended; or

(ii) the corporation did not have any class of its equity securities held of record by 100 or more persons on the last business day of the year preceding the year in which equity securities of the corporation would otherwise be subject to Subsections (1) and (2).

(4) No person may, in contravention of rules the commissioner adopts for the protection of investors or the public, solicit or permit the use of his name to solicit a

proxy, consent, or authorization regarding an equity security of a domestic stock corporation having 100 or more shareholders of record.

(5) No provision of this section imposing liability applies to an act done or omitted in good faith in conformity with any rule of the commissioner. Liability does not apply even if the rule is amended, rescinded, or determined by judicial or other authority to be invalid after the act or omission.

(6) As used in this section, "equity security" means any stock or similar security; any security convertible, with or without consideration, into stock or a similar security; carrying any warrant or right to subscribe to or purchase stock or a similar security; any such warrant or right; or any other security which the commissioner considers to be of similar nature and designates as an equity security by rules promulgated in the public interest or for the protection of investors.

Enacted by Chapter 242, 1985 General Session

31A-5-304. Promoter stock.

(1) While the organization permit is effective, the incorporators, directors, and principal officers of a stock corporation shall in the aggregate subscribe and pay, at the public offering price, at least $150,000 in cash or in property of equivalent value approved by the commissioner under Subsection 31A-5-207(1)(a) or (2)(a), for shares offered by the corporation under the organization permit.

(2) (a) Certificates representing promotional securities and any stock received on those shares as the result of a stock dividend, stock split, or exercise of preemptive or conversion rights, shall be placed in escrow with a depository satisfactory to the commissioner under an agreement providing that the shares may not be transferred without the approval of the commissioner.

(b) If the corporation issues any life insurance policies, any shares subject to this section shall be released from escrow five years after issuance of the certificate of authority. In other cases, the shares shall be released from escrow three years after issuance of the certificate of authority.

(3) The commissioner's approval of the transfer of promoter stock under Subsection (2)(a):

(a) shall be granted upon request, if the corporation has made an addition to earned surplus in each of the two immediately preceding years of at least 15% of the capital and surplus raised by the sale of shares under the organization permit; and

(b) may be granted upon a showing of hardship by the shareholder or his estate or legatee, if the release from escrow of the shares or a portion of the shares would not, in the commissioner's opinion, endanger the interests of insureds or the public.

(4) For three years after the issuance of the certificate of authority, an option to purchase stock may be issued only under a plan approved by the commissioner.

(5) This section does not apply to promotional securities issued prior to July 1, 1986.

Enacted by Chapter 242, 1985 General Session

31A-5-305. Authorized securities.

(1) (a) The articles of incorporation of a stock corporation may authorize the kind of shares permitted by Sections 16-10a-601 and 16-10a-602, and stock rights and options, except that:

(i) nonvoting common stock may not be issued;

(ii) all classes of common stock shall have equal voting rights;

(iii) all common stock shall have a stated par value; and

(iv) except with the commissioner's approval, for two years after the initial issuance of a certificate of authority, the corporation may issue no shares and no other securities convertible into shares except a single class of common stock.

(b) Section 16-10a-604 applies to the issuance of certificates for fractional shares or scrip.

(c) The consideration and payment for shares and certificates representing shares is governed by Subsection 31A-5-207(1)(a).

(d) The liability of subscribers and shareholders for unpaid subscriptions and the status of stock is governed by Section 16-10a-622.

(e) A shareholder's preemptive rights is governed by Section 16-10a-630.

(f) Stock corporations may issue bonds and contribution notes on the same basis as mutuals under Subsections (2)(a) and (b).

(2) (a) The articles of incorporation of a nonassessable mutual may authorize bonds of one or more classes. The articles of incorporation shall specify the amount of each class of bonds the corporation is authorized to issue, their designations, preferences, limitations, rates of interest, relative rights, and other terms, subject to all of the following provisions:

(i) During the first year after the initial issuance of a certificate of authority, the corporation may issue only a single class of bonds with identical rights.

(ii) After the first year, but within five years after the initial issuance of a certificate of authority, additional classes of bonds may be authorized after receiving the approval of the commissioner. The commissioner shall approve the issuance if the commissioner finds that policyholders and prior bondholders will not be prejudiced.

(iii) The rate of interest shall be fair.

(iv) The bonds shall bear a maturity date not later than 10 years from the date of issuance, when principal and accrued interest shall be due and payable, subject to Subsection (2)(d).

(b) A mutual may issue contribution notes with the commissioner's approval. The contribution notes may be denominated by any name that is not misleading. The contribution notes are subject to this subsection. The commissioner may approve the issuance only if the commissioner finds that:

(i) the notes will not be issued in denominations of less than $2,500, and no single issue will be sold to more than 15 persons;

(ii) no discount, commission, or other fee will be paid or allowed;

(iii) the notes will not be the subject of a public offering;

(iv) the terms of the notes are not prejudicial to policyholders, holders of mutual bonds, or prior contribution notes; and

(v) the mutual's articles or bylaws do not forbid their issuance.

(c) A mutual may not:

(i) if it has any outstanding obligations on bonds or contribution notes, borrow on

contribution notes from, or sell bonds to, any other insurer without the approval of the commissioner; or

(ii) make a loan to another insurer except a fully secured loan at usual market rates of interest.

(d) Payment of the principal or interest on bonds or contribution notes may be made in whole or in part only after approval by the commissioner. The commissioner's approval shall be given if all the financial requirements of the issuer to do the insurance business it is then doing will continue to be satisfied after that payment, and if the interests of its insureds and the public are not endangered by the payment. In the event of liquidation under Chapter 27a, Insurer Receivership Act, unpaid amounts of principal and interest on contribution notes are subordinate to the payment of principal and interest on any bonds issued by the corporation.

(e) This section does not prevent a mutual from borrowing money on notes which are its general obligations, nor from pledging any part of its disposable assets.

(3) This section does not apply to securities issued prior to July 1, 1986.

Amended by Chapter 297, 2011 General Session

31A-5-306. Corporate repurchase of shares.

(1) (a) To the extent of excess surplus, a stock corporation may repurchase its own shares 15 days after giving written notice to the commissioner.

(b) A stock corporation without excess surplus shall obtain written approval of the commissioner prior to repurchasing its own shares.

(c) Any repurchase of stock is subject to Section 16-10a-631.

(d) A stock corporation may not repurchase its own shares if it is hazardous or would become hazardous as a result of the repurchase.

(2) Within 10 days after the end of any month in which it purchases more than 1% of any class of its outstanding shares, the corporation shall report the price and the names of the registered shareholders from whom the shares are acquired and of any other persons beneficially interested in those shares, so far as the latter are known to the corporation. The corporation shall make a similar report within 10 days after the end of any three-month period in which it purchases more than 2% of any class of its outstanding shares and within 10 days after the end of any 12-month period in which it purchases more than 5% of any class of its outstanding shares. Section 16-10a-631 applies to the corporation's acquisition of its outstanding shares.

(3) Treasury shares may be disposed of by the corporation for their current market value or, if there is no market, for the consideration the board of directors determines to be the fair value of the shares.

(4) Section 31A-17-407 applies to accounting for treasury shares.

Amended by Chapter 9, 1996 Special Session 2

31A-5-307. Reduction in capital.

A stock corporation may reduce its capital by amendment of its articles of incorporation under Section 31A-5-219, if the commissioner is notified of the proposed reduction at least 60 days prior to the proposed effective date of the reduction. The

commissioner may disapprove the reduction within 45 days after the notice if he finds that it would violate the law or would be contrary to the interests of insureds. His order shall explain in detail why the distribution is disapproved.

Amended by Chapter 277, 1992 General Session

31A-5-401. Principal office and registered agent.

Each domestic insurance corporation shall have its principal office and place of business in this state. By order, the commissioner may exempt a corporation from this requirement, in which case it is subject to the requirement of Section 31A-14-204. The location of a domestic insurance corporation's principal office and the existence of a registered agent are governed by Title 16, Chapter 17, Model Registered Agents Act.

Amended by Chapter 364, 2008 General Session

31A-5-401.1. Definitions.

As used in this Part 4:

(1) "Voting members of mutuals" and "voting members" mean persons entitled to vote at annual or special meetings of the members of a mutual, as set forth in the articles of incorporation or amendments to the articles.

(2) Voting members of mutuals and voting members do not necessarily include policyholders of the mutual, if the articles of incorporation or amendments to the articles of incorporation so provide, and if the articles of incorporation or amendments have been approved by the commissioner after a hearing.

Amended by Chapter 90, 2004 General Session

31A-5-402. Shareholders' meetings.

(1) Sections 16-10a-701, 16-10a-702, 16-10a-705, 16-10a-721, 16-10a-724, 16-10a-726, and 16-10a-728 apply to the meetings, notices, quorums, and voting of stock corporations. Except where a greater percentage is required or allowed under this title, the articles of incorporation of domestic insurers may not require more than 50% of the shares represented for the approval of an action requiring shareholder approval.

(2) Sections 16-10a-707 and 16-10a-720 apply to the closing of transfer books, the fixing of the record date, and the voting lists of stock corporations.

(3) Section 16-10a-731 applies to stock corporations. The transfer of shares to a voting trust does not preclude the trustor, or trustee, from being subject to Chapter 16.

Amended by Chapter 277, 1992 General Session

31A-5-403. Corruption in shareholders' meetings.

No person may, in connection with any meeting of shareholders, members, or policyholders of an insurer, buy or sell a vote or proxy for money or any other thing of value, or engage in any corrupt or dishonest practice in connection with the conduct of

the shareholders' meeting.

Enacted by Chapter 242, 1985 General Session

31A-5-404. Communications to shareholders, policyholders, and voting members -- Commissioner's attendance at meetings.

(1) (a) Sections 16-10a-1601 through 16-10a-1604 apply to the books and records and their inspection by shareholders of stock corporations. Section 16-6a-1602 applies to the books and records and inspection rights of policyholders or voting members of mutuals. However, the inspection of the records of the names and addresses of policyholders or voting members of mutuals is permitted only to communicate with other policyholders or voting members regarding the nomination and election of candidates for the board, or for other corporate matters which may be submitted to a vote of the policyholders or voting members. No person may, directly or indirectly, use any information obtained in an inspection for any other purpose.

(b) Any books, records, or minutes may be in written form or in any other form capable of being converted into written form within a reasonable time.

(c) Any provision of this chapter or of any articles or bylaws of a mutual, which requires keeping a record of the names and addresses of policyholders entitled to vote or voting members, is complied with by keeping a record of the names of policyholders or voting members and the names and addresses of insureds or persons paying premiums. This provision requires mailing or sending of notices, reports, proposals, ballots, or other materials to policyholders or voting members of record.

(2) Subject to Subsection (4), the commissioner may by rule prescribe that copies of specified classes of communications circulated generally by a corporation to shareholders, policyholders, or voting members be communicated to the commissioner at the same time.

(3) Subject to Subsection (4), the commissioner may attend any shareholders', policyholders', or voting members' meeting as an observer.

(4) Subsection (3) and, so far as it relates to communications to shareholders, Subsection (2) do not apply to stock corporations whose voting shares are owned by a single person, or whose shareholders are either members of the board or are explicitly represented on it.

Amended by Chapter 300, 2000 General Session

31A-5-405. Meetings of mutuals and mutual policyholders' and members' voting rights.

(1) (a) Subject to this section, Sections 16-6a-701, 16-6a-702, 16-6a-704, and 16-6a-714 apply to the meetings of members, the notice, and the voting in mutuals.

(b) Subject to this section and Section 31A-5-409, Section 16-6a-711 applies to the voting of members of mutuals.

(2) (a) Policyholders or voting members in all mutuals have the right to vote on:

(i) conversion;

(ii) voluntary dissolution;

(iii) amendment of the articles; and

(iv) the election of directors except public directors appointed in accordance with Subsections 31A-5-409(1) and (2).

(b) The mutual may adopt reasonable provisions in its bylaws to determine:

(i) which individual among joint policyholders may exercise a voting right; and

(ii) how to deal with cases where the same individual is one of several joint policyholders in various policies.

(c) The articles of any mutual may give the policyholders or voting members additional voting rights. These articles may require a greater percentage of affirmative votes to approve an action than the statutes require.

(3) (a) The articles or bylaws shall contain rules governing voting procedures and voting eligibility consistent with Subsection (1).

(b) An amendment to a rule described in this Subsection (3) is not effective until at least 30 days after the rule has been filed with the commissioner.

(4) (a) The articles or bylaws may provide for regular or special meetings of the policyholders or voting members, and, if meetings are not provided for, then mail elections shall be provided for in lieu of elections at meetings.

(b) Notice of the time and place of regular meetings or elections shall be given to each policyholder or voting member in a reasonable manner as the commissioner approves or requires. Changes may be made by written notice mailed, properly addressed, and stamped, to the last-known address of all policyholders or voting members.

(5) (a) The articles may provide that representatives or delegates selected by the policyholders or voting members shall be from specific geographical districts or defined classes of policyholders or voting members, as determined on a reasonable basis.

(b) After the representative assembly has been selected by the policyholder or voting members, the assembly or the respective classes of policyholders or voting members may choose replacements for members unable to complete their terms, if the articles provide for their replacement.

(c) The vote of a person holding a valid proxy is treated as the vote of the policyholders or voting members who gave the proxy.

Amended by Chapter 308, 2002 General Session

31A-5-407. Board of directors.

(1) Subject to this section, Sections 16-10a-801 through 16-10a-803, 16-10a-805, and 16-10a-811 apply to the board of directors of a stock corporation and Sections 16-6a-802 and 16-6a-805 apply to the governing board and trustees of mutuals.

(2) A majority of the directors shall be residents of this state unless the commissioner is satisfied that the corporation's financial condition, management, and other circumstances give assurance that the interests of insureds and the public will not be endangered by the majority being nonresidents.

(3) Employees and agents of a corporation that receive more than 10% of their income from the corporation, and persons related to any of them within the second degree by blood or marriage, if directors, are considered "inside directors." Inside

directors may not constitute a majority of the corporation's board.

(4) Subsections (2) and (3) and the required number of directors for committees under Subsection 31A-5-412(1) do not apply to an insurance subsidiary authorized under Subsection 31A-5-218(1), nor to a stock insurance corporation, more than 50% of whose outstanding shares entitled to vote are owned or controlled by a single person or all of whose voting shareholders are either members of or are individually represented on the board.

(5) If the directors of a corporation are divided into classes by the articles or the bylaws, no class may contain fewer than one-third of the total number of directors. Subject to this requirement, Section 16-10a-804 applies to the classification of directors of stock corporations. When classes of trustees or directors are provided in a mutual corporation, the terms of office of the several classes need not be uniform.

(6) The board shall manage the business and affairs of the corporation and may not delegate its power or responsibility, except as authorized by Section 31A-5-412.

(7) Section 16-10a-824 applies to the determination of a quorum of directors of a stock corporation and Section 16-6a-816 applies to the determination of a quorum of trustees for a mutual, except as specifically provided otherwise in this title.

(8) (a) Sections 16-10a-820 and 16-10a-821 apply to the meetings and action without a meeting of the board of directors of stock corporations.

(b) Sections 16-6a-812 through 16-6a-819 apply to the meetings and notice of mutuals.

(9) Sections 16-10a-1601 through 16-10a-1604 apply to stock corporations and Section 16-6a-1602 applies to mutuals regarding the examination of books and records of these entities.

Amended by Chapter 300, 2000 General Session

31A-5-408. Election and removal of directors and officers of stock corporations.

(1) Sections 16-10a-721, 16-10a-724, and 16-10a-728 apply to the voting of shares of a stock corporation.

(2) At each annual meeting of shareholders, the shareholders shall elect directors to hold office until the next succeeding annual election, except as provided under Subsection (3) or (4). Each director shall hold office for the term for which he is elected and until his successor is elected and qualified, if qualification is required.

(3) Sections 16-10a-808 and 16-10a-832 apply to removal of directors and officers of a stock corporation.

(4) Each director shall be subject to election at least once every three years.

(5) A vacancy in the board of directors may be filled by the affirmative vote of a majority of the remaining directors even though the number of remaining directors is less than a quorum. The director elected through this process shall serve only until the next regular shareholders meeting at which a director's election may be held.

Amended by Chapter 277, 1992 General Session

31A-5-409. Selection and removal of directors and officers of mutuals.

(1) The articles or bylaws of a mutual shall state:
(a) the number of directors of the mutual including the directors that are:
(i) appointed as public directors under this Subsection (1) and Subsection (2); or
(ii) elected under Subsection (3);
(b) the number of directors of the mutual that may be appointed as public directors; and
(c) the plan that specifies the manner in which:
(i) a public director is to be appointed; and
(ii) a director who is not a public director is to be elected.
(2) (a) The plan for the appointment of public directors specified in Subsection (1) shall assure true public representation on the board.
(b) A person appointed as a public director shall have insurance business or other business or professional experience that qualifies that person to serve responsibly and impartially as a director.
(c) A public director may be an uncompensated member of the board of directors.
(d) Notwithstanding Subsection (2)(c), a public director shall meet the qualifications of Subsection (2)(b).
(3) (a) A director who is not a public director shall be elected by:
(i) the policyholders; or
(ii) voting members.
(b) If the directors who are not public directors are divided into classes, one class shall be elected:
(i) at least every four years; and
(ii) for a term not exceeding six years.
(4) A director may be removed from office for cause by an affirmative vote of a majority of the full board at a meeting of the board called for that purpose.
(5) Subject to Subsections (1) through (4), Section 16-6a-810 applies to vacancies on the governing board.

Amended by Chapter 308, 2002 General Session

31A-5-410. Supervision of management changes.
(1) (a) Immediately after the selection of a person as a director or principal officer, the insurer shall report to the commissioner:
(i) the name of the person selected as a director or principal officer of a corporation; and
(ii) pertinent biographical and other data that the commissioner requires by rule.
(b) For five years after the initial issuance of a certificate of authority to a corporation, the commissioner may, within 30 days after receipt of a report under Subsection (1)(a), disapprove any person selected who fails to satisfy the commissioner that the person:
(i) is trustworthy; and
(ii) has the competence and experience necessary to discharge that person's responsibilities.
(2) (a) Whenever a director or principal officer of a corporation is removed under

a provision listed in Subsection (2)(b), the insurer shall immediately report to the commissioner:

(i) the removal; and

(ii) a statement of the reasons for the removal.

(b) Subsection (2)(a) applies to a removal under:

(i) Subsection 16-6a-820(4);

(ii) Section 16-10a-808;

(iii) Section 16-10a-832; and

(iv) Subsection 31A-5-409(4).

(3) The commissioner may order the removal of a director or officer if the commissioner finds, after a hearing, that:

(a) a director or officer:

(i) is incompetent;

(ii) untrustworthy;

(iii) is not qualified under Section 31A-5-409; or

(iv) has wilfully violated:

(A) this title;

(B) a rule adopted under Subsection 31A-2-201(3); or

(C) an order issued under Subsection 31A-2-201(4); and

(b) the circumstances described in Subsection (3)(a) endangers the interests of:

(i) insureds; or

(ii) the public.

Amended by Chapter 308, 2002 General Session

31A-5-411. Continuity of management in emergencies.

(1) If an emergency is caused by an attack on the United States or by a nuclear or other disaster which makes it impracticable for a corporation to conduct its business in strict accord with applicable provisions of law, its articles, bylaws, or its charter, this section facilitates the continued operation of a domestic insurance corporation.

(2) The board of any corporation may adopt emergency bylaws, subject to repeal or change by action of those having power to adopt regular bylaws. These bylaws shall operate during a national emergency. Notwithstanding any different provisions in the regular bylaws, the applicable statutes, or the corporation's articles or charter, these emergency bylaws may make any provision that is reasonably necessary for operation during the emergency.

(3) If the board of a corporation has not adopted emergency bylaws, the following provisions are effective in a national emergency:

(a) Three directors constitute a quorum for the transaction of business at all meetings of the board.

(b) A vacancy on the board may be filled by a majority of the remaining directors, though less than a quorum, or by a sole remaining director.

(c) (i) If there are no surviving directors, but at least three officers of the corporation survive, the three officers with the longest term of service become the directors and possess all of the powers of the previous board and the powers that are granted under this section. The emergency board may elect other directors by a

majority vote.

(ii) If there are not three surviving officers, the commissioner shall appoint three natural persons, including any surviving officers, as directors. They shall possess all of the powers of the previous board and any powers granted under this section. The emergency board may elect other directors by majority vote.

(4) The board of a corporation may, by resolution adopted by the board, provide that in the event of a national emergency and in the event of the death or incapacity of specified officers of the corporation, those officers shall be succeeded by the persons described in a succession list. The list may name persons or position titles. It shall establish the order of priority, successors in office, and it may prescribe the conditions for exercise of the powers of the office.

(5) The board of a corporation may, by resolution, provide that in a national emergency the home office or principal place of business is a location named in the resolution. The resolution may provide for alternate locations and establish an order of preference.

Enacted by Chapter 242, 1985 General Session

31A-5-412. Committees of directors.

(1) (a) If provided for in the articles or bylaws of a corporation, the board, by resolution adopted by a majority of the full board, may designate one or more committees.

(b) A committee designated under this Subsection (1) shall consist of three or more directors serving at the pleasure of the board.

(c) The board may designate one or more directors as alternate members of a committee to substitute for an absent member at any meeting of the committee.

(d) The designation of a committee and delegation of authority to the committee does not relieve the board or a director of responsibility imposed by law upon the board or director.

(2) (a) (i) Except for a corporation described under Subsection 31A-5-407(4), a corporation shall have an audit committee.

(ii) A corporation's entire board constitutes the audit committee if the corporation:

(A) is described under Subsection 31A-5-407(4); and

(B) does not have an audit committee that complies with this Subsection (2).

(b) If a corporation is required to have an audit committee under Subsection (2)(a), a member of the audit committee may not be an inside director as defined under Subsection 31A-5-407(3).

(c) An audit committee shall maintain an overview of the audit activities, systems, and staff of the company and of the activities of the outside auditors, in order to advise the board on the adequacy of fiscal control.

(d) A corporation shall give an audit committee direct and private access to company data and personnel as that committee considers necessary.

(e) An audit committee may meet privately with the outside directors as the audit committee sees fit.

(f) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking

Act, the commissioner may make rules pertaining to audit committee requirements similar to those outlined in the Annual Financial Reporting Model Regulation of the National Association of Insurance Commissioners.

(3) (a) When the board is not in session, a committee may exercise the powers of the board in the management of the business and affairs of the corporation to the extent authorized in the resolution or in the articles or bylaws, except action regarding:

(i) compensation or indemnification of a person who is:

(A) a director;

(B) a principal officer; or

(C) one of the three most highly paid employees;

(ii) benefits or payments requiring shareholder or policyholder approval;

(iii) approval of a contract requiring board approval under Section 31A-5-414;

(iv) approval of a transaction in which a director has a material interest adverse to the corporation;

(v) amendment of the articles or bylaws;

(vi) merger or consolidation under Section 31A-5-501, 31A-5-502, or 31A-5-503;

(vii) conversion under Section 31A-5-505, 31A-5-506, 31A-5-507, or 31A-5-509;

(viii) voluntary dissolution under Section 31A-5-504;

(ix) transfer of business or assets under Section 31A-5-508;

(x) any other decision requiring shareholder or policyholder approval;

(xi) amendment or repeal of an action taken by the full board, which by its terms is not subject to amendment or repeal by a committee;

(xii) dividends or other distributions to shareholders, policyholders, or voting members other than in the routine implementation of a policy determination of the full board;

(xiii) selection of a principal officer; and

(xiv) filling a vacancy on the board or on a committee created under Subsection (1), except that the articles or bylaws may provide for a temporary appointment to fill a vacancy on the board or a committee.

(b) A temporary appointment provided for in Subsection (3)(a)(xiv) may last only until the end of the next board meeting.

(4) The full board shall review a transaction in which an officer has a material financial interest adverse to the corporation at the next board meeting after the transaction.

Amended by Chapter 349, 2009 General Session

31A-5-413. Interlocking directorates and other relationships.

Any person who is simultaneously an officer or director of more than one insurer shall, upon the commissioner's request, disclose all conflicts of interest arising from holding those positions simultaneously. This disclosure shall be given to the directors of the insurers and to the commissioner within 15 working days after receipt of the commissioner's request.

Amended by Chapter 204, 1986 General Session

31A-5-414. Transactions in which directors and others are interested.

(1) Any material transaction between an insurance corporation and one or more of its directors or officers, or between an insurance corporation and any other person in which one or more of its directors or officers or any person controlling the corporation has a material interest, is voidable by the corporation unless all the following exist:

(a) At the time the transaction is entered into it is fair to the interests of the corporation.

(b) The transaction has, with full knowledge of its terms and of the interests involved, been approved in advance by the board or by the shareholders.

(c) The transaction has been reported to the commissioner immediately after approval by the board or the shareholders.

(2) A director, whose interest or status makes the transaction subject to this section, may be counted in determining a quorum for a board meeting approving a transaction under Subsection (1)(b), but may not vote. Approval requires the affirmative vote of a majority of those present.

(3) The commissioner may by rule exempt certain types of transactions from the reporting requirement of Subsection (1)(c). The commissioner has standing to bring an action on behalf of an insurer to have a contract in violation of Subsection (1) declared void. Such an action shall be brought in the Third Judicial District Court for Salt Lake County.

Enacted by Chapter 242, 1985 General Session

31A-5-415. Officers', directors', and employees' liability and indemnification.

(1) Section 16-10a-841 applies to the liabilities of directors of a stock corporation. Subsection 16-6a-825(3) applies to loans to trustees and officers of a mutual. A director who votes for or assents to a violation of Subsection 16-6a-825(3) or Section 16-10a-842 is jointly and severally liable to the corporation for any loss on the distribution.

(2) Part 9, Indemnification, of Title 16, Chapter 10a, Utah Revised Business Corporation Act, applies to stock and mutual corporations, but no indemnification may be paid until 30 or more days after sending a notice to the commissioner of the full details of the proposed indemnification. The commissioner may bring an action in Third Judicial District Court for Salt Lake County to have such indemnification enjoined. The court may enjoin the indemnification to the extent it would render the insurer in a hazardous condition, or exacerbate an existing financially hazardous condition.

Amended by Chapter 300, 2000 General Session

31A-5-416. Compensation of director, officer, employee, person with investment authority, or others.

(1) Subject to this section, Subsections 16-10a-302(11) and (12) apply to:

(a) a stock corporation; and

(b) a mutual corporation.

(2) Shareholders' approval is required:

(a) of any benefit or payment to a director or officer for services rendered to a stock corporation more than 90 days before the agreement or decision to give the benefit or make the payment, unless the benefit or payment is made under a plan approved by the shareholders; and

(b) for a new pension plan, profit-sharing plan, stock option plan, or an amendment to an existing plan which, so far as it pertains to any director or officer, substantially increases the financial burden on the stock corporation.

(3) An action taken by the board of a mutual on the compensation of officers, directors, or employees, other than setting individual salaries or standards for salaries of classes of employees, shall be reported to the commissioner within 30 days.

(4) The annual statement of a stock or mutual corporation shall include the amount of all direct and indirect remuneration for services, including retirement and other deferred compensation benefits and stock options paid each year:

(a) for the benefit of each of the following whose remuneration exceeds an amount established by the commissioner by rule:

(i) a director;

(ii) an officer; or

(iii) an employee;

(b) for all directors and officers as a group; and

(c) (i) for the five most highly compensated officers;

(ii) for the five most highly compensated directors; and

(iii) for the five most highly compensated employees.

(5) An arrangement for compensation or other employment benefits for any director, officer, or employee with decision-making power may not be made if it would:

(a) measure the compensation or other benefits in whole or in part by any criteria that would create a financial inducement to act contrary to the best interests of the stock or mutual corporation; or

(b) have a tendency to make the stock or mutual corporation depend for continuance or soundness of operation upon the continuation of any director, officer, or employee in the person's position of director, officer, or employee.

(6) Except for the insurer, a person having any authority in the investment or disposition of the funds of a domestic insurer may not:

(a) accept any fee, brokerage, gift, or other emolument because of any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the insurer; or

(b) be financially interested in the investment or disposition of funds in any capacity.

(7) Unless the commissioner, acting in the corporation's best interests, orders otherwise, if an order of rehabilitation or liquidation is issued under Section 31A-27a-301 or Section 31A-27a-401, the contractual obligations of the insurer for unperformed services of any director, principal officer, or person performing similar functions or having similar powers are terminated. This Subsection (7) does not apply to obligations vested before July 1, 1986.

Amended by Chapter 307, 2007 General Session
Amended by Chapter 309, 2007 General Session

31A-5-417. Exclusive management and exclusive agency contracts.

(1) No domestic insurer may enter into a contract that grants or surrenders the control and management of the insurer, unless the commissioner gives express approval of the contract. Such contracts, once approved, may not be amended without the commissioner's approval. Any contracts between a domestic reciprocal insurer, which insurers are governed under this chapter as any other mutual, and the insurer's attorney-in-fact are subject to this subsection.

(2) Unless the contract is filed and approved by the commissioner, no domestic insurer may enter into a contract granting, or allowing a person to have the exclusive or dominant right to produce the entire insurance business for the insurer. This type of contract is considered approved, unless disapproved by the commissioner within 30 days after filing. If disapproved, the commissioner shall notify the insurer in writing of the grounds of the disapproval.

(3) The commissioner may not approve any contract under Subsection (1) or (2) that:

(a) subjects the insurer to excessive charges for expenses or commissions;

(b) vests any control in a person over the general affairs of the insurer to the exclusion of its board of directors or officers;

(c) extends for an unreasonable length of time; or

(d) contains other inequitable provisions or provisions that may jeopardize the security of policyholders.

Enacted by Chapter 242, 1985 General Session

31A-5-418. Dividends and other distributions.

(1) Subject to the requirements of Section 16-10a-842 and Subsection 31A-16-106(2), a stock corporation may make distributions under Section 16-10a-640 if all the following conditions are satisfied:

(a) A dividend may not be paid that would reduce the insurer's total adjusted capital below the insurer's company action level RBC as defined in Subsection 31A-17-601(8)(b).

(b) Except as to excess surplus, or unless the commissioner issues an order allowing otherwise, a dividend may not be paid that exceeds the insurer's net gain from operations or net income for the period ending December 31 of the preceding year.

(2) Title 67, Chapter 4a, Unclaimed Property Act, applies to unclaimed dividends and distributions in insurance corporations.

Amended by Chapter 116, 2001 General Session

31A-5-420. Payment of dividends by mutual insurers.

(1) When it is in the best interests of the company, the directors of a domestic mutual insurer shall declare, apportion, and pay to its members dividends from its net savings and earnings.

(2) The insurer shall make a reasonable classification of its participating policies and its assumed risks. No dividend shall be paid that is inequitable, unfairly discriminates between classifications of insurance contracts, or unfairly discriminates

between policies within the same classification.

(3) Unless stated in the policy, no dividend, otherwise earned, shall be contingent upon the payment of the renewal premium on any policy.

(4) Subsection (1) may not be construed to require an insurer determined by the United States Internal Revenue Service to be a nonprofit organization to pay a dividend in a manner which would jeopardize that status.

Enacted by Chapter 242, 1985 General Session

31A-5-501. Merger of subsidiary corporation.

The merger of subsidiary insurance corporations is subject to the provisions of Chapter 16. In addition, the merger procedures outlined under Title 16, Chapter 10a, Utah Revised Business Corporation Act, apply to the mergers of subsidiary insurance corporations. For the purposes of this section, if the surviving corporation owns at least 80% of the outstanding shares of each class of the corporation to be merged into the surviving corporation, the procedures of Section 16-10a-1104, including no requirement of shareholder approval, may be used.

Amended by Chapter 277, 1992 General Session

31A-5-502. Merger and consolidation of stock insurance corporations.

Any two or more stock insurance corporations may merge or consolidate, under the procedures set forth under Title 16, Chapter 10a, Utah Revised Business Corporation Act. All mergers are subject to the provisions of Chapter 16.

Amended by Chapter 277, 1992 General Session

31A-5-503. Merger and consolidation of mutuals.

Any two or more mutuals may merge or consolidate, under the procedures set forth under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act. All mergers of mutuals are subject to Chapter 16.

Amended by Chapter 300, 2000 General Session

31A-5-504. Voluntary dissolution of domestic insurance corporations.

(1) (a) Except as otherwise modified by this section, a domestic stock insurance corporation may dissolve under Sections 16-10a-1401 through 16-10a-1409 and Section 16-10a-1440.

(b) Except as otherwise modified by this section, a domestic mutual insurance corporation may dissolve under Sections 16-6a-1401 through 16-6a-1409 and Section 16-6a-1419.

(2) (a) At least 60 days prior to the submission to shareholders or policyholders of any proposed voluntary dissolution of an insurance corporation, the plan of dissolution shall be filed with the commissioner.

(b) The commissioner may require the submission of any information in addition to the plan of dissolution that will establish:

(i) the financial condition of the corporation; or

(ii) other facts relevant to the proposed dissolution.

(c) If the shareholders or policyholders adopt the resolution to dissolve, the commissioner shall, within 30 days after the adoption of the resolution, begin an examination of the corporation.

(d) The commissioner shall approve the dissolution unless the commissioner finds, after a hearing, that the corporation:

(i) is insolvent; or

(ii) may become insolvent in the process of dissolution.

(e) Upon approval, the corporation may:

(i) transfer all of its obligations under insurance policies to other insurers approved by the commissioner; and

(ii) after the transfers described in Subsection (2)(e)(i), dissolve under Subsection (1).

(f) If the commissioner disapproves the dissolution, the commissioner shall petition the court for a liquidation under Section 31A-27a-207.

(3) During the dissolution under Subsection (1), the corporation may apply to the commissioner to have the dissolution continued under the commissioner's supervision. After receiving this application, the commissioner shall apply to the court for a liquidation under Section 31A-27a-207.

(4) If the corporation revokes the voluntary dissolution proceedings under Section 16-6a-1404 or 16-10a-1404, the corporation shall file a copy of the revocation of voluntary dissolution proceedings with the commissioner.

(5) In distributing the assets in the dissolution of a nonlife mutual, Section 31A-27a-705 applies.

(6) (a) No remedy available to or against the corporation, its directors, officers, or shareholders is taken away or impaired if an action or other proceeding is brought within two years after dissolution for any right or claim existing, or any liability incurred, prior to the voluntary dissolution under this section.

(b) The action or proceeding described in Subsection (6)(a) may be prosecuted or defended by the corporation in its corporate name. The shareholders, directors, and officers may take appropriate corporate or other action to protect the remedy, right, or claim.

(c) A corporation which is dissolved by the expiration of its period of duration may amend its articles of incorporation during the two years to provide for perpetual existence.

(7) During the voluntary dissolution of a domestic insurance corporation under this section, its corporate existence continues to allow the winding up of the corporation's affairs regarding any property and assets not distributed or otherwise disposed of prior to dissolution. To effect that purpose, the corporation may:

(a) sell or otherwise dispose of the property and assets;

(b) sue and be sued;

(c) contract; and

(d) exercise all other necessary powers.

Amended by Chapter 309, 2007 General Session

31A-5-505. Conversion of a domestic stock corporation into a mutual.

A domestic stock corporation may be converted into a domestic mutual as follows:

(1) The board shall adopt a plan of conversion. After adopting the plan, no additional shares of capital stock may be issued, except that the board may continue to issue stock options under existing contracts, and holders of outstanding options may continue to exercise these options until the conversion is completed under Subsection (5).

(2) (a) The plan of conversion shall provide for the corporation's purchase of all of its outstanding capital stock. The purchase price shall either be specified in the plan or be determined under a formula specified in the plan, for cash, specified debt securities to be issued by the mutual corporation, or both. All holders of capital stock of the same class have the same rights under the plan. Shareholders may be given an election to take all or a portion of the price in the specified debt securities. Debt securities may be of any class authorized for mutual corporations under Subsection 31A-5-305(2).

(b) The plan shall provide an equitable procedure for valuing contractual obligations of the stock corporation, including those relating to stock options, which options terminate on the date of conversion and are subject to being extinguished under Subsection (5)(b).

(3) No conversion may be effected unless the plan of conversion is approved by the commissioner under Chapter 16.

(4) After the commissioner approves the plan of conversion, it shall be submitted to the shareholders for approval by the affirmative vote of a majority of each class of shares entitled to vote. Only shareholders of record on the date of the board's action under Subsection (1) may vote.

(5) (a) If the shareholders approve the plan of conversion under Subsection (4), the commissioner shall issue a new certificate of authority and the board shall then implement the plan of conversion. The issuance of the certificate is the conversion of the corporation to a mutual. The corporation is no longer a stock corporation. The mutual is considered as having been organized at the time the converted stock corporation was organized.

(b) Any contractual obligation inconsistent with the nature of a mutual, including any obligation to issue or to redeem stock options, terminates upon the conversion under Subsection (5)(a), without compensation other than provided under Subsection (2)(b), unless the obligation was legally binding before July 1, 1986.

(6) The corporation may not pay any person, in connection with the proposed conversion, compensation other than regular salaries to existing personnel and compensation for clerical and mailing expenses. With the commissioner's approval, the corporation in connection with the proposed conversion may pay reasonable printing costs and legal and other professional fees for services actually rendered. All expenses of the conversion, including the expenses incurred by the commissioner and the prorated salaries and fringe benefits of any Insurance Department staff members involved, shall be paid by the corporation being converted.

Enacted by Chapter 242, 1985 General Session

31A-5-506. Conversion of a domestic mutual into a stock corporation.

(1) (a) Except as provided in Subsection (1)(b), a domestic mutual may be converted into a domestic stock corporation under Subsections (2) through (11).

(b) A domestic mutual that is affiliated with other mutuals may not be converted into a stock corporation, unless all the affiliated mutuals are converted at the same time, or the commissioner finds that the interests of the policyholders of the remaining mutuals can be permanently protected by limitations on the corporate powers of the new stock corporation or on its authority to do business, or otherwise.

(2) The board shall pass a resolution stating that the conversion is in the best interests of the policyholders. The resolution shall specify the reasons for and the purposes of the proposed conversion, and how the conversion is expected to benefit policyholders.

(3) (a) Chapter 16, Insurance Holding Companies, applies to the conversion of a domestic mutual into a stock corporation. In addition, the commissioner shall order the examination and appraisal of the corporation, unless the commissioner finds that:

(i) the resolution is defective upon its face; or

(ii) the basis or the purposes of the proposed conversion are contrary to law, to the interests of the policyholders, or to the public.

(b) The commissioner shall examine the company and all of its controlled affiliates under Section 31A-2-203 to determine their financial condition and whether they are operating in accordance with law.

(c) The commissioner shall appoint an appraisal committee, consisting of at least three qualified and disinterested persons with differing expertise, to determine the value of the corporation on the date of the resolution required by Subsection (2). Members of the appraisal committee shall receive reasonable compensation and shall be reimbursed for reasonable expenses in discharging their duties. They may employ consultants to advise them on technical problems of the appraisal, if necessary. The appraisal committee shall consider the assets and liabilities of the corporation, adjusting liabilities to take account of:

(i) the amounts of any reserves in excess of or below realistic estimates;

(ii) the value of the marketing organization;

(iii) the value of goodwill;

(iv) the going-concern value; and

(v) any other factor having an influence on the value of the corporation.

(4) When the examination and appraisal reports have been made to the commissioner, the commissioner shall make copies available to the board. The board shall then prepare and adopt by resolution a plan of conversion. The plan shall be consistent with Subsections (4)(a) through (e) and shall state how the requirements of those subsections are satisfied.

(a) The plan of conversion shall state the number of shares proposed to be authorized for the new stock corporation, their par value, if any, and the price per share at which they will be offered to policyholders. The price per share may not exceed 1/2 of the median equitable share of all policyholders under Subsection (4)(b).

(b) (i) When an insurer has the type of policies with no investment value to the policyholders, each person who has been a policyholder and has paid premiums within five years prior to the resolution under Subsection (2) is entitled, without additional

payment, to as much common stock of the new stock corporation as that person's equitable share of the value of the converting corporation will purchase. The equitable share is determined by the ratio which the net premium that person has paid to the corporation during the five years immediately preceding the resolution required by Subsection (2) bears to the total net premiums received by the corporation during the same period. The net premium is the gross premium less the return premium and dividends paid. If the equitable share would only purchase a fraction of a share of stock, the policyholder has the option of either receiving the value of the fractional share in cash or purchasing a full share by paying the balance in cash.

(ii) When an insurer has the type of policies with specifically attributable investment value to the policyholders, each policyholder is entitled, without additional payment, to as much common stock of the new stock corporation as the policyholder's investment value in the converting corporation will purchase, determined by the proportion of the policyholder's investment value to the aggregate investment values of all policyholders. If the policyholder's share would only purchase a fraction of a share of stock, the policyholder has the option of either receiving the value of the fractional share in cash or purchasing a full share by paying the balance in cash.

(c) A written offer shall be sent to each policyholder indicating the policyholder's individual equitable share and the terms upon which the policyholder may subscribe for stock.

(d) Common shares may not be subscribed by or issued to persons other than policyholders, until all subscriptions by the policyholders have been filled. After those subscriptions have been filled, any new issue of stock for five years after the conversion shall first be offered to the persons who have become shareholders under Subsection (4)(b) in proportion to their interests under Subsection (4)(b).

(e) A policyholder in a nonlife mutual may not receive a distribution of shares valued under Subsection (4)(b)(i), which distribution is greater than the amount the policyholder is entitled to under Section 31A-27a-701. Any excess over the policyholder's entitlement under Section 31A-27a-701 shall be distributed in accordance with Section 31A-27a-705.

(5) The plan of conversion shall be submitted to the commissioner for approval, together with:

(a) the proposed articles and bylaws of the new stock corporation which comply with Section 31A-5-203;

(b) any information specified under Subsection 31A-5-204(2), which the commissioner reasonably requires; and

(c) a projection of the planned or anticipated financial situation of the new corporation for five years after the conversion.

(6) The commissioner shall then hold a hearing. The notice of the hearing shall be mailed to each person who was a policyholder of the corporation on the date of the resolution required by Subsection (2). This notice shall include a copy of the plan of conversion and any comments the commissioner considers necessary to adequately inform the policyholders.

(7) The commissioner shall approve the plan of conversion unless the commissioner finds that the plan violates the law or is contrary to the interests of policyholders or the public.

(8) After approval under Subsection (7), the conversion plan shall be submitted to a vote of:

(a) for mutuals subject to Subsection (4)(b)(i), those persons who were policyholders of the mutual on the date of the resolution required by Subsection (2); or

(b) for mutuals subject to Subsection (4)(b)(ii), those persons who had investment values in their policies as of the date of the resolution required by Subsection (2).

(9) If the policyholders approve the conversion under Subsection (8), the commissioner shall issue a new certificate of authority. The issuance of the certificate is the conversion of the mutual to a stock corporation. This stock corporation is considered as being organized at the time the converted mutual was organized. Subject to the plan of conversion, the directors, officers, agents, and employees of the mutual shall continue in their same positions with the stock corporation.

(10) In the proposed conversion, the corporation may not pay any person compensation other than regular salaries to existing personnel and compensation for clerical and mailing expenses. With the commissioner's approval, the corporation may pay, at reasonable rates, for printing costs and for legal and other professional fees for services actually rendered. All expenses of the conversion, including the expenses incurred by the commissioner and the prorated salaries of any department staff members involved, shall be paid by the corporation being converted.

(11) The commissioner's approval of the plan of conversion satisfies the registration requirement of Section 31A-5-302.

Amended by Chapter 309, 2007 General Session

31A-5-507. Conversion of assessable to nonassessable and nonassessable to assessable mutuals.

(1) When an assessable mutual accumulates enough surplus to satisfy the financial requirements for the operation of a nonassessable mutual, it may apply for a certificate of authority authorizing it to sell nonassessable policies. The commissioner shall issue a certificate of authority designating it a nonassessable mutual, if he finds that the applicant satisfies the requirements of the law and that the issuance of nonassessable policies will not endanger the interests of its insureds or the public. Policies issued after the issuance of this certificate of authority are nonassessable. Existing policies remain in effect and are nonassessable.

(2) A nonassessable mutual may apply to the commissioner for a certificate of authority designating it an assessable mutual. The commissioner shall issue the certificate if the law permits the corporation to issue assessable policies and if he finds that the conversion will not endanger the interests of insureds or the public. All policies issued after conversion are assessable, unless otherwise provided by contract.

Enacted by Chapter 242, 1985 General Session

31A-5-508. Transfer of business or assets.

(1) In the sale, lease, exchange, or mortgage of assets with or without shareholder action, and concerning the rights of dissenting shareholders in those

transactions, Sections 16-10a-1201, 16-10a-1202, 16-10a-1320 through 16-10a-1328, 16-10a-1330, and 16-10a-1331 apply to stock corporations. In the sale, lease, exchange, or mortgage of assets, Section 16-6a-1201 applies to mutuals.

(2) Chapter 16 applies to:

(a) the sale of a domestic insurer's assets or book of business, other than in the ordinary course of business; or

(b) the insurer entering into contracts of reinsurance which have substantially the same effect as a merger.

Amended by Chapter 300, 2000 General Session

31A-5-509. Conversion of a domestic mutual life insurance company into a fraternal.

A domestic mutual life insurance company may be converted into a fraternal under Chapter 9 in the following manner:

(1) The board of directors of the company shall adopt a plan of conversion stating:

(a) the basis for and the purposes of the proposed action;

(b) the proposed articles and bylaws for the new fraternal; and

(c) the proposed procedure and estimated expenses for implementing the conversion.

(2) The plan shall be filed with the commissioner for approval, together with the information under Subsection 31A-9-205(2) required by the commissioner. The commissioner shall approve the plan unless he finds, after a hearing, that:

(a) the conversion would be contrary to the law;

(b) the new fraternal would not satisfy the requirements for a certificate of authority under Section 31A-5-212 as incorporated by Section 31A-9-210; or

(c) the plan would be contrary to the interests of the policyholders or the public.

(3) After being approved by the commissioner, the plan shall be submitted to the policyholders for their approval.

(4) A copy of the plan adopted by the policyholders shall be filed with the commissioner, with a statement indicating the number and percentages of policyholders voting, the method of voting, and the number of votes cast in favor of the plan.

(5) If all requirements of the law are met, the commissioner shall issue a certificate of authority for the new fraternal. Upon this issuance, the mutual ceases its legal existence and the corporate existence of the new fraternal begins. The new fraternal is considered as having been incorporated on the date the converted mutual was incorporated. The new fraternal has all of the assets and is liable for all of the obligations of the converted mutual. The commissioner may grant a fraternal an adjustment period, not to exceed one year, for compliance with the requirements of Chapter 9. The commissioner's extension shall specify the extent to which particular provisions of Chapter 9 do not apply.

Amended by Chapter 204, 1986 General Session

31A-5-601. Duties of officers, directors, agents, and employees.

(1) Any officer, director, agent, attorney, or employee upon whom legal process is properly served or who receives notice of any legal action that may affect or involve the property or business of the insurer, shall promptly communicate the service or notice and detailed information about it to facilitate informed response to persons in the insurer's organization who have authority to take responsive action or to instigate responsive action by those in authority.

(2) A director of an insurer is assumed to have enough knowledge of its affairs to determine whether any act, proceeding, or omission of its directors is a violation of any provision of this chapter. If a director is present at a meeting of directors at which a violation of any provision of this chapter occurs, he is considered as concurring in the violation unless at the meeting he requires his dissent to be entered on the minutes. If a director is absent from the meeting, he is considered as concurring in any violation if the facts of violation appear on the minutes of the meeting and he remains a director for six months after the violation without requiring that his dissent from the violation be entered upon the record or the minutes.

Enacted by Chapter 242, 1985 General Session

31A-5-602. Doing business in other states.

(1) Subject to Subsection (2), no domestic insurer may do an insurance business in any state in which it does not have a certificate of authority. It may not knowingly solicit in those states in any manner. Advertisements through printed media, radio, or television do not violate this subsection if they originate outside the state where there is no authority to do business, are not specifically directed to citizens of that state, and have a majority of their audience in states in which the insurer does have a certificate of authority.

(2) A domestic insurer may do a surplus lines business in a state in which it is not authorized, only if it complies with the surplus lines law of that state.

Enacted by Chapter 242, 1985 General Session

31A-5-701. General reporting requirement.

(1) An insurer domiciled in this state shall file a report with the commissioner disclosing any transaction listed in Subsection (2), unless the transaction has been submitted to the commissioner for review, approval, or information purposes pursuant to other provisions of this title or rules or other requirements made pursuant to this title.

(2) A report is required under Subsection (1) to disclose:

(a) material acquisitions and dispositions of assets; or

(b) material nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

(3) The report required in Subsection (1) is due within 15 days after the end of the calendar month in which any of the transactions described in Subsection (2) occurs.

(4) (a) Except as provided in Subsection (4)(b), reports obtained by or disclosed to the commissioner pursuant to this part are confidential and are not subject to subpoena and may not be made public by the commissioner or any other person or organization, without the prior written consent of the insurer to which it pertains.

(b) (i) The commissioner may publish all or any part of a report in the manner the commissioner considers appropriate if the commissioner determines that the interest of policyholders, shareholders, or the public will be served by publication, after giving notice and an opportunity to be heard to the insurer who would be affected.

(ii) All or any part of a report may be disclosed without notice or consent to insurance departments of other states.

Enacted by Chapter 9, 1996 Special Session 2

31A-5-702. Acquisitions and dispositions of assets.

(1) (a) An acquisition or disposition of asset is not subject to the reporting requirements of Section 31A-5-701 if the acquisitions or dispositions are not material.

(b) For purposes of this part, an acquisition, a disposition, or the aggregate of any series of related acquisitions or related dispositions during any 30-day period, is material if it is:

(i) nonrecurring;

(ii) not in the ordinary course of business; and

(iii) involves more than 5% of the reporting insurer's total admitted assets as reported in its most recent statutory statement.

(2) (a) An asset acquisition subject to this part includes every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for that purpose.

(b) An asset disposition subject to this part includes every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(3) (a) The following information is required to be disclosed in any report filed pursuant to Section 31A-5-701 of a material acquisition or disposition of assets:

(i) the date of the transaction;

(ii) the manner of acquisition or disposition;

(iii) a description of the assets involved;

(iv) the nature and amount of the consideration given or received;

(v) the purpose of, or reason for, the transaction;

(vi) the manner by which the amount of consideration was determined;

(vii) any gain or loss recognized or realized as a result of the transaction; and

(viii) the name of any person from whom the assets were acquired or to whom they were disposed.

(b) (i) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer:

(A) is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves; and

(B) ceded substantially all of its direct and assumed business to the pool.

(ii) For purposes of this section, an insurer is considered to have ceded substantially all of its direct and assumed business to a pool if:

(A) the insurer has less than $1,000,000 total direct plus assumed written

premiums during a calendar year that are not subject to a pooling arrangement; and

(B) the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

Enacted by Chapter 9, 1996 Special Session 2

31A-5-703. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

(1) (a) A nonrenewal, cancellation, or revision of ceded reinsurance agreements is not subject to the reporting requirements of Section 31A-5-701 if:

(i) the nonrenewal, cancellation, or revision is not material; or

(ii) with respect to a property and casualty business, the insurer's total ceded written premium, on an annualized basis, is less than 10% of its total written premium for direct and assumed business; or

(iii) with respect to a life, annuity, and accident and health business, the total reserve credit taken for business ceded, on an annualized basis, is less than 10% of the statutory reserve requirement prior to a cession.

(b) For purposes of this part, a material nonrenewal, cancellation, or revision is one that affects:

(i) with respect to a property and casualty business:

(A) more than 50% of the insurer's total ceded written premium; or

(B) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves;

(ii) with respect to a life, annuity, and accident and health business, more than 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement; or

(iii) with respect to either property and casualty or life, annuity, or accident and health business:

(A) an authorized reinsurer representing more than 10% of a total cession is replaced by one or more unauthorized reinsurers; or

(B) previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than 10% of a total cession.

(2) (a) The following information is required to be disclosed in any report filed pursuant to Section 31A-5-701 of a material nonrenewal, cancellation, or revision of a ceded reinsurance agreement:

(i) the effective date of the nonrenewal, cancellation, or revision;

(ii) the description of the transaction with an identification of the initiator of the transaction;

(iii) the purpose of, or reason for the transaction; and

(iv) if applicable, the identity of the replacement reinsurers.

(b) (i) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer:

(A) is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's

reserves; and

(B) ceded substantially all of its direct and assumed business to the pool.

(ii) An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if:

(A) the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement; and

(B) the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

Amended by Chapter 116, 2001 General Session

31A-6a-101. Definitions.

(1) "Mechanical breakdown insurance" means a policy, contract, or agreement issued by an insurance company that has complied with either Title 31A, Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Title 31A, Chapter 14, Foreign Insurers, that undertakes to perform or provide repair or replacement service on goods or property, or indemnification for repair or replacement service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear.

(2) "Nonmanufacturers' parts" means replacement parts not made for or by the original manufacturer of the goods commonly referred to as "after market parts."

(3) (a) "Service contract" means a contract or agreement for the repair or maintenance of goods or property, for their operational or structural failure due to a defect in materials, workmanship, or normal wear and tear, with or without additional provision for incidental payment of indemnity under limited circumstances.

(b) "Service contract" does not include mechanical breakdown insurance as defined in Subsection (1).

(4) "Service contract holder" or "contract holder" means a person who purchases a service contract.

(5) "Service contract provider" means a person who issues, makes, provides, administers, sells or offers to sell a service contract, or who is contractually obligated to provide service under a service contract.

(6) "Service contract reimbursement policy" or "reimbursement insurance policy" means a policy of insurance providing coverage for all obligations and liabilities incurred by the service contract provider under the terms of the service contract issued by the provider.

Enacted by Chapter 203, 1992 General Session

31A-6a-102. Scope and purposes.

(1) The purposes of this chapter are to:

(a) create a legal framework within which service contracts may be sold in this state;

(b) encourage innovation in the marketing and development of more economical and effective ways of providing services under service contracts, while placing the risk of innovation on the service contract providers rather than on consumers; and

(c) permit and encourage fair and effective competition among different systems of providing and paying for these services.

(2) Service contracts may not be issued, sold, or offered for sale in this state unless the provider has complied with this chapter.

(3) This chapter applies only to a service contract not otherwise exempted from this title by Section 31A-1-103.

Amended by Chapter 116, 2001 General Session

31A-6a-103. Requirements for doing business.

(1) A service contract may not be issued, sold, or offered for sale in this state unless the service contract is insured under a service contract reimbursement insurance policy issued by:

(a) an insurer authorized to do business in this state; or

(b) a recognized surplus lines carrier.

(2) (a) A service contract may not be issued, sold, or offered for sale unless the service contract provider completes the registration process described in this Subsection (2).

(b) To register, a service contract provider shall submit to the department the following:

(i) an application for registration;

(ii) a fee established in accordance with Section 31A-3-103;

(iii) a copy of any service contract that the service contract provider offers in this state; and

(iv) a copy of the service contract provider's reimbursement insurance policy.

(c) A service provider shall submit the information described in Subsection (2)(b) no less than 30 days before the day on which the service provider issues, sells, offers for sale, or uses a service contract or reimbursement insurance policy in this state.

(d) A service provider shall file any modification of the terms of a service contract or reimbursement insurance policy 30 days before the day on which it is used in this state.

(e) A person complying with this chapter is not required to comply with:

(i) Subsections 31A-21-201(1) and 31A-23a-402(3); or

(ii) Chapter 19a, Utah Rate Regulation Act.

(3) (a) Premiums collected on a service contract are not subject to premium taxes.

(b) Premiums collected by an issuer of a reimbursement insurance policy are subject to premium taxes.

(4) A person marketing, selling, or offering to sell a service contract for a service contract provider that complies with this chapter is exempt from the licensing requirements of this title.

(5) A service contract provider complying with this chapter is not required to comply with:

(a) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(b) Chapter 7, Nonprofit Health Service Insurance Corporations;

(c) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(d) Chapter 9, Insurance Fraternals;
(e) Chapter 10, Annuities;
(f) Chapter 11, Motor Clubs;
(g) Chapter 12, State Risk Management Fund;
(h) Chapter 13, Employee Welfare Funds and Plans;
(i) Chapter 14, Foreign Insurers;
(j) Chapter 19a, Utah Rate Regulation Act;
(k) Chapter 25, Third Party Administrators; and
(l) Chapter 28, Guaranty Associations.

Amended by Chapter 345, 2008 General Session

31A-6a-104. Required disclosures.

(1) A service contract reimbursement insurance policy insuring a service contract that is issued, sold, or offered for sale in this state shall conspicuously state that, upon failure of the service contract provider to perform under the contract, the issuer of the policy shall:

(a) pay on behalf of the service contract provider any sums the service contract provider is legally obligated to pay according to the service contract provider's contractual obligations under the service contract issued or sold by the service contract provider; or

(b) provide the service which the service contract provider is legally obligated to perform, according to the service contract provider's contractual obligations under the service contract issued or sold by the service contract provider.

(2) (a) A service contract may not be issued, sold, or offered for sale in this state unless the service contract contains the following statements in substantially the following form:

(i) "Obligations of the provider under this service contract are guaranteed under a service contract reimbursement insurance policy. Should the provider fail to pay or provide service on any claim within 60 days after proof of loss has been filed, the contract holder is entitled to make a claim directly against the Insurance Company."; and

(ii) "This service contract or warranty is subject to limited regulation by the Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."

(b) A service contract or reimbursement insurance policy may not be issued, sold, or offered for sale in this state unless the contract contains a statement in substantially the following form, "Coverage afforded under this contract is not guaranteed by the Property and Casualty Guaranty Association."

(3) A service contract shall:

(a) conspicuously state the name, address, and a toll free claims service telephone number of the reimbursement insurer;

(b) identify the service contract provider, the seller, and the service contract holder;

(c) conspicuously state the total purchase price and the terms under which the service contract is to be paid;

(d) conspicuously state the existence of any deductible amount;

(e) specify the merchandise, service to be provided, and any limitation, exception, or exclusion;

(f) state a term, restriction, or condition governing the transferability of the service contract; and

(g) state a term, restriction, or condition that governs cancellation of the service contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder or service contract provider.

(4) If prior approval of repair work is required, a service contract shall conspicuously state the procedure for obtaining prior approval and for making a claim, including:

(a) a toll free telephone number for claim service; and

(b) a procedure for obtaining reimbursement for emergency repairs performed outside of normal business hours.

(5) A preexisting condition clause in a service contract shall specifically state which preexisting condition is excluded from coverage.

(6) (a) Except as provided in Subsection (6)(c), a service contract shall state the conditions upon which the use of a nonmanufacturers' part is allowed.

(b) A condition described in Subsection (6)(a) shall comply with applicable state and federal laws.

(c) This Subsection (6) does not apply to a home warranty contract.

Amended by Chapter 297, 2011 General Session

31A-6a-105. Prohibited acts.

(1) Except as provided in Subsection 31A-6a-104(2), a service contract provider may not use in its name, a contract, or literature:

(a) any of the following words:

(i) "insurance";

(ii) "casualty";

(iii) "surety";

(iv) "mutual"; or

(v) another word descriptive of the insurance, casualty, or surety business; or

(b) a name deceptively similar to the name or description of:

(i) an insurance or surety corporation; or

(ii) another service contract provider.

(2) A service contract provider or the service contract provider's representative may not:

(a) make, permit, or cause to be made a false or misleading statement in connection with the sale, offer to sell, or advertisement of a service contract; or

(b) deliberately omit a material statement that would be considered misleading if omitted, in connection with the sale, offer to sell, or advertisement of a service contract.

(3) A bank, savings and loan association, insurance company, or other lending institution may not require the purchase of a service contract as a condition of a loan.

(4) Except for a bank, savings and loan association, industrial bank, or credit union, a service contract provider may not sell, or be the obligated party for:

(a) a guaranteed asset protection waiver, unless registered with the

commissioner under Chapter 6b, Guaranteed Asset Protection Waiver Act;
(b) a debt cancellation agreement, unless licensed by the commissioner; or
(c) a debt suspension agreement, unless licensed by the commissioner.

Amended by Chapter 274, 2010 General Session

31A-6a-106. Recordkeeping requirements.

(1) (a) All service contract providers shall keep accurate accounts, books, and records concerning transactions regulated under this chapter.
(b) A service contract provider's accounts, books, and records shall include:
(i) copies of all service contracts issued;
(ii) the name and address of each service contract holder; and
(iii) claims files.
(c) Service contract providers shall retain all records pertaining to each service contract holder for at least three years after the specified period of coverage has expired.
(2) A provider discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to contract holders in this state.
(3) Service contract providers shall make all accounts, books, and records concerning transactions regulated under this chapter or other pertinent chapters available to the commissioner for the purpose of examination as provided in Sections 31A-2-203 and 31A-2-204.

Enacted by Chapter 203, 1992 General Session

31A-6a-107. Cancellation of reimbursement insurance.

The issuer of a reimbursement insurance policy may not cancel the policy until a notice of cancellation in accordance with Section 31A-21-303, 31A-21-304, or 31A-21-305 has been mailed or delivered to the commissioner and to each insured provider. The cancellation of a reimbursement policy may not reduce the issuer's responsibility for service contracts issued by providers prior to the date of the cancellation.

Amended by Chapter 10, 1997 General Session

31A-6a-108. Obligation of reimbursement insurance issuers.

Providers under this chapter are considered to be the agent of the issuer of the reimbursement insurance for purposes of Section 31A-23a-410. In cases where a provider is acting as an administrator and enlists other providers, the provider acting as the administrator shall notify the issuer of the reimbursement insurance of the other providers.

Amended by Chapter 298, 2003 General Session

31A-6a-109. Enforcement provisions.

Anyone violating of any of the provisions of this chapter or any rule made pursuant to the grant of rulemaking authority under this title may be assessed an administrative forfeiture equal to two times the amount of any profit gained from the violation. In addition an administrative forfeiture may be assessed for each violation not to exceed $1,000 per violation. If the violations are continuing, or are of a serious nature, or a person's business practices in connection with the solicitation, sale, offering for sale, or performance under a service contract subject to this chapter, constitute a danger to the legitimate interests of consumers or the public, the commissioner may enjoin the person from soliciting, selling, or offering to sell service contracts in this state either permanently or for a stated period of time.

Enacted by Chapter 203, 1992 General Session

31A-6a-110. Rulemaking.

(1) Pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules necessary to assist in the enforcement of this chapter.

(2) The commissioner may by rule or order, after a hearing, exempt certain service contract providers or service contract providers for a specific class of service contracts that are not otherwise exempt under Subsection 31A-1-103(3) from any provision of this title. The commissioner may order substitute requirements on a finding that a particular provision of this title is not necessary for the protection of the public or that the substitute requirement is reasonably certain to provide equivalent protection to the public.

Amended by Chapter 382, 2008 General Session

31A-6b-101. Title.

This chapter is known as the "Guaranteed Asset Protection Waiver Act."

Enacted by Chapter 274, 2010 General Session

31A-6b-102. Definitions.

(1) This section defines a term only for purposes of this chapter. A term defined in this section is not required to be used in a guaranteed asset protection waiver.

(2) For purposes of this chapter:

(a) "Administrative functions" includes providing:

(i) document development, processing, and management;

(ii) data processing and support;

(iii) compliance services;

(iv) waiver fee processing;

(v) benefit determination;

(vi) technology support; or

(vii) personnel support.

(b) "Administrator" means a person who provides administrative functions related to a guaranteed asset protection waiver.

(c) "Borrower" means a person who under a finance agreement is:

(i) a debtor;
(ii) a retail buyer; or
(iii) a lessee.
(d) "Creditor" means a person who is:
(i) a lender in a loan or credit transaction;
(ii) a retail seller of a vehicle that provides credit to a retail buyer of the vehicle;
(iii) a lessor in a lease transaction;
(iv) a seller in a commercial retail installment transaction; or
(v) an assignee of a person listed in this Subsection (2)(d) to whom a credit obligation is payable.
(e) "Finance agreement" means one or more of the following for the purchase or lease of a vehicle:
(i) a loan;
(ii) a retail installment sales contract; or
(iii) a lease.
(f) "Guaranteed asset protection waiver" means a contract for a separate charge:
(i) under which a creditor agrees to waive all or part of the amounts due on a borrower's finance agreement if a vehicle is subject to:
(A) a total physical damage loss; or
(B) unrecovered theft; and
(ii) that is made part of a finance agreement, even if the guaranteed asset protection waiver is stated in a separate addendum to the finance agreement.
(g) "Preliminary period" means a time period that:
(i) begins the day on which a guaranteed asset protection waiver becomes effective; and
(ii) ends the last day on which a borrower may cancel the guaranteed asset protection waiver with a full refund if no benefits have been provided.
(h) "Restricted account" means the Guaranteed Asset Protection Waiver Restricted Account created in Section 31A-6b-204.
(i) (i) "Vehicle" means a vehicle that is:
(A) self propelled or towed; and
(B) designed for personal or commercial use.
(ii) "Vehicle" includes:
(A) an automobile;
(B) a truck;
(C) a motorcycle;
(D) a recreational vehicle;
(E) an all terrain vehicle;
(F) a snowmobile;
(G) a camper;
(H) a boat;
(I) a personal watercraft; or
(J) a trailer for a motorcycle, boat, camper, or personal watercraft.

Enacted by Chapter 274, 2010 General Session

31A-6b-103. Relationship to title -- Scope -- Exemptions.

(1) A guaranteed asset protection waiver:

(a) is not an insurance contract; and

(b) is not considered a debt cancellation or debt suspension contract for purposes of Section 31A-21-109.

(2) A guaranteed asset protection waiver is exempt from the provisions of this title other than this chapter, except to the extent otherwise provided in this chapter.

(3) This chapter does not apply to:

(a) an insurance contract offered by an insurer under this title; or

(b) a debt cancellation or debt suspension contract that:

(i) is not a guaranteed asset protection waiver; and

(ii) is offered in compliance with:

(A) 12 C.F.R. Part 37;

(B) 12 C.F.R. Part 721;

(C) other federal law; or

(D) Section 31A-21-109.

(4) A person required to be licensed or registered in accordance with this chapter may not be required to be licensed under another provision of this title for engaging in an act regulated by this chapter.

(5) A guaranteed asset protection waiver offered in connection with a loan, lease, or retail installment sale associated with a commercial vehicle transaction is not subject to this title.

(6) The following are exempt from this chapter:

(a) a bank, as defined in Section 7-1-103;

(b) a credit union, as defined in Section 7-1-103;

(c) an industrial bank, as defined in Section 7-1-103;

(d) a savings and loan association, as defined in Section 7-1-103; or

(e) a subsidiary of an entity described in Subsections (6)(a) through (d).

Enacted by Chapter 274, 2010 General Session

31A-6b-104. Severability.

If a provision of this chapter or the application of a provision to a person or circumstance is held invalid, the remainder of this chapter shall be given effect without the invalid provision or application. The provisions of this chapter are severable.

Enacted by Chapter 274, 2010 General Session

31A-6b-201. Persons who may provide a guaranteed asset protection waiver -- Requirement to be licensed or registered.

(1) Except as provided in Subsection (2), on and after July 1, 2010, a person may not sell, offer to sell, or otherwise provide a guaranteed asset protection waiver to a borrower in this state unless the person:

(a) (i) is:

(A) a creditor; or

(B) an administrator; and

(ii) is registered in accordance with this part; or

(b) (i) is an individual who sells vehicles at retail; and

(ii) holds a limited line producer license in accordance with Section 31A-23a-103.

(2) (a) Subject to the other provisions of this Subsection (2), an entity retail seller of a vehicle may sell, offer to sell, or otherwise provide a guaranteed asset protection waiver to a borrower without being registered under this chapter if the retail seller assigns finance agreements within 90 days.

(b) The commissioner may assess each retail seller described in Subsection (2)(a) that is located in this state an annual assessment in accordance with this Subsection (2).

(c) The commissioner may assess an annual assessment under this section only if the fees received by the commissioner under Section 31A-6b-202 do not equal or exceed $100,000.

(d) The commissioner shall determine the amount of the annual assessment under this section in accordance with Section 31A-3-103, except that:

(i) the annual assessment may not exceed $50; and

(ii) the commissioner may not impose an amount that would reasonably be expected to result in the commissioner receiving in excess of $100,000 in a fiscal year from the aggregate of:

(A) the fees received under Section 31A-6b-202; and

(B) the annual assessments under this section.

(e) The commissioner shall deposit an annual assessment collected under this section into the restricted account.

Enacted by Chapter 274, 2010 General Session

31A-6b-202. Registration process -- Annual fee.

(1) If a person is required to register under Section 31A-6b-201, to register the person shall submit to the commissioner:

(a) an application for registration;

(b) a copy of any guaranteed asset protection waiver that the person will issue, market, sell, offer to sell, or otherwise provide in this state; and

(c) a registration fee established by the commissioner in accordance with Section 31A-3-103, except that the registration fee may not exceed $1,000.

(2) (a) On and after July 1, 2011, a person registered under this title shall pay to the commissioner an annual fee:

(i) by no later than July 1 of each year after the day on which the person registers; and

(ii) established by the commissioner in accordance with Section 31A-3-103, except that the annual fee may not exceed $1,000.

(b) If a person fails to pay the annual fee required under this Subsection (2) by October 1, the person's registration expires.

(3) The commissioner shall deposit a fee collected under this section into the restricted account.

Enacted by Chapter 274, 2010 General Session

31A-6b-203. Filing new or changed guaranteed asset protection waiver.

A person required to be registered under Section 31A-6b-201 shall submit to the commissioner at least 30 days before the day on which the person issues, markets, sells, offers to sell, or otherwise provides a guaranteed asset protection waiver in this state:

(1) a change to a term of a guaranteed asset protection waiver previously submitted to the commissioner under this chapter; or

(2) a guaranteed asset protection waiver that has not previously been submitted to the commissioner under this chapter.

Enacted by Chapter 274, 2010 General Session

31A-6b-204. Guaranteed Asset Protection Waiver Restricted Account.

(1) There is created in the General Fund a restricted account known as the "Guaranteed Asset Protection Waiver Restricted Account."

(2) The restricted account shall consist of the money received by the commissioner under this part.

(3) The commissioner shall administer the restricted account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the restricted account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of this chapter.

Enacted by Chapter 274, 2010 General Session

31A-6b-301. General requirements for a guaranteed asset protection waiver.

(1) A person may not issue, market, sell, offer to sell, or otherwise provide a guaranteed asset protection waiver except in compliance with this chapter.

(2) If a creditor assigns, sells, or transfers a finance agreement, a guaranteed asset protection waiver remains a part of the finance agreement.

(3) (a) If a borrower finances or otherwise pays the charge for a guaranteed asset protection waiver, the creditor is liable to the borrower for a benefit due under the guaranteed asset protection waiver regardless of whether the retail seller, administrator, or other person who receives the payment from the borrower remits the charge.

(b) This Subsection (3) may not be construed to prejudice any claim a creditor may have against a retail seller, administrator, or other person who receives a payment from a borrower but fails to remit the payment.

(4) A creditor may require that a guaranteed asset protection waiver that the creditor issues be sold for:

(a) a single payment; or

(b) periodic payments.

(5) The following may not be conditioned on a borrower purchasing a guaranteed asset protection waiver:

(a) the extension of credit;

(b) a term of credit; or
(c) a term of the related vehicle sale or lease.

Enacted by Chapter 274, 2010 General Session

31A-6b-302. Required disclosures.

(1) A guaranteed asset protection waiver shall disclose the information described in Subsection (2):
(a) in writing; and
(b) in understandable language that is easy to read.
(2) A guaranteed asset protection waiver shall disclose:
(a) the name and address of the initial creditor and the borrower at the time the guaranteed asset protection waiver is executed;
(b) if there is an administrator for the guaranteed asset protection waiver:
(i) the name of the administrator;
(ii) the address of the administrator; and
(iii) a toll-free number to contact the administrator;
(c) the charge for the guaranteed asset protection waiver;
(d) the terms of the guaranteed asset protection waiver, including:
(i) the requirements for receiving the protection of the guaranteed asset protection waiver;
(ii) the conditions imposed by the guaranteed asset protection waiver; and
(iii) the exclusions from the protection of the guaranteed asset protection waiver;
(e) the procedure the borrower must follow, if any, to obtain a benefit under the guaranteed asset protection waiver, including a telephone number and address where the borrower may apply for a benefit under the guaranteed asset protection waiver;
(f) that the borrower may cancel the guaranteed asset protection waiver;
(g) the rights the borrower has to a refund under Section 31A-6b-303;
(h) if the guaranteed asset protection waiver is cancelled or terminated after the preliminary period:
(i) the procedures for requesting a refund under Section 31A-6b-303, including that the borrower request a refund in writing in accordance with Section 31A-6b-303; and
(ii) the methodology for calculating the refund due, if any;
(i) that none of the following may be conditioned on the purchase of a guaranteed asset protection waiver:
(i) the extension of credit;
(ii) a term of credit; or
(iii) a term of the related vehicle sale or lease; and
(j) (i) that a guaranteed asset protection waiver is subject to limited regulation by the commissioner; and
(ii) that a complaint regarding a guaranteed asset protection waiver may be submitted to the commissioner.

Enacted by Chapter 274, 2010 General Session

31A-6b-303. Cancellation or termination of a guaranteed asset protection waiver.

(1) (a) A borrower may cancel a guaranteed asset protection waiver in accordance with this section.

(b) A borrower may not waive by contract the borrower's right to cancel a guaranteed asset protection waiver in accordance with this section.

(c) A guaranteed asset protection waiver terminates on the day on which the related finance agreement terminates.

(2) (a) A guaranteed asset protection waiver shall provide for a preliminary period of at least 30 days.

(b) If a borrower cancels a guaranteed asset protection waiver or if a guaranteed asset protection waiver terminates within the preliminary period, the borrower is entitled to a refund of the charge for the guaranteed asset protection waiver as follows:

(i) if benefits have not been provided, a full refund; or

(ii) if benefits have been provided, a refund to the extent provided for in the guaranteed asset protection waiver.

(3) (a) If a guaranteed asset protection waiver is cancelled by the borrower or terminates after the preliminary period, to obtain a refund of any portion of the charge for the guaranteed asset protection waiver, the borrower shall request the refund:

(i) in a writing provided to:

(A) the creditor;

(B) an administrator; or

(C) another person designated in the guaranteed asset protection waiver;

(ii) within 90 days of the day on which an event occurs that terminates the finance agreement if the refund is sought on the basis of termination of a finance agreement; and

(iii) in accordance with any additional terms in the guaranteed asset protection waiver.

(b) If a guaranteed asset protection waiver is cancelled by the borrower or terminates after the preliminary period, but before the term of the finance agreement ends, a borrower is entitled to a refund:

(i) of the portion of the charge for the guaranteed asset protection waiver that under the terms of the guaranteed asset protection waiver is considered unearned; and

(ii) subject to any other terms of the guaranteed asset protection waiver.

(4) (a) If the cancellation of a guaranteed asset protection waiver occurs as a result of any of the following, a refund may be paid directly to the creditor or administrator and applied as provided in Subsection (4)(b):

(i) a default under the finance agreement;

(ii) the repossession of the vehicle associated with the finance agreement; or

(iii) any other type of termination of the finance agreement or guaranteed asset protection waiver.

(b) A creditor may apply a refund described in this Subsection (4) to reduce the amount owed under a finance agreement, unless the borrower can show that the finance agreement is paid in full.

Enacted by Chapter 274, 2010 General Session

31A-6b-401. Cease and desist order -- Fines.

(1) In accordance with Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(a) order a person who violates this chapter to cease and desist from an act that violates this chapter;

(b) impose a penalty:

(i) up to $500 per violation; and

(ii) not to exceed the aggregate of $40,000 in a calendar year for the violations under this chapter of a similar nature; or

(c) take a combination of actions under this Subsection (1).

(2) For purposes of this section, a violation is of a similar nature if the violation consists of the same or similar action, course of conduct, or practice, irrespective of the number of times the action, conduct, or practice occurs that is determined to violate this chapter.

Enacted by Chapter 274, 2010 General Session

31A-7-101. Definition.

As used in this chapter, unless stated otherwise:

"Subscriber" means the person entitled by contract to health care benefits from a corporation licensed under this chapter. "Subscriber" is used interchangeably with "policyholder" in individual contracts or "certificate holder" in group contracts.

Amended by Chapter 91, 1987 General Session
Amended by Chapter 95, 1987 General Session

31A-7-102. Scope.

(1) Domestic insurers authorized under former Title 31, Chapter 37, are, on July 1, 1986, automatically converted to domestic insurers authorized under this chapter. The commissioner may adopt any rules necessary to efficiently and safely effect the conversion.

(2) Any nonprofit corporation incorporated under this chapter, or subject to this chapter under Subsection (1), and organized for the purpose of establishing, maintaining, and operating a nonprofit plan, whereby hospital care, medical-surgical care, dental care, and other health services are made available to persons who become subscribers to such a plan or plans under a contract with the nonprofit corporation, are subject to the provisions of this chapter.

(3) This chapter does not apply to persons licensed under Chapter 5, 8, 9, 10, 11, 13, or 14.

Amended by Chapter 20, 1995 General Session

31A-7-103. Applicability of other provisions.

(1) Except for exemptions specifically granted under this title, nonprofit health service insurance corporations organized or operating under this chapter are subject to all of the provisions of this title.

(2) Nonprofit health service corporations are exempt from the provisions of Chapter 5 except where sections or parts are specifically referenced and made applicable in this chapter, in which case the referenced provisions under Chapter 5 that apply to mutual corporations apply to nonprofit health service insurance corporations.

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to nonprofit health service insurance corporations except as specifically made applicable by:

(a) this chapter;

(b) a provision adopted by reference under this chapter; or

(c) a rule adopted by the commissioner to deal with corporate law issues of nonprofit health service insurance corporations which are not settled under this chapter.

(4) Any insurer authorized under this chapter that is not in compliance with the applicable capital and surplus requirements, yet has assets in excess of its liabilities, has until July 1, 1988, to comply with the applicable capital and surplus requirements. One-half of any shortage in capital and surplus on July 1, 1986, shall be remedied by July 1, 1987.

Amended by Chapter 300, 2000 General Session

31A-7-104. General corporate powers and procedures.

(1) Corporations organized or operating under this chapter have the powers specified under Section 31A-5-104.

(2) Subject to the limitations upon subsidiary investment valuation otherwise stated under this title, corporations organized or operating under this chapter may invest in corporations organized for profit.

(3) Corporations subject to the provisions of this chapter may enter into contracts for the rendering of hospital services, medical-surgical services, and other health services on behalf of any of their subscribers with hospitals maintained by the state, or by any of its political subdivisions, or maintained by a nonprofit corporation organized for hospital purposes, or with other corporations, associations, partnerships, or individuals furnishing hospital services, medical-surgical services, or other health services. This chapter does not require any corporation to contract or remain under contract with any individual, hospital, physician, or other provider of health services.

Amended by Chapter 91, 1987 General Session

31A-7-105. Documents as evidence.

Section 31A-5-105 applies to documents as evidence in corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-106. Unauthorized assumption of corporate power.

Section 31A-5-106 applies to the unauthorized assumption of corporate power in corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-201. Organization, incorporation, and licensing.

Chapter 5, Part 2, Organization of Corporations, governs the organization, incorporation, and licensing of nonprofit health service corporations with the following exceptions:

(1) Section 16-6a-201 applies in place of Section 31A-5-202.

(2) Sections 16-6a-401 and 31A-1-109 apply in place of Subsection 31A-5-203(2)(a).

(3) The last sentence of Subsection 31A-5-203(2)(e) does not apply.

Amended by Chapter 90, 2004 General Session

31A-7-202. Members.

Sections 16-6a-601 and 16-6a-602 apply to members of corporations organized or operating under this chapter. Sections 16-6a-701, 16-6a-702, 16-6a-704, 16-6a-711, and 16-6a-712 apply to corporations organized or operating under this chapter which have members.

Amended by Chapter 300, 2000 General Session

31A-7-301. Principal office and registered agent.

Section 31A-5-401 governs the location of the principal office and existence of a registered agent for corporations organized and operating under this chapter.

Amended by Chapter 204, 1986 General Session

31A-7-302. Annual report to policyholders.

Every insurer organized or operating under this chapter shall send to each policyholder or electronically post on the insurer's public website an abbreviated annual report which contains basic financial and operating data, and information about important business and corporate developments.

Amended by Chapter 253, 2012 General Session

31A-7-303. Board of directors.

(1) Subject to other provisions under this section, Sections 16-6a-801 through 16-6a-805, and Sections 16-6a-810, 16-6a-812, 16-6a-814, 16-6a-815, and 16-6a-816 apply to the board of directors of insurers organized or operating under this chapter.

(2) The property and lawful business of every corporation subject to this chapter shall be held and managed by a governing board of trustees or directors with the powers and authority as is necessary or incidental to the complete execution of the purposes of each corporation as limited by its articles of incorporation and bylaws. A board may not consist of less than five members. A majority of the directors shall be residents of Utah.

(3) Any person employed by or receiving more than 10% of his income from a

corporation licensed under this chapter, and any person related to that person within the second degree by blood or marriage, is an "insider." Insiders may not constitute a majority of the board of a corporation organized and operating under this chapter.

(4) The board shall manage the business and affairs of the corporation and may not delegate its power or responsibility to do so, except to the extent authorized by Section 31A-7-307.

(5) Section 16-6a-814 applies to the place and notice of directors' meetings.

(6) Any director may be removed from office for cause by an affirmative vote of a majority of the full board at a meeting of the board called for that purpose.

Amended by Chapter 300, 2000 General Session

31A-7-304. Waiver and consent.

Sections 16-6a-813 and 16-6a-815 apply to waiver and consent in corporations organized or operating under this chapter.

Amended by Chapter 300, 2000 General Session

31A-7-305. Supervision of management changes.

Subsections 31A-5-410(1)(a) and 31A-5-410(3) apply to supervision and management changes in corporations organized and operating under this chapter. If a trustee is removed from the board of trustees in the manner specified under Subsection 31A-7-303(6), the action shall be reported to the commissioner within 10 days of the removal.

Amended by Chapter 91, 1987 General Session

31A-7-306. Continuity of management in emergencies.

Section 31A-5-411 applies to continuity of management in emergencies in corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-307. Committees of directors.

(1) If provided by the articles or bylaws of a corporation, the board of directors may, by a resolution adopted by a majority of the full board, designate one or more committees, each consisting of three or more directors, to serve at the pleasure of the board. The board may designate one or more directors as alternate members of any committee to substitute for any absent member at any meeting of the committee. The designation of a committee and delegation of authority to it does not relieve the board or any director of responsibility imposed upon it or him by law.

(2) (a) Corporations organized and operating under this chapter shall have an audit committee and a nominating committee.

(b) A majority of the members of the audit and nominating committees may not be insiders as defined under Subsection 31A-7-303(3).

(3) When the board is not in session, a committee may exercise the powers of

the board in the management of the business and affairs of the corporation to the extent authorized in the resolution or in the articles or bylaws, except final action regarding:

(a) compensation or indemnification of any person who is a director, principal officer, or one of the three most highly paid employees, and any benefits or payments requiring shareholder or policyholder approval;

(b) approval of any contract required to be approved by the board under Section 31A-7-309 or of any other transaction in which a director has a material interest adverse to the corporation;

(c) amendment of the articles or bylaws;

(d) corporate reorganization under Part 4, Reorganization;

(e) any other decision requiring shareholder or policyholder approval;

(f) amendment or repeal of any action previously taken by the full board which by its terms is not subject to amendment or repeal by a committee;

(g) dividends or other distributions to shareholders or policyholders, other than in the routine implementation of policy determinations of the full board;

(h) selection of principal officers; and

(i) filling vacancies on the board or any committee created under Subsection (1) except that the articles or bylaws may provide for temporary appointments to fill vacancies on the board or any committee, the appointments to last no longer than the end of the next board meeting.

(4) Subsection 31A-5-412(4) applies to the subsequent review provided in corporations organized and operating under this chapter.

Amended by Chapter 90, 2004 General Session

31A-7-308. Interlocking directorates and other relationships.

Section 31A-5-413 applies to interlocking directorates and other relationships in corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-309. Transactions in which directors and others are interested.

Section 31A-5-414 applies to corporations organized and operating under this chapter, except that, for purposes of this chapter, Section 31A-5-414 does not preclude standard contracts for the provision of health care services with directors who are also providers of health care services.

Enacted by Chapter 242, 1985 General Session

31A-7-310. Officers', directors', and employees' liability and indemnification.

Section 31A-5-415 applies to officers', directors', and employees' liability and indemnification in corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-311. Executive compensation.

Subsections 31A-5-416(4), (5), (6), and (7) apply to executive compensation in corporations organized and operating under this chapter.

Amended by Chapter 316, 1994 General Session

31A-7-312. Exclusive management and exclusive agency contracts.

Section 31A-5-417 applies to exclusive management and exclusive agency contracts in corporations organized and operating under this chapter, except that in this chapter, Subsection 31A-5-417(2) does not preclude exclusive agency contracts with controlled subsidiaries of the insurer organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-313. Books and records.

Section 16-6a-1602 applies to the books and records of corporations organized and operating under this chapter.

Amended by Chapter 300, 2000 General Session

31A-7-401. Mergers and consolidations.

Sections 31A-5-501 and 31A-5-503 apply to mergers and consolidations of corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-402. Voluntary dissolution.

Section 31A-5-504 applies to the voluntary dissolution of corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-403. Conversion to a Title 31A, Chapter 5, mutual insurer.

(1) An insurer organized and operating under this chapter may be converted into a mutual insurer under Chapter 5 as provided in this section.

(2) (a) The board shall pass a resolution that the conversion is not contrary to the interests of the policyholders specifying the reasons for and the purposes of the proposed conversion, and the manner in which the conversion is expected to affect policyholders, particularly the policyholders that are members.

(b) The board's resolution shall also set forth a plan of conversion which shall include:

(i) the articles of incorporation of the new Chapter 5 mutual insurer, including a description of the classes of policyholders who, by virtue of being policyholders, will have an interest in the converted insurer;

(ii) the bylaws of the new Chapter 5 mutual insurer;

(iii) a description of any changes in the insurer's mode of operations after

conversion to a Chapter 5 mutual insurer; and

(iv) any other items specified by rule.

(3) The provisions of Chapter 16 apply to the conversion of a Chapter 7 insurer to a Chapter 5 mutual insurance corporation.

(4) The plan of conversion shall be submitted to the commissioner for approval, together with a projection of the planned or anticipated financial condition of the insurer for two years after the conversion.

(5) The commissioner shall hold an adjudicative proceeding concerning the conversion application.

(6) The commissioner shall approve the plan of conversion, unless he finds that the plan violates the law, is contrary to the interests of policyholders or the public, or would result in an unfair distribution of interest among the insurer's policyholders.

(7) (a) Upon the commissioner approving the conversion under Subsection (6), the commissioner shall issue a new certificate of authority.

(b) The issuance of the certificate is the conversion, and upon issuance of the certificate the Chapter 7 insurer at once becomes a mutual insurance corporation organized under and fully subject to Chapter 5.

(c) The mutual insurer is considered to have been organized at the time the converted Chapter 7 insurer was organized.

(d) Unless otherwise provided in the plan of conversion, the directors, officers, agents, and employees of the Chapter 7 insurer shall continue in like capacity with the mutual insurance corporation.

Amended by Chapter 161, 1987 General Session

31A-7-404. Transfer of business or assets.

Section 31A-5-508 applies to the transfer of business or assets of corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-501. Duties of officers, directors, agents, and employees.

Section 31A-5-601 applies to the duties of officers, directors, agents, and employees of corporations organized and operating under this chapter.

Enacted by Chapter 242, 1985 General Session

31A-7-502. Doing business in other states.

Section 31A-5-602 applies to corporations organized and operating under this chapter doing business in other states.

Enacted by Chapter 242, 1985 General Session

31A-8-101. Definitions.

For purposes of this chapter:

(1) "Basic health care services" means:

(a) emergency care;
(b) inpatient hospital and physician care;
(c) outpatient medical services; and
(d) out-of-area coverage.
(2) "Director of health" means:
(a) the executive director of the Department of Health; or
(b) the authorized representative of the executive director of the Department of Health.
(3) "Enrollee" means an individual:
(a) who has entered into a contract with an organization for health care; or
(b) in whose behalf an arrangement for health care has been made.
(4) "Health care" is as defined in Section 31A-1-301.
(5) "Health maintenance organization" means any person:
(a) other than:
(i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or
(ii) an individual who contracts to render professional or personal services that the individual directly performs; and
(b) that:
(i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount prior to the time during which the health care may be furnished; and
(ii) is obligated to the enrollee to arrange for or to directly provide available and accessible health care.
(6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person who furnishes, either directly or through arrangements with others, services:
(i) of:
(A) dentists;
(B) optometrists;
(C) physical therapists;
(D) podiatrists;
(E) psychologists;
(F) physicians;
(G) chiropractic physicians;
(H) naturopathic physicians;
(I) osteopathic physicians;
(J) social workers;
(K) family counselors;
(L) other health care providers; or
(M) reasonable combinations of the services described in this Subsection (6)(a)(i);
(ii) to an enrollee;
(iii) in return for prepaid periodic payments agreed to in amount prior to the time during which the services may be furnished; and
(iv) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible services described in this Subsection (6)(a).

(b) "Limited health plan" does not include:

(i) a health maintenance organization;

(ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(iii) an individual who contracts to render professional or personal services that the individual performs.

(7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.

(b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

(8) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:

(a) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or

(b) "organization expenses," which is described in Section 31A-8-208.

(9) "Participating provider" means a provider as defined in Subsection (10) who, under a contract with the health maintenance organization, agrees to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the health maintenance organization, other than copayment.

(10) "Provider" means any person who:

(a) furnishes health care directly to the enrollee; and

(b) is licensed or otherwise authorized to furnish the health care in this state.

(11) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

(12) "Unusual or infrequently used health services" means those health services that are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.

Amended by Chapter 308, 2002 General Session

31A-8-102. Scope and purposes.

(1) No person may operate an organization in this state without complying with and obtaining a certificate of authority under this chapter.

(2) The purposes of this chapter include to:

(a) provide for the establishment of health maintenance organizations which provide readily available, accessible, and quality comprehensive health care to their enrollees;

(b) provide for the establishment of limited health plans which provide readily available, accessible, and quality care to their enrollees;

(c) encourage the development of organizations as an alternative method of health care delivery; and

(d) assure that organizations offering health plans within this state are financially

and administratively sound and that these organizations are in fact able to deliver the benefits as promised.

Enacted by Chapter 204, 1986 General Session

31A-8-103. Applicability to other provisions of law.

(1) (a) Except for exemptions specifically granted under this title, an organization is subject to regulation under all of the provisions of this title.

(b) Notwithstanding any provision of this title, an organization licensed under this chapter:

(i) is wholly exempt from:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations;

(B) Chapter 9, Insurance Fraternals;

(C) Chapter 10, Annuities;

(D) Chapter 11, Motor Clubs;

(E) Chapter 12, State Risk Management Fund;

(F) Chapter 13, Employee Welfare Funds and Plans;

(G) Chapter 19a, Utah Rate Regulation Act; and

(H) Chapter 28, Guaranty Associations; and

(ii) is not subject to:

(A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1, Funding the Insurance Department;

(B) Section 31A-4-107;

(C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for provisions specifically made applicable by this chapter;

(D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by this chapter;

(E) Chapter 17, Determination of Financial Condition, except:

(I) Part 2, Qualified Assets, and Part 6, Risk-Based Capital; or

(II) as made applicable by the commissioner by rule consistent with this chapter;

(F) Chapter 18, Investments, except as made applicable by the commissioner by rule consistent with this chapter; and

(G) Chapter 22, Contracts in Specific Lines, except for Part 6, Accident and Health Insurance, Part 7, Group Accident and Health Insurance, and Part 12, Reinsurance.

(2) The commissioner may by rule waive other specific provisions of this title that the commissioner considers inapplicable to health maintenance organizations or limited health plans, upon a finding that the waiver will not endanger the interests of:

(a) enrollees;

(b) investors; or

(c) the public.

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as specifically made applicable by:

(a) this chapter;

(b) a provision referenced under this chapter; or

(c) a rule adopted by the commissioner to deal with corporate law issues of health maintenance organizations that are not settled under this chapter.

(4) (a) Whenever in this chapter, Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization, the application is:

(i) of those provisions that apply to a mutual corporation if the organization is nonprofit; and

(ii) of those that apply to a stock corporation if the organization is for profit.

(b) When Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:

(a) this chapter; and

(b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(6) This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or

(b) obtain or maintain federal qualification status.

(7) Except as provided in Section 31A-8-501, an organization is exempt from statutes in this title or department rules that restrict or limit the organization's freedom of choice in contracting with or selecting health care providers, including Section 31A-22-618.

(8) An organization is exempt from the assessment or payment of premium taxes imposed by Sections 59-9-101 through 59-9-104.

Amended by Chapter 324, 2010 General Session

31A-8-104. Determination of ability to provide services.

(1) The commissioner may not issue a certificate of authority to an applicant for a certificate of authority under this chapter unless the commissioner has determined that the applicant has:

(a) demonstrated the willingness and potential ability to furnish the proposed health care services in a manner to assure both availability and accessibility of adequate personnel and facilities and continuity of service;

(b) arrangements for an ongoing quality of health care assurance program concerning health care processes and outcomes, established in accordance with rules adopted by the director of the Department of Health based upon prevailing standards for quality assurance for other forms of health care delivery in this state; and

(c) a procedure, established in accordance with rules of the director of the Department of Health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by

the director of the Department of Health.

(2) Upon receipt of an application for a certificate of authority under this chapter, the commissioner shall transmit a copy of the application and accompanying documents to the director of the Department of Health. Upon receipt of the application, the director of the Department of Health shall review the application, investigate the surrounding facts and circumstances, and make a finding concerning whether the applicant satisfies the requirements of Subsection (1). The director of the Department of Health is considered to have found the applicant to comply with Subsection (1) unless he delivers to the commissioner a finding of noncompliance within 90 days after receiving the application from the commissioner.

(3) In determining whether the requirements of Subsection (1) are satisfied, the commissioner shall rely on the findings of the director of the Department of Health delivered to the commissioner in accordance with Subsection (2).

(4) A finding of noncompliance with Subsection (1) shall specify in what respects the applicant is deficient in meeting the requirements of Subsection (1).

(5) An organization's certificate of authority issued under this chapter is conclusive evidence of compliance with Subsection (1), as to the services authorized to be performed under the certificate of authority, except in a proceeding by the state against the organization. Licensing under this chapter does not exempt an organization from any licensing requirement applicable under Title 26, Chapter 21.

Amended by Chapter 185, 1997 General Session

31A-8-105. General powers of organizations.

Organizations may:

(1) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals, health care clinics, other health care facilities, and other real and personal property incidental to and reasonably necessary for the transaction of the business and for the accomplishment of the purposes of the organization;

(2) furnish health care through providers which are under contract with the organization;

(3) contract with insurance companies licensed in this state or with health service corporations authorized to do business in this state for insurance, indemnity, or reimbursement for the cost of health care furnished by the organization;

(4) offer to its enrollees, in addition to health care, insured indemnity benefits, but only for emergency care, out-of-area coverage, unusual or infrequently used health services as defined in Section 31A-8-101, and adoption benefits as provided in Section 31A-22-610.1;

(5) receive from governmental or private agencies payments covering all or part of the cost of the health care furnished by the organization;

(6) lend money to a medical group under contract with it or with a corporation under its control to acquire or construct health care facilities or for other uses to further its program of providing health care services to its enrollees;

(7) be owned jointly by health care professionals and persons not professionally licensed without violating Utah law; and

(8) do all other things necessary for the accomplishment of the purposes of the

organization.

Amended by Chapter 329, 1998 General Session

31A-8-105.5. Primary care physicians.

With regard to participating providers who are physicians who are members of the American College of Obstetrics and Gynecology, organizations operating under this chapter shall:

(1) permit a female enrollee to receive at least one outpatient examination per year from the enrollee's choice of one of those participating providers. An organization may not require the enrollee to receive a preapproval, preauthorization, or referral from the enrollee's primary care physician before receiving this examination; and

(2) clearly state in the organization's health benefit plan literature that enrollees may seek the care described in Subsection (1) without preapproval, preauthorization, or referral from the patient's primary care physician.

Amended by Chapter 10, 1997 General Session

31A-8-106. Other business.

No organization may engage, directly or indirectly, in any business other than that of an organization and business reasonably incidental to that business.

Enacted by Chapter 204, 1986 General Session

31A-8-107. Documents as evidence.

Section 31A-5-105 applies to documents as evidence in organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-108. Unauthorized assumption of corporate power.

Section 31A-5-106 applies to the unauthorized assumption of corporate power in organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-201. Scope of part.

This part applies to all organizations doing business in this state.

Amended by Chapter 123, 2005 General Session

31A-8-202. Corporate name -- Office -- Registered agent.

(1) Sections 16-10a-402, 16-10a-403, and 42-2-5 apply to the reservation and registration of the corporate name in domestic health maintenance organizations. Reservation and registration fees under Section 31A-3-103 apply.

(2) The location of an organization's principal office and the existence of a registered agent are governed by Title 16, Chapter 17, Model Registered Agents Act.

Amended by Chapter 364, 2008 General Session

31A-8-203. Incorporators.

One or more adult natural persons may organize and act as the incorporators of a domestic health maintenance organization under this part.

Enacted by Chapter 204, 1986 General Session

31A-8-204. Articles and bylaws.

(1) The articles of a nonprofit organization shall conform to Subsections 16-6a-202(1)(a) through (e). The articles of other organizations shall conform to Section 16-10a-202. In addition:

(a) the powers of the corporation shall be limited to those permitted under Section 31A-8-105;

(b) the articles shall state whether the organization is a health maintenance organization or a limited health plan;

(c) the articles shall state the services to be provided or for which indemnity is to be paid, which services provided and indemnity guaranteed shall be consistent with the organization's designation under Subsection (1)(b);

(d) the articles shall state that as to health care services for which individual providers are required to be licensed, the services provided by the organization shall be provided by persons properly licensed to perform the services;

(e) the articles shall state whether providers of services are subject to assessment or withholding to pay operating costs or financial deficits;

(f) the articles shall state, for organizations having members, how persons become members and that only members vote; and

(g) the articles of an organization not having members shall state how the directors of the organization shall be selected and removed.

(2) The articles or bylaws shall designate three or more officers as the principal officers of the corporation. The principal offices shall be held by at least three separate natural persons.

(3) Section 31A-5-219 applies to amendments to articles of organizations.

(4) Organizations shall adopt and maintain bylaws. Section 16-6a-206 applies to organizations, except for the statement that bylaws need not be adopted.

Amended by Chapter 364, 2008 General Session

31A-8-205. Organization permit and certificate of incorporation.

(1) Section 31A-5-204 applies to the formation of organizations, except that "Section 31A-5-211" in Subsection 31A-5-204(5) shall be read "Section 31A-8-209."

(2) In addition to the requirements of Section 31A-5-204, the application for a permit shall include a description of the initial locations of facilities where health care will be available to enrollees, the hours during which various services will be provided, the types of health care personnel to be used at each location and the approximate number of each personnel type to be available at each location, the methods to be

used to monitor the quality of health care furnished, the method of resolving adverse benefit determinations initiated by enrollees or providers, the method used to give enrollees an opportunity to participate in matters of policy, the medical records system, and the method for documentation of utilization of health care by persons insured.

Amended by Chapter 308, 2002 General Session

31A-8-206. Powers under organization permit -- Deposit of proceeds of subscriptions.

Sections 31A-5-207 and 31A-5-208 apply to the powers of an organization under an organization permit and the deposit of proceeds of subscriptions, except that there are no qualifying insurance policies as referred to in Subsection 31A-5-207(2)(a).

Enacted by Chapter 204, 1986 General Session

31A-8-207. Termination of organization permit -- Payment of organization expenses.

Section 31A-5-209, other than Subsection 31A-5-209(3)(c), applies to the termination of the organization permit and the payment of organization expenses of organizations, except that "Section 31A-5-212" shall be read "Section 31A-8-213."

Amended by Chapter 185, 2002 General Session

31A-8-208. Incorporators' liability and organization expenses.

Section 31A-5-210 applies to incorporators' liability and organization expenses in organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-209. Minimum capital or minimum permanent surplus.

(1) (a) A health maintenance organization being organized or operating under this chapter shall have and maintain a minimum capital or minimum permanent surplus of $100,000.

(b) Each health maintenance organization authorized to do business in this state shall have and maintain qualified assets as defined in Subsection 31A-17-201(2) in an amount not less than the total of:

(i) the health maintenance organization's liabilities;

(ii) the health maintenance organization's minimum capital or minimum permanent surplus required by Subsection (1)(a); and

(iii) the greater of:

(A) the company action level RBC as defined in Subsection 31A-17-601(8)(b); or

(B) $1,300,000.

(2) (a) The minimum required capital or minimum permanent surplus for a limited health plan may not:

(i) be less than $10,000; or

(ii) exceed $100,000.

(b) The initial minimum required capital or minimum permanent surplus for a limited health plan required by Subsection (2)(a) shall be set by the commissioner, after:

(i) a hearing; and

(ii) consideration of:

(A) the services to be provided by the limited health plan;

(B) the size and geographical distribution of the population the limited health plan anticipates serving;

(C) the nature of the limited health plan's arrangements with providers; and

(D) the arrangements, agreements, and relationships of the limited health plan in place or reasonably anticipated with respect to:

(I) insolvency insurance;

(II) reinsurance;

(III) lenders subordinating to the interests of enrollees and trade creditors;

(IV) personal and corporate financial guarantees;

(V) provider withholds and assessments;

(VI) surety bonds;

(VII) hold harmless agreements in provider contracts; and

(VIII) other arrangements, agreements, and relationships impacting the security of enrollees.

(c) Upon a material change in the scope or nature of a limited health plan's operations, the commissioner may, after a hearing, alter the limited health plan's minimum required capital or minimum permanent surplus.

(3) The commissioner may allow the minimum capital or permanent surplus account of an organization to be designated by some other name.

(4) A pattern of persistent deviation from the accounting and investment standards under this section may be grounds for the commissioner to find that the one or more persons with authority to make the organization's accounting or investment decisions are incompetent for purposes of Subsection 31A-5-410(3).

Amended by Chapter 308, 2002 General Session

31A-8-211. Deposit.

(1) Except as provided in Subsection (2), each health maintenance organization authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum of:

(a) $100,000; and

(b) 50% of the greater of:

(i) $900,000;

(ii) 2% of the annual premium revenues as reported on the most recent annual financial statement filed with the commissioner; or

(iii) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner.

(2) (a) After a hearing the commissioner may exempt a health maintenance organization from the deposit requirement of Subsection (1) if:

(i) the commissioner determines that the enrollees' interests are adequately protected;

(ii) the health maintenance organization has been continuously authorized to do business in this state for at least five years; and

(iii) the health maintenance organization has $5,000,000 surplus in excess of the health maintenance organization's company action level RBC as defined in Subsection 31A-17-601(8)(b).

(b) The commissioner may rescind an exemption given under Subsection (2)(a).

(3) (a) Each limited health plan authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the minimum capital or permanent surplus plus 50% of the greater of:

(i) .5 times minimum required capital or minimum permanent surplus; or

(ii) (A) during the first year of operation, 10% of the limited health plan's projected uncovered expenditures for the first year of operation;

(B) during the second year of operation, 12% of the limited health plan's projected uncovered expenditures for the second year of operation;

(C) during the third year of operation, 14% of the limited health plan's projected uncovered expenditures for the third year of operation;

(D) during the fourth year of operation, 18% of the limited health plan's projected uncovered expenditures during the fourth year of operation; or

(E) during the fifth year of operation, and during all subsequent years, 20% of the limited health plan's projected uncovered expenditures for the previous 12 months.

(b) Projections of future uncovered expenditures shall be established in a manner that is approved by the commissioner.

(4) A deposit required by this section may be counted toward the minimum capital or minimum permanent surplus required under Section 31A-8-209.

Amended by Chapter 308, 2002 General Session

31A-8-213. Certificate of authority.

(1) An organization may apply for a certificate of authority at any time prior to the expiration of its organization permit. The application shall include:

(a) a detailed statement by a principal officer about any material changes that have taken place or are likely to take place in the facts on which the issuance of the organization permit was based; and

(b) if any material changes are proposed in the business plan, the information about the changes that would be required if an organization permit were then being applied for.

(2) The commissioner shall issue a certificate of authority, if the commissioner finds that:

(a) the organization's capital and surplus complies with the requirements of Section 31A-8-209 as to the operations proposed under the new certificate of authority;

(b) there is no basis for revoking the organization permit under Section 31A-8-207;

(c) the deposit required by Section 31A-8-211 has been made;

(d) the organization satisfies the requirements of Section 31A-8-104; and

(e) all other applicable requirements of the law have been met.

(3) The certificate of authority shall specify any limits imposed by the commissioner upon the organization's business or methods of operation, including the general types of health care services the organization is authorized to provide.

(4) Upon the issuance of the certificate of authority:

(a) the board shall authorize and direct the issuance of certificates for shares, bonds, or notes subscribed to under the organization permit, and of insurance policies upon qualifying applications obtained under the organization permit; and

(b) the commissioner shall authorize the release to the organization of all funds held in escrow under Section 31A-5-208, as adopted by Section 31A-8-206.

(5) (a) An organization may at any time apply to the commissioner for a new or amended certificate of authority altering the limits on its business or methods of operation. The application shall contain or be accompanied by that information reasonably required by the commissioner under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall issue the new certificate as requested if the commissioner finds that the organization continues to satisfy the requirements specified under Subsection (2).

(b) If the commissioner issues an order under Chapter 27, Part 5, Administration Actions, against an organization, the commissioner may also revoke the organization's certificate and issue a new one with any limitation the commissioner considers necessary.

Amended by Chapter 309, 2007 General Session

31A-8-214. Securities.

Chapter 5, Part 3, Securities of Domestic Insurance Corporations, applies to securities of organizations, except that the amount "$150,000" in Subsection 31A-5-304(1) shall be read "one-half of the minimum capital required of the organization."

Amended by Chapter 90, 2004 General Session

31A-8-215. Management.

Chapter 5, Part 4, Management of Insurance Corporations, applies to organizations, except that for purposes of this chapter, Subsections 31A-5-412(3)(a)(vi) through (ix) shall be read: "corporate reorganizations under Section 31A-8-216."

Amended by Chapter 349, 2009 General Session

31A-8-216. Corporate reorganizations.

Sections 31A-5-501 through 31A-5-506 and Section 31A-5-508 apply to corporate reorganizations of organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-217. Material transactions by insurers which are part of holding

company system.

(1) This section applies to an insurer licensed under this chapter that is part of a holding company system, for purposes of:

(a) the reporting requirements of Section 31A-16-105; and

(b) the material transaction standards of Section 31A-16-106.

(2) Unless otherwise provided by rule, a transaction is not material under Subsection 31A-16-105(4) if the transaction involves an amount:

(a) of not more than:

(i) 10% for each transaction; or

(ii) 20% for cumulative transactions during any one calendar year; and

(b) calculated:

(i) on the basis of the organization's surplus requirement, determined in accordance with Section 31A-5-211; and

(ii) as of December 31 of the year immediately preceding the transaction.

Amended by Chapter 252, 2003 General Session

31A-8-301. Requirements for doing business in state.

(1) Only a corporation incorporated and licensed under Part 2, Domestic Organizations, may do business in this state as an organization.

(2) To do business in this state as an organization, a foreign corporation doing a similar business in other states shall incorporate a subsidiary and license it under Part 2, Domestic Organizations, for its Utah business. Except as to Chapter 16, Insurance Holding Companies, the laws applicable to a domestic organization apply only to the domestic organization and not to its foreign parent corporation.

Amended by Chapter 319, 2013 General Session

31A-8-401. Enrollee participation.

Every organization shall provide a reasonable procedure, consistent with Section 31A-4-116, for allowing enrollees to participate in matters of policy of the organization and for resolving complaints and adverse benefit determinations initiated by enrollees or providers.

Amended by Chapter 308, 2002 General Session

31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides,

or works in:
(A) the service area of the insurer; or
(B) the area for which the insurer is authorized to do business; and
(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or
(b) for coverage made available in the small or large employer market only through an association, if:
(i) the employer's membership in the association ceases; and
(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.
(3) A health benefit plan for a plan sponsor may be discontinued if:
(a) a condition described in Subsection (2) exists;
(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;
(c) the plan sponsor:
(i) performs an act or practice that constitutes fraud; or
(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
(d) the insurer:
(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and
(ii) (A) provides notice of the discontinuation in writing:
(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
(II) at least 90 days before the date the coverage will be discontinued;
(B) provides notice of the discontinuation in writing:
(I) to the commissioner; and
(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;
(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
(I) all other health benefit products currently being offered by the insurer in the market; or
(II) in the case of a large employer, any other health benefit product currently being offered in that market; and
(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:
(I) the claims experience of a plan sponsor;
(II) any health status-related factor relating to any covered participant or beneficiary; or
(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or
(e) the insurer:
(i) elects to discontinue all of the insurer's health benefit plans in:
(A) the small employer market;

(B) the large employer market; or
(C) both the small employer and large employer markets; and
(ii) (A) provides notice of the discontinuation in writing:
(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
(II) at least 180 days before the date the coverage will be discontinued;
(B) provides notice of the discontinuation in writing:
(I) to the commissioner in each state in which an affected insured individual is known to reside; and
(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;
(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and
(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
(4) A large employer health benefit plan may be discontinued or nonrenewed:
(a) if a condition described in Subsection (2) exists; or
(b) for noncompliance with the insurer's:
(i) minimum participation requirements; or
(ii) employer contribution requirements.
(5) A small employer health benefit plan may be discontinued or nonrenewed:
(a) if a condition described in Subsection (2) exists; or
(b) for noncompliance with the insurer's employer contribution requirements.
(6) A small employer health benefit plan may be nonrenewed:
(a) if a condition described in Subsection (2) exists; or
(b) for noncompliance with the insurer's minimum participation requirements.
(7) (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:
(i) engages in an act or practice in connection with the coverage that constitutes fraud; or
(ii) makes an intentional misrepresentation of material fact in connection with the coverage.
(b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
(i) 12 months after the date of discontinuance; and
(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.
(c) At the time the eligible employee's coverage is discontinued under Subsection (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.
(d) An eligible employee may not be discontinued under this Subsection (7) because of a fraud or misrepresentation that relates to health status.
(8) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:
(a) with respect to coverage provided to an employer member of the association; and
(b) if the health benefit plan is made available by an insurer in the employer

market only through:
(i) an association;
(ii) a trust; or
(iii) a discretionary group.
(9) An insurer may modify a health benefit plan for a plan sponsor only:
(a) at the time of coverage renewal; and
(b) if the modification is effective uniformly among all plans with that product.

Amended by Chapter 329, 2004 General Session

31A-8-402.5. Individual discontinuance and nonrenewal.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:
(i) with respect to all individuals or dependents; and
(ii) at the option of the individual.
(b) Subsection (1)(a) applies regardless of:
(i) whether the contract is issued through:
(A) a trust;
(B) an association;
(C) a discretionary group; or
(D) other similar grouping; or
(ii) the situs of delivery of the policy or contract.
(2) A health benefit plan may be discontinued or nonrenewed:
(a) for a network plan, if:
(i) the individual no longer lives, resides, or works in:
(A) the service area of the insurer; or
(B) the area for which the insurer is authorized to do business; and
(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or
(b) for coverage made available through an association, if:
(i) the individual's membership in the association ceases; and
(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.
(3) A health benefit plan may be discontinued if:
(a) a condition described in Subsection (2) exists;
(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;
(c) the individual:
(i) performs an act or practice in connection with the coverage that constitutes fraud; or
(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
(d) the insurer:
(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and
(ii) (A) provides notice of the discontinuation in writing:

(I) to each individual provided coverage; and
(II) at least 90 days before the date the coverage will be discontinued;
(B) provides notice of the discontinuation in writing:
(I) to the commissioner; and
(II) at least three working days prior to the date the notice is sent to the affected individuals;
(C) offers to each covered individual on a guaranteed issue basis, the option to purchase all other individual health benefit products currently being offered by the insurer for individuals in that market; and
(D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage; or
(e) the insurer:
(i) elects to discontinue all of the insurer's health benefit plans in the individual market; and
(ii) (A) provides notice of the discontinuation in writing:
(I) to each individual provided coverage; and
(II) at least 180 days before the date the coverage will be discontinued;
(B) provides notice of the discontinuation in writing:
(I) to the commissioner in each state in which an affected insured individual is known to reside; and
(II) at least 30 working days prior to the date the notice is sent to the affected individuals;
(C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for issuance in the individual market; and
(D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

Amended by Chapter 252, 2003 General Session

31A-8-402.7. Discontinuance and nonrenewal limitations.

(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsections 31A-8-402.3(3)(e) and 31A-8-402.5(3)(e) is prohibited from writing new business:
(a) in the market in this state for which the insurer discontinues or does not renew; and
(b) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.
(2) If an insurer is doing business in one established geographic service area of the state, Sections 31A-8-402.3 and 31A-8-402.5 apply only to the insurer's operations in that service area.
(3) The commissioner may, by rule or order, define the scope of service area.

Amended by Chapter 78, 2005 General Session

31A-8-403. Examination of organization and providers.

Examinations of a health maintenance organization and its providers shall be conducted according to the provisions of Chapter 2. Except during an audit of the internal quality control system, medical records of individual patients kept by the organization or its providers are not subject to examination.

Enacted by Chapter 204, 1986 General Session

31A-8-404. Annual audit of internal quality control.

Each organization shall prepare an annual report of the effectiveness of the organization's internal quality control. The report shall be in a form prescribed by the commissioner after consultation with the director of the Department of Health, and shall be certified and signed by two officers of the organization. The commissioner may at any time require an audit of an organization's quality control system. The audit shall be performed by qualified persons designated by the commissioner. Auditors shall have full access to all records of the organization and its providers, including medical records of individual patients. The information contained in the medical records of individual patients shall remain confidential, and information derived from those records may not be used in a manner that could directly or indirectly identify an individual. All information, interviews, reports, statements, memoranda, or other data furnished by reason of the audit and any findings or conclusions of the auditors are privileged and are not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner or the director of the Department of Health concerning alleged violations of the provisions of this chapter.

Amended by Chapter 314, 1994 General Session

31A-8-405. Confidentiality of medical records and audits.

Unless a court orders otherwise, the department shall treat the following records and information as confidential and prevent their disclosure to the public:

(1) the medical records of enrollees of an organization; and

(2) the annual audits performed under Section 31A-8-404.

Enacted by Chapter 204, 1986 General Session

31A-8-406. Distribution by nonprofit organizations.

A nonprofit organization may pay compensation in a reasonable amount to its members, trustees, or officers for services rendered, may make reasonable incentive payments to its providers, may confer benefits upon its members in conformity with its purposes, may pay interest on certificates of indebtedness issued by it evidencing capital contributions, and upon dissolution or final liquidation may make distributions to its members as permitted by Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and no such payment, benefit, or distribution shall be considered to be a dividend or distribution of income. Notwithstanding Section 31A-8-105, and in addition to the powers granted in that section, a nonprofit organization has all powers conferred upon it by Section 16-6a-302.

Amended by Chapter 300, 2000 General Session

31A-8-407. Written contracts -- Limited liability of enrollee -- Provider claim disputes -- Leased networks.

(1) (a) Every contract between an organization and a participating provider of health care services shall be in writing and shall set forth that if the organization:

(i) fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the organization; and

(ii) becomes insolvent, the rehabilitator or liquidator may require the participating provider of health care services to:

(A) continue to provide health care services under the contract between the participating provider and the organization until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise entitled to receive from the organization under the contract between the participating provider and the organization during the time period described in Subsection (1)(a)(ii)(A).

(b) If the conditions of Subsection (1)(c) are met, the participating provider shall:

(i) accept the reduced payment as payment in full; and

(ii) relinquish the right to collect additional amounts from the insolvent organization's enrollee.

(c) Notwithstanding Subsection (1)(a)(ii)(B):

(i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the participating provider contract; and

(ii) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the participating provider that the enrollee was required to pay before the filing of:

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

(2) A participating provider may not collect or attempt to collect from the enrollee sums owed by the organization or the amount of the regular fee reduction authorized under Subsection (1)(a)(ii) if the participating provider contract:

(a) is not in writing as required in Subsection (1); or

(b) fails to contain the language required by Subsection (1).

(3) (a) A person listed in Subsection (3)(b) may not bill or maintain any action at law against an enrollee to collect:

(i) sums owed by the organization; or

(ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).

(b) Subsection (3)(a) applies to:

(i) a participating provider;

(ii) an agent;

(iii) a trustee; or

(iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).

(c) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the organization's written payment policies in effect at the time services were rendered.

(d) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (3)(d) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(e) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(4) If an organization permits another private entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks that include participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network unless payment for services is governed by a public program's fee schedule.

Amended by Chapter 3, 2005 Special Session 1

31A-8-408. Organizations offering point of service or point of sales products.

Effective July 1, 1991, a health maintenance organization offering products that permit members the option of obtaining covered services from a noncontracted provider, which is a point of service or point of sale product, shall comply with the requirements of Subsections (1) through (7).

(1) The cost of an encounter with a noncontracted provider is considered an uncovered expenditure as defined in Section 31A-8-101.

(2) (a) An organization shall report to the commissioner on a monthly basis the number of encounters with contracted and noncontracted providers if the organization offers to sell a:

(i) point of service product; or

(ii) point of sale product.

(b) The commissioner shall:

(i) define the form, content, and due date of the report required by this Subsection (2); and

(ii) require audited reports of the information on a yearly basis.

(3) An organization may not offer a point of service product or a point of sale product unless the organization has secured contracts with participating providers located within the organization's service area for each covered service other than those unusual or infrequently used health services that are not available from the organization's health care providers.

(4) An organization may not enroll a member who does not work or reside in the service area as defined by rule, except this Subsection (4) does not apply to a dependent of an enrollee.

(5) Any organization that exceeds the 10% limit of unusual or infrequently used

health services as defined in Section 31A-8-101 is subject to a forfeiture of up to $50 per encounter.

(6) An organization shall disclose to employees and members the existence of the 10% limit:

(a) at enrollment; or

(b) prior to enrollment.

(7) The commissioner shall hold hearings and adopt rules providing any additional limitations or requirements necessary to secure the public interest in conformity with this section.

Amended by Chapter 308, 2002 General Session

31A-8-501. Access to health care providers.

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a health maintenance organization contract.

(c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center.

(d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x.

(e) "Independent hospital" means a general acute hospital or a critical access hospital that:

(i) is either:

(A) located 20 miles or more from any other general acute hospital or critical access hospital; or

(B) licensed as of January 1, 2004;

(ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and

(iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located and:

(A) the board of directors is ultimately responsible for the policy and financial decisions of the hospital; or

(B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization.

(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member who has not contracted with a health maintenance organization to provide health care services to enrollees of the organization.

(2) Except for a health maintenance organization which is under the common

ownership or control of an entity with a hospital located within 10 paved road miles of an independent hospital, a health maintenance organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the independent hospital; or

(ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the independent hospital than a contracting hospital;

(b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(3) A health maintenance organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the federally qualified health center; or

(ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider;

(b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(4) (a) A health maintenance organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it pays to contracting providers under a noncapitated arrangement for comparable services.

(b) A health maintenance organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the health maintenance organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service.

(5) (a) A noncontracting independent hospital may not balance bill a patient when the health maintenance organization reimburses a noncontracting independent hospital or an enrollee in accordance with Subsection (4)(a).

(b) A noncontracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b).

(6) A noncontracting provider may only refer an enrollee to another noncontracting provider so as to obligate the enrollee's health maintenance organization to pay for the resulting services if:

(a) the noncontracting provider making the referral or the enrollee has received prior authorization from the organization for the referral; or

(b) the practice location of the noncontracting provider to whom the referral is made:

(i) is located in a county with a population density of less than 25 people per square mile; and

(ii) is within 30 paved road miles of:

(A) the place where the enrollee lives or resides; or

(B) the independent hospital or federally qualified health center at which the enrollee may receive covered services pursuant to Subsection (2) or (3).

(7) Notwithstanding this section, a health maintenance organization may contract directly with an independent hospital, federally qualified health center, or credentialed staff member.

(8) (a) A health maintenance organization that violates any provision of this section is subject to sanctions as determined by the commissioner in accordance with Section 31A-2-308.

(b) Violations of this section include:

(i) failing to provide the notice required by Subsection (8)(d) by placing the notice in any health maintenance organization's provider list that is supplied to enrollees, including any website maintained by the health maintenance organization;

(ii) failing to provide notice of an enrollee's rights under this section when:

(A) an enrollee makes personal contact with the health maintenance organization by telephone, electronic transaction, or in person; and

(B) the enrollee inquires about his rights to access an independent hospital or federally qualified health center; and

(iii) refusing to reprocess or reconsider a claim, initially denied by the health maintenance organization, when the provisions of this section apply to the claim.

(c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner:

(i) adopt rules as necessary to implement this section;

(ii) identify in rule:

(A) the counties with a population density of less than 100 people per square mile;

(B) independent hospitals as defined in Subsection (1)(e); and

(C) federally qualified health centers as defined in Subsection (1)(d).

(d) (i) A health maintenance organization shall:

(A) use the information developed by the commissioner under Subsection (8)(c) to identify the rural counties, independent hospitals, and federally qualified health centers that are located in the health maintenance organization's service area; and

(B) include the providers identified under Subsection (8)(d)(i)(A) in the notice required in Subsection (8)(d)(ii).

(ii) The health maintenance organization shall provide the following notice, in bold type, to enrollees as specified under Subsection (8)(b)(i), and shall keep the notice current:

"You may be entitled to coverage for health care services from the following non-HMO contracted providers if you live or reside within 30 paved road miles of the listed providers, or if you live or reside in closer proximity to the listed providers than to your HMO contracted providers:

This list may change periodically, please check on our website or call for verification. Please be advised that if you choose a noncontracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a provider on this list you may contact your health maintenance organization at _____. If the HMO does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free."

(e) A person whose interests are affected by an alleged violation of this section may contact the Office of Consumer Health Assistance and request assistance, or file a complaint as provided in Section 31A-2-216.

Amended by Chapter 369, 2012 General Session

31A-8-502. Court ordered coverage for minor children who reside outside the service area.

(1) (a) The requirements of Subsection (2) apply to a health maintenance organization if the health maintenance organization plan:

(i) restricts coverage for nonemergency services to services provided by contracted providers within the organization's service area; and

(ii) does not offer a benefit that permits members the option of obtaining covered services from a non-contracted provider.

(b) The requirements of Subsection (2) do not apply to a health maintenance organization if:

(i) the child that is the subject of a court or administrative support order is over the age of 18 and is no longer enrolled in high school; or

(ii) a parent's employer offers the parent a choice to select health insurance coverage that is not a health maintenance organization plan either at the time of the court or administrative support order, or at a subsequent open enrollment period. This exemption from Subsection (2) applies even if the parent ultimately chooses the health maintenance organization plan.

(2) If a parent is required by a court or administrative support order to provide health insurance coverage for a child who resides outside of a health maintenance organization's service area, the health maintenance organization shall:

(a) comply with the provisions of Section 31A-22-610.5;

(b) allow the enrollee parent to enroll the child on the organization plan;

(c) pay for otherwise covered health care services rendered to the child outside of the service area by a noncontracted provider:

(i) if the child, noncustodial parent, or custodial parent has complied with prior authorization or utilization review otherwise required by the organization; and

(ii) in an amount equal to the dollar amount the organization pays under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the services; and

(d) make payments on claims submitted in accordance with Subsection (2)(c) directly to the provider, custodial parent, the child who obtained benefits, or state Medicaid agency.

(3) (a) The parents of the child who is the subject of the court or administrative

support order are responsible for any charges billed by the provider in excess of those paid by the organization.

(b) This section does not affect any court or administrative order regarding the responsibilities between the parents to pay any medical expenses not covered by accident and health insurance or a health maintenance organization plan.

(4) The commissioner shall adopt rules as necessary to administer this section and Section 31A-22-610.5.

Enacted by Chapter 178, 2004 General Session

31A-8a-101. Title.

This chapter is known as the "Health Discount Program Consumer Protection Act."

Enacted by Chapter 58, 2005 General Session

31A-8a-102. Definitions.

For purposes of this chapter:

(1) "Fee" means any periodic charge for use of a discount program.

(2) "Health care provider" means a health care provider as defined in Section 78B-3-403, with the exception of "licensed athletic trainer," who:

(a) is practicing within the scope of the provider's license; and

(b) has agreed either directly or indirectly, by contract or any other arrangement with a health discount program operator, to provide a discount to enrollees of a health discount program.

(3) (a) "Health discount program" means a business arrangement or contract in which a person pays fees, dues, charges, or other consideration in exchange for a program that provides access to health care providers who agree to provide a discount for health care services.

(b) "Health discount program" does not include a program that does not charge a membership fee or require other consideration from the member to use the program's discounts for health services.

(4) "Health discount program marketer" means a person, including a private label entity, that markets, promotes, sells, or distributes a health discount program but does not operate a health discount program.

(5) "Health discount program operator" means a person that provides a health discount program by entering into a contract or agreement, directly or indirectly, with a person or persons in this state who agree to provide discounts for health care services to enrollees of the health discount program and determines the charge to members.

(6) "Value-added benefit" means a discount offering with no additional charge made by a health insurer or health maintenance organization that is licensed under this title, in connection with existing contracts with the health insurer or health maintenance organization.

Amended by Chapter 104, 2013 General Session
Amended by Chapter 135, 2013 General Session

31A-8a-103. Scope and purposes.

(1) A person shall comply with the provisions of this chapter if the person operates a health discount program in this state.

(2) Notwithstanding any provision in this title, a person who only operates or markets a health discount program is exempt from:

(a) Section 31A-4-113;

(b) Section 31A-4-113.5;

(c) Chapter 6a, Service Contracts;

(d) Chapter 7, Nonprofit Health Service Insurance Corporations;

(e) Section 31A-8-209;

(f) Section 31A-8-211;

(g) Section 31A-8-214;

(h) Chapters 9 through 12;

(i) Chapters 17 and 18;

(j) Chapter 19a, Utah Rate Regulation Act;

(k) Sections 31A-23a-103 and 31A-23a-104;

(l) Chapters 25 and 26;

(m) Chapters 28 and 29; and

(n) Chapters 35 through 38.

(3) A person licensed under this title as an accident and health insurer or health maintenance organization:

(a) is not required to obtain a license as required by Section 31A-8a-201 to operate a health discount program; and

(b) is required to comply with all other provisions of this chapter.

(4) The purposes of this chapter include:

(a) full disclosure in the sale of health discount programs;

(b) reasonable regulation of the marketing and disclosure practices of health discount program operators; and

(c) licensing standards for health discount programs.

(5) Nothing in this chapter prohibits a health discount program operator from marketing a health discount program operator's own services without a health discount program marketer license.

Amended by Chapter 135, 2013 General Session

31A-8a-201. License required.

(1) Except as provided in Subsection 31A-8a-103(3), prior to operating or marketing a health discount program, a person shall:

(a) be authorized to transact business in this state; and

(b) be licensed by the commissioner.

(2) (a) An application for licensure under this chapter shall be filed with the commissioner on a form prescribed by the commissioner.

(b) The application shall be sworn to by an officer or authorized representative of the health discount program and shall include:

(i) articles of incorporation with bylaws or other enabling documents that establish the organizational structure;

(ii) information required by the commissioner by administrative rule which the commissioner determines is necessary to:

(A) identify and locate principals, operators, and marketers involved with the health discount program; and

(B) protect the interests of enrollees of health discount programs, health care providers, and consumers;

(iii) biographical information, and when requested by the commissioner, a criminal background check, under the provisions of Subsection 31A-23a-105(3);

(iv) the disclosures required in Section 31A-8a-203; and

(v) the fee established in accordance with Section 31A-3-103.

Amended by Chapter 135, 2013 General Session

31A-8a-202. Commissioner to issue license -- Renewals.

(1) The commissioner may issue a license to a person:

(a) who files an application and pays the fee in accordance with Section 31A-8a-201; and

(b) who the commissioner determines is in compliance with this chapter.

(2) (a) A license issued under this chapter is valid until the immediately following December 31 and may be renewed in accordance with Subsection (2)(b).

(b) A license may be renewed if:

(i) the commissioner finds that the person operating the health discount program is in compliance with this chapter;

(ii) the health discount program operator or health discount program marketer submits the appropriate renewal application and pays any applicable fees for renewal; and

(iii) the health discount program certifies that the information in the application for renewal is accurate.

Amended by Chapter 135, 2013 General Session

31A-8a-202.5. Reporting of administrative actions and criminal prosecution.

(1) A health discount program operator or health discount program marketer shall report to the commissioner any administrative action or criminal prosecution brought against the health discount program operator, health discount program marketer, or an owner, officer, or principal of the health discount program operator or health discount program marketer, other than an administrative action brought by the department.

(2) The health discount program operator or health discount program marketer shall file the report described in Subsection (1):

(a) at the time the health discount program operator or health discount program marketer files an application for licensure or renewal; and

(b) (i) for an administrative action that occurs on or after the day on which the health discount program operator or health discount program marketer files an application for licensure or renewal, within 30 days after the day on which the final

disposition of the administrative action is issued; or

(ii) for a criminal prosecution, within 30 days after the health discount program operator's or health discount program marketer's initial appearance before a court.

(3) The report described in Subsection (1) shall include:

(a) a copy of the complaint or other relevant legal documents related to the administrative action or criminal prosecution; and

(b) an explanation or other information that the health discount program operator or health discount program marketer desires to submit in relation to the action or charge.

Enacted by Chapter 135, 2013 General Session

31A-8a-203. Information filed with the department.

(1) Prior to operating a health discount program, a person shall submit the following to the commissioner:

(a) a copy of contract forms used by the health discount program for:

(i) health care providers or health care provider networks participating in the health discount program, including the discounts for medical services provided to enrollees;

(ii) marketing;

(iii) administration of the health discount program;

(iv) enrollment;

(v) investment management for the health discount programs; and

(vi) subcontracts for any services;

(b) the program's proposed marketing plan; and

(c) dispute resolution procedures for program holders.

(2) The company shall file prior to use:

(a) the form of contracts used by the health discount program operator;

(b) the marketing plan; and

(c) dispute resolution procedures.

(3) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.

Amended by Chapter 297, 2011 General Session

31A-8a-204. Advertising restrictions and requirements.

(1) An operator of a health discount program may not:

(a) use any form of words or terms that may confuse health discount programs with other types of health insurance in advertising or marketing such as "health plan," "health benefit plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," and "preferred provider";

(b) use other terms as designated by the commissioner by administrative rule in advertisement or marketing that could reasonably mislead a consumer to believe that a discount health program is any other form of health insurance; or

(c) refer to sales representatives as "agents," "producers," or "consultants."

(2) A health discount program operator:

(a) shall have a written agreement with any marketer of the health discount program prior to marketing, selling, promoting, or distributing the health discount programs;

(b) shall file with the commissioner all advertisement, marketing materials, brochures, and discount programs prior to their use or distribution; and

(c) shall make the following disclosures:

(i) in writing in at least 10-point type and bolded; and

(ii) with any marketing or advertising to the public and with any enrollment forms given to an enrollee:

(A) the program is not a health insurance policy;

(B) the program provides discounts only at certain health care providers for health care services;

(C) the program holder is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the health discount program; and

(D) the corporate name and the location of the health discount program operator.

(3) A health discount program operator or marketer who sells the health discount program with another product shall provide the consumer a written itemization of the fees of the health discount program separate from any fees or charges for the other product, which can be purchased separately.

Amended by Chapter 297, 2011 General Session

31A-8a-205. Disclosure of health discount program terms.

(1) (a) Health discount program operators shall provide to each purchaser or potential purchaser a copy of the terms of the discount program at the time of purchase.

(b) For purposes of this section "purchaser" means the employer in an employer sponsored plan, or an individual purchasing outside of an employer relationship.

(2) The disclosure required by Subsection (1) should be clear and thorough and should include any administrative or monthly fees, trial periods, procedures for securing discounts, cancellation procedures and corresponding refund requests, and procedures for filing disputes.

(3) (a) A contract shall be signed by the purchaser acknowledging the terms before any fees are collected and shall include notice of the purchaser's 30-day free look rights.

(b) For purposes of this Subsection (3) and Section 46-4-201, when a contract is entered into via telephone, facsimile transmission or the Internet, the following is considered a signing of the contract:

(i) if via the Internet, the online application form is completed and sent by the purchaser to the health discount program operator;

(ii) if via facsimile transmission, the application is completed, signed and faxed to the health discount program operator; or

(iii) if via telephone, the script used by the health discount program operator to solicit the purchaser shall include any limitations or exclusions to the program, and the

contract shall be provided to the purchaser via facsimile, mail, or email within 10 working days of the purchaser consenting to enrolling over the telephone.

Amended by Chapter 135, 2013 General Session

31A-8a-205.5. Free look right.

(1) Except as provided in Subsection (2), a person that purchases a health discount program may, with or without cause, within 30 days after the day on which the purchase contract is signed, cancel the contract without payment, damages, penalty, or liability of any kind by giving written notice of cancellation to the other party to the contract.

(2) A person may not exercise the right of cancellation described in Subsection (1) if the person has used the services of the health discount program under the contract.

(3) If a person cancels a contract under Subsection (1), the other party to the contract shall refund all money and other consideration paid in relation to the health discount program, less a maximum of $25 of any enrollment charge, regardless of whether the enrollment charge was designated as nonrefundable.

Enacted by Chapter 135, 2013 General Session

31A-8a-206. Provider agreements -- Record keeping.

(1) A health discount program operator may not place any restrictions on an enrollee's access to health care providers such as waiting periods or notification periods.

(2) A health discount program operator may not reimburse health care providers for services rendered to an enrollee, unless the health discount program operator is a licensed third party administrator.

(3) (a) A health discount program operator shall have a written agreement with a health care provider who agrees to provide discounts to health discount program enrollees.

(b) If the written agreement is with a provider network, the health discount plan shall require the provider network to have written agreements with each of its health care providers.

(4) The health discount program operator shall maintain a copy of each active health care provider agreement.

Amended by Chapter 297, 2011 General Session

31A-8a-207. Notice of change.

(1) A health discount program operator shall provide the commissioner notice of:

(a) any change in the health discount program's organizational name, change of business or mailing address, or change in ownership or principals; and

(b) any change in the information submitted in accordance with Section 31A-8a-203.

(2) (a) The notice required by Subsection (1) shall be submitted 30 days prior to

any change.

(b) Approval by the commissioner is required for any changes in forms that required approval under Section 31A-8a-203.

(3) A health insurer or health maintenance organization licensed under this title shall annually file with the Accident and Health Data Survey, a list of all value-added benefits offered at no cost to its enrollees.

Amended by Chapter 297, 2011 General Session

31A-8a-208. Representing or aiding an unauthorized insurer.

(1) The provisions of this chapter and Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups, apply to the activities of an unlicensed health discount program operator as if the health discount program was an unauthorized insurance contract and the unlicensed health discount program operator was an unauthorized insurer.

(2) A person who knowingly and intentionally represents or aids an unauthorized insurer in violation of the provisions of this chapter or Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups, is guilty of a third degree felony.

Enacted by Chapter 58, 2005 General Session

31A-8a-209. Health discount program fraud.

For purposes of Chapter 31, Insurance Fraud Act, a health discount program operator is an insurer as defined in Section 31A-31-102 and is subject to the provisions of Chapter 31, Insurance Fraud Act.

Enacted by Chapter 58, 2005 General Session

31A-8a-210. Rulemaking authority.

The commissioner has authority to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(1) to enforce this chapter; and

(2) as necessary to protect the public interest.

Amended by Chapter 382, 2008 General Session

31A-9-101. Definitions.

(1) As used in this chapter:

(a) "Fraternal" or "fraternal benefit society" means a corporation organized or operating under this chapter that:

(i) has no capital stock;

(ii) exists solely for:

(A) the benefit of its members and their beneficiaries; and

(B) any lawful social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purpose for the benefit of its members or the public, carried on through voluntary activity of its members in their local lodges or through

institutional programs of the fraternal or its local lodges;

(iii) has a lodge system;

(iv) has a representative form of government; and

(v) provides insurance benefits authorized under this chapter.

(b) "Laws of a fraternal" include its articles of incorporation and bylaws, however designated.

(c) "Lodge system" means one in which:

(i) there is a supreme governing body;

(ii) subordinate to the supreme governing body are local lodges, however designated, into which natural persons are admitted as members in accordance with the laws of the fraternal;

(iii) the local lodges are required by the laws of the fraternal to hold regular meetings at least monthly; and

(iv) the local lodges regularly engage in programs involving member participation to implement the purposes of Subsection (1)(a)(ii).

(d) "Representative form of government" means the fraternal complies with Section 31A-9-403.

(2) In any provisions of law made applicable to fraternals by this chapter, the technical terms used in those provisions are applicable to fraternals despite the use of other parallel terms by fraternals.

(3) The definitions in Section 31A-1-301 and the definitions to the following terms in Section 16-6a-102 apply to fraternals:

(a) "articles of incorporation";

(b) "bylaws"; and

(c) "member."

Amended by Chapter 386, 2009 General Session

31A-9-102. Scope and purposes.

(1) (a) This chapter applies to all fraternals organized under the laws of this state.

(b) Except as expressly provided in this chapter and in Section 31A-14-210, this chapter does not apply to nondomestic fraternals.

(2) The purposes of this chapter include:

(a) providing a complete, self-contained procedure for the formation of fraternals;

(b) assuring the solidity of fraternals by providing an organizational framework to facilitate sound management, operation, and regulation;

(c) strengthening internal fraternal democracy through member participation; and

(d) encouraging the fulfillment of the special purposes of fraternals.

Enacted by Chapter 242, 1985 General Session

31A-9-103. Orders imposing and relaxing restrictions.

(1) The commissioner may subject any fraternal to some or all of the restrictions

of Subsections 31A-5-305(2)(a)(i) and (ii), and Subsection 31A-5-410(1)(b), as such provisions are incorporated by Sections 31A-9-303 and 31A-9-407.

(2) The commissioner may free a fraternal from any of the restrictions applicable to fraternals under the provisions enumerated in Subsection (1), if he is satisfied that the fraternal's financial condition, management, and other circumstances give assurance that the interests of insureds and the public will not be endangered by the waiver.

Amended by Chapter 204, 1986 General Session

31A-9-104. Applicability of other insurance laws to fraternals.

(1) No section of Chapter 5 applies to fraternals unless it is specifically made applicable by this chapter.

(2) Each section of the Insurance Code, other than in Chapter 5, that applies to mutuals subject to Chapter 5, also applies to domestic and nondomestic fraternals unless:

(a) this chapter or the particular section provides otherwise; or

(b) the particular section is inconsistent with a provision applying explicitly to fraternals, in this chapter or elsewhere.

Enacted by Chapter 242, 1985 General Session

31A-9-105. General corporate powers and procedures.

(1) Section 16-10a-302 applies to the general powers of fraternals.

(2) Section 16-6a-304 applies to ultra vires issues in fraternals.

(3) Subsection 31A-5-104(3) applies to the omission of a seal in a fraternal.

(4) Sections 16-6a-705 and 16-6a-707 apply to waiver of notice and consent to action without a meeting in a fraternal.

(5) Subsection 31A-5-104(5) applies to the power to hold assets as a trustee in a fraternal.

Amended by Chapter 300, 2000 General Session

31A-9-106. Miscellaneous provisions.

Sections 31A-5-105 and 31A-5-106 apply to fraternals.

Amended by Chapter 10, 1997 General Session

31A-9-201. Reservation of corporate name.

Section 31A-5-201 applies to the reservation of a corporate name for a fraternal.

Enacted by Chapter 242, 1985 General Session

31A-9-202. Members and applicants in fraternals.

(1) A fraternal may admit any natural person to membership under the conditions and for the type of insurance and other benefits its laws prescribe, subject to

this chapter and other applicable laws. A member without insurance ceases to be a member for insurance purposes if the fraternal is converted to a mutual.

(2) Subject to Section 31A-21-104, fraternals may provide insurance for the benefit of members, their dependents, and persons who are eligible for membership except for age.

(3) A fraternal may organize lodges for children who are not old enough for membership, but who are to be covered by insurance. Membership in local lodges is not required for those children, and they have no voting rights.

(4) A fraternal may extend temporary or conditional insurance coverage to a nonmember who has applied for membership in the fraternal.

Enacted by Chapter 242, 1985 General Session

31A-9-203. Incorporators.

One or more adult natural persons may organize and act as the incorporators of a fraternal under this chapter.

Amended by Chapter 204, 1986 General Session

31A-9-204. Articles of incorporation and bylaws.

(1) The articles of incorporation shall set forth:

(a) the name of the corporation, which shall include the word "fraternal" or words of equivalent meaning;

(b) the location of the principal office of the fraternal, which shall be in this state;

(c) the purposes of the corporation, which shall include one or more of the purposes specified in Subsection 31A-9-101(1)(a)(ii)(B), but shall otherwise be restricted to those permitted under Section 31A-4-107;

(d) the classes of members, and the qualifications and rights of the members of each class;

(e) a description of the fraternal's representative form of government, conforming to Section 31A-9-403;

(f) the manner in which local lodges or branches may be formed and the powers they shall have, or a statement that the formation and powers of local lodges or branches is provided for in the bylaws;

(g) a provision for fraternal bonds, if any are to be authorized, which shall conform to Section 31A-9-303; and

(h) a provision for amendment of the articles, which shall conform to Section 31A-9-213.

(2) The articles of incorporation are not required to recite the corporate powers enumerated in this chapter, as these powers are authorized by law.

(3) Section 16-6a-818 applies to the officers of fraternals. The articles or bylaws shall specifically designate three or more offices, which shall be held by the principal officers of the fraternal. The principal offices shall be held by at least three separate natural persons.

(4) The bylaws shall comply with the provisions of this chapter. A copy of the bylaws and any amendments to them shall be filed with the commissioner promptly

after their adoption. Notice of amendments to the bylaws shall be given promptly to members. Subject to this chapter, Section 16-6a-206 applies to the bylaws and resolutions of fraternals.

Amended by Chapter 300, 2000 General Session

31A-9-205. Organization permit and certificate of incorporation.

(1) Section 31A-5-204 applies to fraternals except that the word "mutual" shall be read "fraternal" and "Section 31A-5-211" in Subsection 31A-5-204(5) shall be read "Section 31A-9-209."

(2) The application for an organization permit shall include, in addition to those things required under Subsection 31A-5-204(2), a statement of the plan for fraternal activities and for the formation of a representative government under Section 31A-9-403.

Enacted by Chapter 242, 1985 General Session

31A-9-206. Powers under organization permit and deposit of proceeds of subscriptions.

Subsection 31A-5-207(2) and Section 31A-5-208 apply to fraternals, except that:

(1) the word "mutual" shall be read "fraternal"; and

(2) there are no qualifying insurance policies as referred to in Subsection 31A-5-207(2) (a).

Enacted by Chapter 242, 1985 General Session

31A-9-207. Termination of organization permit and payment of organization expenses.

Section 31A-5-209, other than Subsection (3)(c), applies to fraternals, except that:

(1) the word "mutual" shall be read "fraternal"; and

(2) the reference to "Section 31A-5-212" shall be read "Section 31A-9-210."

Enacted by Chapter 242, 1985 General Session

31A-9-208. Incorporators' liability and organization expenses.

Subsections 31A-5-210(1) and (2)(b) apply to fraternals, except that the word "mutual" shall be read "fraternal."

Enacted by Chapter 242, 1985 General Session

31A-9-209. Initial surplus requirements.

(1) (a) The requirements of Subsections 31A-5-211(1) through (4) apply to fraternals with respect to the amount of permanent surplus required of the fraternal.

(b) For purposes of Subsection (1)(a):

(i) wherever the word "mutual" appears in Subsections 31A-5-211(1) through

(4), it means "fraternal;" and

(ii) the reference to "Section 31A-5-212" in Subsection 31A-5-211(1) means "Section 31A-9-210."

(2) (a) Every fraternal shall include in its laws a provision that if the financial position of the fraternal becomes impaired, the board of directors or the supreme governing body may determine on an equitable basis the proportionate share of the deficiency of each member of the fraternal.

(b) The member may then:

(i) pay the member's share of the deficiency;

(ii) accept the imposition of a lien on the certificate of insurance, to bear interest at the rate charged on policy loans under the certificate, compounded annually until paid; or

(iii) accept a proportionate reduction in benefits under the certificate.

(c) The fraternal may specify the manner of the election and which alternative is to be presumed if no election is made.

(3) Except as provided in Subsection (2), no fraternal may operate on an assessment basis.

Amended by Chapter 9, 1996 Special Session 2

31A-9-210. Certificate of authority.

Section 31A-5-212 applies to certificates of authority for fraternals, except that references to other sections in Chapter 5 shall be read to refer to the corresponding sections in Chapter 9.

Enacted by Chapter 242, 1985 General Session

31A-9-211. Accelerated organization procedure.

Section 31A-5-213 applies to the accelerated organization procedure for fraternals, except that the word "mutual" shall be read "fraternal."

Enacted by Chapter 242, 1985 General Session

31A-9-212. Separate accounts and subsidiaries.

(1) Except as provided in Subsections (2) and (3), Sections 31A-5-217 and 31A-5-218 apply to separate accounts and subsidiaries of fraternals. If a fraternal issues contracts on a variable basis, Subsections 31A-22-902(2) and (6) and 31A-9-209(2) do not apply, except that Subsection 31A-9-209(2) applies to any benefits contained in the variable contracts which are fixed or guaranteed dollar amounts.

(2) If a fraternal engages in any insurance business other than life, accident and health, annuities, property, or liability insurance, it shall do so through a subsidiary under Section 31A-5-218.

(3) (a) A local lodge may incorporate under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, or the corresponding law of the state where it is located, to carry out the noninsurance activities of the local lodge.

(b) Corporations may be formed under Title 16, Chapter 6a, Utah Revised

Nonprofit Corporation Act, to implement Subsection 31A-9-602(2).

Amended by Chapter 116, 2001 General Session

31A-9-213. Amendment of articles of incorporation.

(1) The articles of a fraternal may provide for amendment by the supreme governing body or by the board of directors, and may also provide for amendment by an affirmative vote of a majority of those members who vote in a referendum. Only votes cast within 60 days from the date of mailing the first ballot by the fraternal are counted. The timeliness of a vote is determined by the date of its mailing as evidenced by its postmark or other suitable evidence.

(2) For five years after the initial issuance of a certificate of authority, proposed amendments of the articles shall be filed with the commissioner at least 30 days before the amendment is submitted for approval to the members or to the supreme governing body. If the approval of the members or the supreme governing body is not required, proposed amendments to the articles shall be filed with the commissioner at least 30 days before their effective date.

(3) No amendment is effective until the articles of amendment are filed with the commissioner, together with a statement of the results of the voting on the amendment or a statement that no vote is required.

(4) Within four months after filing the articles of amendment with the commissioner, they shall be furnished to all members either by mail or under Subsection 31A-9-402(1).

Amended by Chapter 204, 1986 General Session

31A-9-301. Securities regulation.

Section 31A-5-301 applies to fraternal bonds but does not apply to contribution notes, as they are defined in Section 31A-5-305, as incorporated by Section 31A-9-303.

Enacted by Chapter 242, 1985 General Session

31A-9-302. Registration of securities.

Section 31A-5-302 applies to securities of fraternals.

Enacted by Chapter 242, 1985 General Session

31A-9-303. Authorized securities.

Subsection 31A-5-305(2) applies to authorized securities of fraternals, except that the words "mutual" and "nonassessable mutual" shall be read "fraternal."

Enacted by Chapter 242, 1985 General Session

31A-9-401. Principal office, registered agent, and corruption in members' meetings.

Section 31A-5-401 governs the location of the principal office and existence of a

registered agent for fraternals. Section 31A-5-403 applies to members' meetings of domestic fraternals.

Amended by Chapter 204, 1986 General Session

31A-9-402. Communications to members.

(1) A fraternal 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 a notice of election, may be published. Any required notice shall be printed conspicuously in the publication.

(2) The commissioner may by rule prescribe that copies of specified classes of communications published generally to members, including the official publication, be sent to the commissioner when they are sent to the members.

(3) If the records of a fraternal show that two or more members have the same mailing address, an official publication mailed to one member is considered to be notice to all members at the same address, unless a member requests a separate copy.

Enacted by Chapter 242, 1985 General Session

31A-9-403. Representative form of government.

(1) A fraternal shall have a supreme governing body consisting either of:

(a) A board of directors is the supreme governing body of a fraternal. It consists of some directors elected directly by the members or by their representatives in intermediate assemblies under Subsection (2), and other directors prescribed in the fraternal's laws. A majority of the board shall be elected directors, having a sufficient number of votes to amend the articles or bylaws of the fraternal which can be amended without the consent of the members. The board shall meet at least quarterly to conduct the business of the fraternal. The elected directors shall be elected on a plan that ensures approximately equal weight to each fraternal member's vote. Voting may be by mail.

(b) Delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates prescribed in the fraternal's laws form an assembly that is a supreme governing body of a fraternal. A majority of the assembly shall be elected delegates, having at least two-thirds of the votes and with a sufficient number of votes to amend the articles or bylaws that can be amended without consent of the members. The assembly, whatever designated, shall meet at least once every four years and shall elect a board of directors to conduct the business of the fraternal between meetings of the assembly. The delegates making up the supreme governing body shall be elected on a plan that ensures approximately equal weight to each fraternal member's vote.

(2) The laws of a fraternal may provide that:

(a) delegates to intermediate assemblies may represent geographical districts or lodges; or

(b) delegates may represent the members in defined classes determined on a reasonable basis; and

(c) the vote of a representative to an intermediate assembly is treated as the

vote of the members represented.

(3) No votes may be cast by proxy.

Amended by Chapter 20, 1995 General Session

31A-9-404. Annual report to fraternal members.

(1) Every domestic fraternal shall send to each member having insurance or shall publish in the official publication under Subsection 31A-9-402(1), an abbreviated annual report.

(2) This report shall contain:

(a) basic financial and operating data;

(b) information about important business and corporate developments;

(c) other information the fraternal wishes to include; or

(d) other information the commissioner by rule requires it to include to adequately inform its members.

(3) The fraternal shall send a business mail reply form on which the member may request a more complete annual report. This complete annual report shall contain the information prescribed by rule under Subsection 31A-2-201(3).

Amended by Chapter 91, 1987 General Session

31A-9-405. Board of directors.

(1) Sections 16-6a-801 and 16-6a-802 apply to fraternals, except that the supreme governing body may act as the board of directors if it meets at least quarterly. Subsections 31A-5-407(2) through (9) apply to fraternals, except that the word "mutual" shall be read "fraternal" and the references to other sections of Chapter 5 shall be to the corresponding sections of Chapter 9.

(2) The terms of directors and officers may not exceed four years.

Amended by Chapter 300, 2000 General Session

31A-9-406. Removal of directors and filling of vacancies.

(1) A director may be removed from office for cause by an affirmative vote of a majority of the full board of directors at a meeting of the board called for that purpose or may be removed under Subsection 16-6a-820(4).

(2) Any vacancy occurring in the board, including a vacancy created by an increase in the number of directors, may be filled by the affirmative vote of a majority of the directors then in office, although less than a quorum.

(3) If the laws of the fraternal provide that at least 2/3 of the directors are elected by the members, elected director vacancies may be filled by the board for the remainder of the terms for which there are vacancies.

(4) If the vacancy is to be filled other than by a regular election, the election by the board is effective only until a reasonable time has elapsed for choosing the director in that other manner.

(5) If less than 2/3 of the directors are elected by the members, elected director vacancies may be filled by the directors only until the next succeeding regular election.

At that time, the elected director vacancy may be filled for the remainder of the term for which there is a vacancy. A director elected under this section to fill the unexpired term of an elected director is an elected director within the meaning of Subsection 31A-9-403(1)(a).

(6) If the board ceases to exist, the commissioner shall arrange the necessary procedures for holding elections to create a new board.

Amended by Chapter 300, 2000 General Session

31A-9-407. Supervision of management changes.

Section 31A-5-410 applies to the supervision of management changes of fraternals.

Enacted by Chapter 242, 1985 General Session

31A-9-408. Continuity of management in emergencies.

Section 31A-5-411 applies to the continuity of management of fraternals in emergencies.

Enacted by Chapter 242, 1985 General Session

31A-9-409. Committees of directors.

Section 31A-5-412 applies to committees of directors in fraternals, except that the references to other sections of Chapter 5 shall be to the corresponding sections of Chapter 9.

Enacted by Chapter 242, 1985 General Session

31A-9-410. Interlocking directorates and other relationships.

Section 31A-5-413 applies to interlocking directorates and other relationships of fraternals.

Enacted by Chapter 242, 1985 General Session

31A-9-411. Transactions in which directors and others are interested.

Section 31A-5-414 applies to transactions in which directors and others are interested within fraternals.

Enacted by Chapter 242, 1985 General Session

31A-9-412. Directors' liability and indemnification.

Section 31A-5-415 applies to directors' liability and indemnification in fraternals, except that the word "mutual" shall be read "fraternal".

Enacted by Chapter 242, 1985 General Session

31A-9-413. Executive compensation.

Section 31A-5-416 applies to executive compensation in fraternals, except that the word "mutual" shall be read "fraternal."

Enacted by Chapter 242, 1985 General Session

31A-9-414. Exclusive agency contracts.

Section 31A-5-417 applies to exclusive agency contracts in fraternals.

Enacted by Chapter 242, 1985 General Session

31A-9-501. Merger and consolidation of fraternals.

(1) Subject to compliance with Chapter 16, any two or more domestic fraternals may merge or consolidate under the provisions of Subsections (3) and (4).

(2) Subject to compliance with Chapter 16, any two or more domestic and nondomestic fraternals may merge or consolidate under the provisions of Subsection (5).

(3) In addition to complying with Chapter 16, the supreme governing body of each domestic fraternal proposing to merge or consolidate shall:

(a) at least 60 days prior to the proposed action, submit the text of the proposed contract to its members as provided in Subsection 31A-9-213(4);

(b) approve the proposed consolidation or merger by a two-thirds vote; and

(c) file with the commissioner:

(i) a certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(ii) a sworn statement by the president and secretary or corresponding officers of each fraternal showing the financial condition of each on a date fixed by the commissioner, but no earlier than the December 31 of the year preceding the proposed contract; and

(iii) evidence of compliance with Subsections (3)(a) and (b).

(4) The commissioner shall issue a certificate approving the merger or consolidation, upon a finding that all of the following conditions exist:

(a) The contract conforms to the provisions of this chapter.

(b) The parties to the proposed contract have complied with the provisions of Subsection (3).

(c) The proposed contract is equitable to the members of each fraternal.

(5) When a nondomestic fraternal is a party to the proposed contract, the parties shall follow the procedure for domestic fraternals under Subsections (3) and (4). However, the commissioner may not issue a certificate of compliance until the parties file a certificate that the proposed contract has been approved in the manner provided by the laws of the jurisdiction under which the fraternal is incorporated, or, if those laws contain no procedure for approval, that the proposed contract has been approved by the commissioner of insurance for that jurisdiction.

(6) The merger or consolidation is effective when the commissioner issues a certificate of approval.

(7) When the merger or consolidation is effective, the surviving or new fraternal

has all the assets and is liable for all of the obligations of each of the participating fraternals.

Enacted by Chapter 242, 1985 General Session

31A-9-502. Voluntary dissolution of solvent domestic fraternals.

(1) Subject to this section, a domestic fraternal may voluntarily dissolve under Sections 16-6a-1401 through 16-6a-1405.

(2) The proposal for voluntary dissolution shall be filed with the commissioner at least 60 days prior to the submission of that proposal to the supreme governing body or the members. The commissioner may require the submission of additional information necessary to establish the financial condition of the fraternal or other facts relevant to the proposed dissolution. If the supreme governing body or the members adopt the resolution to dissolve, by a majority of those voting or a larger number as required by the laws of the fraternal, the commissioner shall, within 30 days after the adoption of the resolution, begin to examine the fraternal. The commissioner shall approve the dissolution unless the commissioner finds, after the examination and a hearing, that it is insolvent or may become insolvent in the process of dissolution. Upon approval, the fraternal may provide for a transfer to other fraternals approved by the commissioner of all its obligations under insurance policies and then may dissolve under Subsection (1). If the commissioner disapproves, the commissioner shall petition the court for liquidation under Section 31A-27a-207.

(3) During the liquidation under Sections 16-6a-1401 through 16-6a-1408, the fraternal may apply to the commissioner to have the liquidation continued under the commissioner's supervision. Upon receiving this request, the commissioner shall apply to the court for liquidation under Section 31A-27a-207.

(4) If the fraternal revokes the voluntary dissolution proceedings under Section 16-6a-1404, a copy of the revocation of voluntary dissolution proceedings shall be filed with the commissioner.

(5) Subsections 31A-5-504(6) and (7) apply to the survival of remedies and continuance of corporate existence of a voluntarily dissolved fraternal.

Amended by Chapter 309, 2007 General Session

31A-9-503. Conversion of a fraternal to a mutual.

A domestic fraternal may be converted into a mutual, as follows:

(1) In addition to complying with the requirements of Chapter 16, Insurance Holding Companies, the board or the supreme governing body shall adopt a plan of conversion stating:

(a) the reasons for and purposes of the proposed action;

(b) the proposed terms, conditions, and procedures and the estimated expenses of implementing the conversion;

(c) the proposed name of the corporation; and

(d) the proposed articles and bylaws.

(2) If the board and the supreme governing body disagree on the conversion plan, the decision of the supreme governing body prevails.

(3) The plan shall be filed with the commissioner for approval, together with any information under Subsection 31A-5-204(2) the commissioner reasonably requires. The commissioner shall approve the plan unless the commissioner finds, after a hearing, that it would be contrary to the law, that the new mutual would not satisfy the requirements for a certificate of authority under Section 31A-5-212, that the plan would be contrary to the interests of members or the public, or that the applicable requirements of Chapter 16, Insurance Holding Companies, have not been satisfied.

(4) After being approved by the commissioner, the plan shall be submitted for approval to the persons who were voting members on the date of the commissioner's approval under Subsection (3). For approval of the plan, at least a majority of the votes cast shall be in favor of the plan, or a larger number if required by the laws of the fraternal.

(5) The officers and directors of the fraternal shall be the initial officers and directors of the mutual.

(6) A copy of the resolution adopted under Subsection (4) shall be filed with the commissioner, stating the number of members entitled to vote, the number voting, the method of voting, and the number of votes cast in favor of the plan, stating separately the votes cast by mail and the votes cast in person.

(7) If the requirements of the law are met, the commissioner shall issue a certificate of authority to the new mutual. The fraternal then ceases its legal existence and the corporate existence of the new mutual begins. However, the new mutual is considered to have been incorporated as of the date the converted fraternal was incorporated. The new mutual has all the assets and is liable for all of the obligations of the converted fraternal. The commissioner may grant a period not exceeding one year for adjustment to the requirements of Chapter 5, Domestic Stock and Mutual Insurance Corporations, specifying the extent to which particular provisions of Chapter 5 do not apply.

(8) The corporation may not pay compensation other than regular salaries to existing personnel in connection with the proposed conversion. With the commissioner's approval, payment may be made at reasonable rates for printing costs and for legal and other professional fees for services actually rendered in connection with the conversion. All expenses of the conversion, including the expenses incurred by the commissioner and the prorated salaries of any insurance office staff members involved, shall be paid by the corporation being converted.

Amended by Chapter 297, 2011 General Session

31A-9-504. Rehabilitation or involuntary conversion.

(1) (a) If the commissioner believes that a fraternal does not satisfy the requirements of this chapter, the commissioner shall call a hearing. If the commissioner then finds that the fraternal does not satisfy the requirements:

(i) if the fraternal is domestic, the commissioner shall petition for rehabilitation under Section 31A-27a-207 to rehabilitate the fraternal or, if that is not possible, convert the fraternal to a mutual; or

(ii) if the fraternal is nondomestic, the commissioner shall order it to comply as soon as practicable with the requirements of this chapter or lose its tax exemption.

(b) An order issued under Subsection (1)(a)(ii) shall specify the ways the nondomestic fraternal does not comply with this chapter.

(2) If the fraternal does not promptly comply with the requirements of this chapter, after notice of the adverse results of a hearing under Subsection (1), it is subject to taxation as a mutual life insurance company. This tax is retroactive to the date on which the commissioner gave the fraternal notice of the hearing under Subsection (1).

Amended by Chapter 309, 2007 General Session

31A-9-601. Tax exemption.

Every domestic and nondomestic fraternal is exempt from all state, county, district, municipal, and school taxes or fees, except the fees required under Section 31A-3-103, and all the taxes and special assessments on its real estate and office equipment.

Enacted by Chapter 242, 1985 General Session

31A-9-602. Fraternal expenditures and activities.

(1) Every fraternal shall report to the commissioner the information required by the commissioner concerning expenditures made by the fraternal and other activities and programs of the fraternal or its members in fulfillment of the purposes of Subsection 31A-9-101(1)(a)(ii)(B) or in maintaining its fraternal character.

(2) A fraternal may create, maintain, and operate social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious institutions for the benefit of its members or their families or dependents or for children insured by the fraternal. For that purpose, it may own, hold, or lease real or personal property within or outside of this state. All that property is reported in the annual statement or an appendix to it, but the property is given only a nominal value in the statement. No profit may be made on those institutions, but the income and expenditures are reported separately in, or as an appendix to, the annual statement. Any of these institutions may be separately incorporated under Title 16, Chapter 10a, Utah Revised Business Corporation Act, and ownership of its stock shall be reported at a nominal value.

(3) The fraternal may not own or operate a funeral or undertaking establishment.

Amended by Chapter 4, 1993 General Session

31A-9-603. Exemption of fraternal benefits.

No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any domestic or nondomestic fraternal is liable to attachment, garnishment, or other process, or may be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay a debt or liability of a member or beneficiary, or any other person who may have a right to them, either before or after their payment by the fraternal.

Enacted by Chapter 242, 1985 General Session

31A-9-604. Duties of officers, directors, agents, and employees.

Section 31A-5-601 applies to the duties of officers, directors, agents, and employees of fraternals.

Enacted by Chapter 242, 1985 General Session

31A-10-201. Definition.

As used in this part:

(1) "Nontraditional insurer" means an insurer incorporated under Chapter 5, Domestic Stock and Mutual Insurance Corporations, or admitted under Chapter 14, Foreign Insurers, that:

(a) exists for the purpose of aiding and strengthening the following by providing them with annuities:

(i) nonprofit entities;

(ii) employees of nonprofit entities;

(iii) governmental entities; and

(iv) employees of governmental entities;

(b) issues only annuities and no other insurance product; and

(c) does not pay any benefit based on a guarantee as to principal, interest rate, return on investment, mortality, and morbidity.

(2) "Nontraditional insurer" does not include an insurer that provides annuities to persons other than:

(a) nonprofit entities;

(b) employees of nonprofit entities;

(c) governmental entities; and

(d) employees of governmental entities.

Amended by Chapter 230, 2003 General Session

31A-10-202. Purposes of part.

The purposes of this part are:

(1) to provide for the continued operation in this state, subject to the provisions of this title, of nontraditional insurers providing annuities to the nonprofit entities and governmental entities of this state and their employees; and

(2) to specify provisions which equitably deal with the operational, structural, and functional differences between nontraditional insurers and other insurers, without compromising the interests of policyholders.

Amended by Chapter 230, 2003 General Session

31A-10-203. Applicability of other provisions.

(1) Except as provided in this section, domestic nontraditional insurers are subject to the same provisions applicable to other domestic insurers, and nondomestic nontraditional insurers are subject to the same provisions applicable to other nondomestic insurers.

(2) Nontraditional insurers are not subject to:

(a) Section 31A-5-211;
(b) Section 31A-5-217;
(c) Subsection 31A-14-205(1)(a);
(d) Chapter 17, Determination of Financial Condition;
(e) Chapter 18, Investments;
(f) Section 31A-20-106;
(g) Chapter 21, Insurance Contracts in General, if:
(i) their contract forms have been approved by the appropriate regulatory authorities in their state of domicile; and
(ii) these contract forms are standard forms generally issued by those nontraditional insurers in the United States;
(h) Chapter 22, Contracts in Specific Lines; or
(i) Chapter 28, Guaranty Associations.

Amended by Chapter 230, 2003 General Session

31A-11-101. Prohibition of unauthorized motor clubs.

(1) No person may act as a motor club, except:
(a) a corporation authorized under Chapter 5 or 14 which actually engages in the insurance of automobiles against liability, physical damage, or both; or
(b) a corporation or division of a corporation authorized under this chapter.
(2) No person is acting as a motor club merely by offering travel-related services that do not constitute insurance, or by arranging, through producers qualified under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, for insurance coverages underwritten by insurers authorized to do business in this state.

Amended by Chapter 298, 2003 General Session

31A-11-102. Activities of motor clubs.

(1) Motor clubs authorized under this chapter may provide or arrange for the following services:
(a) service as producer in obtaining insurance coverage from authorized insurers, subject to Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;
(b) provision of, or payment for, legal services and costs in the defense of traffic offenses or other legal problems connected with the ownership or use of a motor vehicle, provided the maximum amount payable for any one incident is not more than 100 times the annual charge for the motor club contract;
(c) guaranteed arrest bond certificates and cash bond guarantees as specified under Section 31A-11-112;
(d) payment of specified expenses resulting from an automobile accident, other than expenses for personal injury or for damage to an automobile, provided the maximum amount payable for any one accident is not more than 100 times the annual charge for the motor club contract;
(e) towing and emergency road services and theft services; and

(f) any services relating to travel not involving the transfer and distribution of risk.

(2) Unless they are also insurers under Chapter 5 or 14, motor clubs may not provide any liability or physical damage insurance or insurance of life or accident and health, whether or not related to motor vehicles.

(3) If a motor club is a separate division of a corporation, the activities of the other divisions of the corporation are not limited by this section, if the motor club division complies with Subsection 31A-11-106(3).

Amended by Chapter 298, 2003 General Session

31A-11-103. Rates.

(1) Rates charged to holders of motor club service contracts may not be inadequate, excessive, or unfairly discriminatory.

(2) If, after a hearing, the commissioner finds a motor club's rates in violation of this section, the commissioner may issue an order to the club to make a filing under Section 31A-19a-203. After issuance of such an order, the commissioner and the club shall proceed under Chapter 19a until the commissioner determines that the club's rates conform to the requirements of this section. Chapter 19a is then inapplicable to the club until the issuance of another order under this section.

Amended by Chapter 130, 1999 General Session

31A-11-104. Applicability of other portions of this title.

(1) In addition to this chapter, motor clubs are subject to the applicable sections of:

(a) Chapters 1, 2, 4, 16, 21, 22, 26, 27, and 27a;

(b) Chapter 3, Part 1;

(c) Chapter 23a, Parts 1, 4, and 5; and

(d) Section 31A-23a-207.

(2) Sections 31A-14-204 and 31A-14-216 apply to nondomestic motor clubs.

(3) Section 31A-5-401 applies to domestic motor clubs.

(4) Sections 31A-5-105, 31A-5-106, and 31A-5-216 apply to both domestic and nondomestic motor clubs.

(5) Both domestic and nondomestic motor clubs are subject to the department fees under Section 31A-3-103. Other provisions of this title apply to motor clubs only as specifically provided in this chapter.

Amended by Chapter 309, 2007 General Session

31A-11-105. Application of Title 16 -- Incorporation of domestic motor clubs.

Domestic corporations acting or applying to act as a motor club under this chapter are subject to Title 16, Chapter 10a, Utah Revised Business Corporation Act, if for profit, or Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, if not for profit. The Division of Corporations and Commercial Code in the Department of Commerce issues certificates of incorporation for domestic corporations acting as

motor clubs under this chapter, unless they are Chapter 5 corporations. This section does not negate the requirement of a motor club obtaining a certificate of authority from the commissioner. Section 16-6a-301 does not apply to bar a not-for-profit motor club from organizing under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act.

Amended by Chapter 300, 2000 General Session

31A-11-106. Application for certificate of authority -- Deposit or bond.

(1) Any corporation may apply, in the form specified by the commissioner, for a certificate of authority to transact a motor club business. The applicant shall include with the application any documents the commissioner may reasonably require, the deposit described in Subsection (2), which may be waived if net worth exceeds the deposit requirements, and the fee provided for in Section 31A-3-103. No person may engage in the motor club business without complying with this section and receiving a certificate of authority under Section 31A-11-107.

(2) The deposit required under Subsection (1) shall comply with the requirements of Section 31A-2-206, and is $100,000. In lieu of the deposit, the applicant may supply a bond of a corporate surety authorized to do a surety business in this state, in the same sum and in a form prescribed by the commissioner, payable to the state. The deposit, or the bond, shall be conditioned upon the corporation's faithful performance in the sale or rendering of motor club service under the provisions of this chapter, and the payment of fines, fees, or penalties imposed on the motor club under this title. Any person with a claim against the deposit or bond arising from the motor club's breach of the conditions of the deposit or bond may bring suit in his own name to make a claim against the deposit or bond, or the commissioner may bring suit on behalf of claimants. In no event shall the liability of the surety exceed the amount of the bond, regardless of the number of claimants or claims made on the bond. Regardless of the number of years the bond continues in force or the number of premiums payable or paid, the limit of the surety's liability, specified as the amount of liability of the bond, is not cumulative from year to year or from period to period. The bond shall be forfeited up to the amount of actual damages sustained by any claimant or claimants. No cause of action shall be filed against the bond after two years from the date of termination of the bond.

(3) If a motor club is a separate division of a corporation, the commissioner may increase the deposit or bond requirements to take into account the increased risk created by the other business of the corporation. However, the deposit or bond requirement may not be more than twice the amounts required under Subsection (2).

Amended by Chapter 10, 1988 Special Session 2

31A-11-107. Issuance of certificate of authority -- Reinsurance of excess services.

(1) The commissioner shall issue a certificate applied for under Section 31A-11-106 if the commissioner finds that:

(a) the corporation is able to negotiate, execute, and carry out the motor club business in a sound, reliable, and ongoing manner;

(b) the reinsurance requirements of Subsection (2) are satisfied; and
(c) all other applicable requirements of law are satisfied.
(2) If a motor club provides legal expense service other than that authorized in Subsection 31A-11-102(1)(b), or other trip reimbursement service than that authorized in Subsection 31A-11-102(1)(d), or bail service other than that authorized under Section 31A-11-112, it shall fully reinsure the excess service with an insurer authorized under Chapter 5, Domestic Stock and Mutual Insurance Corporations, or 14, Foreign Insurers. That insurer shall assume direct liability to the insured, and shall fully comply with Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

Amended by Chapter 297, 2011 General Session

31A-11-108. Denial of certificate of authority.
If the commissioner declines or fails to issue a certificate of authority under Section 31A-11-107 within a reasonable time, he shall issue an order giving a reasonably detailed explanation for the refusal or the delay.

Enacted by Chapter 242, 1985 General Session

31A-11-109. Alteration or revocation of certificate of authority.
If the commissioner issues an order under Chapter 27, Part 5, Administrative Actions, against a motor club, the commissioner may revoke its certificate of authority or issue a new one with the limits the commissioner considers necessary.

Amended by Chapter 309, 2007 General Session

31A-11-110. Registration of agents.
No person may execute, issue, or deliver any motor club service contract to any person or receive anything of value for the contract either before or after its execution, unless he is registered with the commissioner. A person is registered upon filing a statement including his name, home and business address, telephone number, and motor club represented with the commissioner, on a form prescribed by the commissioner, and upon payment of all the fees due under Section 31A-3-103. Registered persons shall give the commissioner notice of any change in registration information.

Enacted by Chapter 242, 1985 General Session

31A-11-111. Reservation and registration of corporate name.
Sections 16-10a-402, 16-10a-403, and 42-2-5 apply to the reservation and registration of the corporate name of motor clubs.

Amended by Chapter 277, 1992 General Session

31A-11-112. Bail for traffic violations.

(1) Any insurance company that is qualified to transact a surety business in Utah may contract to become surety for any guaranteed arrest bond certificates issued by it or by a motor club, by filing with the commissioner an undertaking to become surety. The undertaking shall be in a form prescribed by the commissioner and shall state the following:

(a) The name and address of the motor club or clubs issuing the guaranteed arrest bond certificates on which the company will be surety, and whether the motor club will issue the certificates itself.

(b) The unqualified obligation of the company to be surety to pay, up to a specified dollar amount, the fine or forfeiture of any person who fails to make an appearance to answer the charges for which the guaranteed arrest bond certificate is posted.

(2) Any guaranteed arrest bond certificate under Subsection (1), when posted by the signatory, shall be accepted in lieu of cash bail or other bond in an amount not exceeding the dollar amount specified under Subsection (1)(b), to guarantee the appearance of the person when required by any court in Utah when the person is arrested for violation of any Utah motor vehicle law, or any motor vehicle ordinance of any Utah municipality, except for driving under the influence of drugs or intoxicating liquors or for any felony. A law enforcement officer who issues a citation to an operator of a vehicle who has a valid guaranteed arrest bond certificate in his possession shall obtain the necessary information for the arrest citation, and if the guaranteed arrest bond certificate covers the fine for the violation, the officer shall release the vehicle and operator after serving the citation and receiving the guaranteed arrest bond from the operator. The officer shall deliver the guaranteed arrest bond to the appropriate court to be held as a bail bond.

(3) A guaranteed arrest bond certificate posted as a bail bond in a district court is subject to the forfeiture and enforcement provisions which govern bail bonds in criminal cases. A guaranteed arrest bond certificate posted as a bail bond in a justice court is subject to the forfeiture and enforcement provisions of the charter or ordinance of the particular municipality which pertains to bail bonds.

(4) A motor club may not agree to exonerate or indemnify an authorized surety issuing guaranteed arrest bonds under Subsection (1) for losses in connection with these bonds.

Amended by Chapter 10, 1997 General Session
Amended by Chapter 215, 1997 General Session

31A-11-114. Reports in lieu of examination of motor club.

In lieu of all or any part of an examination of a motor club under this title, the commissioner may accept the report of an:

(1) audit conducted by a certified public accountant; or

(2) examination made by a government agency.

Enacted by Chapter 344, 1995 General Session

31A-12-101. Definitions.

As used in this chapter:
(1) "Risk Management Fund" means the fund created under Section 63A-4-201.
(2) "Risk manager" means the person appointed under Section 63A-4-101.

Amended by Chapter 212, 1993 General Session

31A-12-103. Rates charged to school districts.

The rates charged to school districts for policies issued under Section 63A-4-204 are not subject to Chapter 19a, except for the filing requirement of Subsection 31A-19a-203(1) and the public availability requirement of Section 31A-19a-204. Rate filing fees under Section 31A-3-103 shall be paid to the department by the Risk Management Fund.

Amended by Chapter 130, 1999 General Session

31A-12-104. Insurance policies issued to school districts.

Insurance policies issued by the Risk Management Fund to school districts under Section 63A-4-204 shall conform to Chapters 21 and 22. Policy forms issued to the school district shall be filed under Section 31A-21-201. The policy form filing fees of Section 31A-3-103 shall be paid to the Insurance Department by the Risk Management Fund.

Amended by Chapter 212, 1993 General Session

31A-12-105. Claim settlements with school districts.

Chapter 26 applies to the Risk Management Fund with respect to the settlement of insurance claims made by school districts against this fund.

Enacted by Chapter 242, 1985 General Session

31A-12-107. Governmental immunity.

Notwithstanding any other provision of this title, a governmental entity is not an insurer for purposes of this title and is not engaged in the business of insurance to the extent that it is:
(1) covering its own liabilities under Title 63G, Chapter 7, Governmental Immunity Act of Utah; or
(2) engaging in other related risk management activities related to the normal course of its activities.

Amended by Chapter 382, 2008 General Session

31A-13-101. Scope.

This chapter applies to every employee welfare fund covering any person employed in this state except to the extent that:
(1) federal law excludes the operation of state law;
(2) the fund qualifies for exemption from regulation under a rule adopted by the

commissioner defining funds which provide no benefits involving insurance risks; or

(3) the commissioner determines by rule that the insurance-like risks are minimal or present no problems requiring active regulation.

Amended by Chapter 204, 1986 General Session

31A-13-102. Regulation in general.

Chapter 2 applies to the regulation of employee welfare funds or plans subject to Chapter 13.

Enacted by Chapter 242, 1985 General Session

31A-13-103. Registration.

The trustees of every employee welfare fund which covers any person employed in this state shall register the fund with the commissioner within three months after the fund becomes subject to this chapter. The registration shall be in the form and shall contain the information relating to the organization, operations, and affairs of the fund as prescribed by the commissioner.

Amended by Chapter 204, 1986 General Session

31A-13-104. Commissioner to file information.

The commissioner may collect and file for public inspection the forms of trust indentures in use, the commission and fee schedules adopted by insurers, the compensation paid to trustees of employee welfare funds, and other matters affecting the establishment and administration of the funds the commissioner determines are in the public interest.

Enacted by Chapter 242, 1985 General Session

31A-13-105. Reports to employers and employees.

(1) The fund or plan's annual report, and any other statement the commissioner indicates, shall be kept on file with the commissioner and at the principal office of the trustees.

(2) The statements, or the portion of the statements the commissioner considers appropriate, shall be made available by the commissioner or by the trustees, or both, for inspection:

(a) by an employer contributing to the fund;

(b) by a labor organization which is a party to an agreement establishing the fund; or

(c) by an employee covered by the fund.

(3) When the commissioner considers it to be in the public interest, he may require the trustees to mail any portions of the statements which the commissioner considers appropriate:

(a) to employees covered by the fund;

(b) to contributing employers; or

(c) to any labor organization which is a party to an agreement establishing the fund.

Enacted by Chapter 242, 1985 General Session

31A-13-106. Annual accounting by insurance companies, service plans, and corporate trustees and agents.

Any insurance company, hospital, surgical or medical service plan providing benefits under an employee welfare fund, and any corporate trustee or agent holding or administering all or any part of an employee welfare fund shall, within four months after the end of each policy or of the fiscal year, furnish to the trustees of the fund a statement of account giving any information that the trustees of the fund need to comply with the requirements of this chapter.

Enacted by Chapter 242, 1985 General Session

31A-13-107. Commissioner's remedies.

If the trustees of any employee welfare fund have failed to register the fund in accordance with Section 31A-13-103, or otherwise fail to comply with this chapter, the commissioner shall notify the employers of the failure. In addition to ordering compliance under Subsection 31A-2-201(4), the commissioner may:

(1) order the employers to stop making payments to the trustees until the employers are notified by the commissioner that the trustees are in compliance with this chapter; or

(2) rehabilitate or liquidate the employee welfare fund under Chapter 27a, Insurer Receivership Act.

Amended by Chapter 309, 2007 General Session

31A-13-108. Investments.

Chapter 18 applies to investments of employee welfare funds or plans, except as otherwise provided by rule.

Enacted by Chapter 242, 1985 General Session

31A-13-109. Political activities.

Subsection 31A-4-112(1) applies to lobbying by employee welfare funds. No employee welfare fund may make political contributions.

Amended by Chapter 204, 1986 General Session

31A-14-101. Purposes of chapter.

This chapter's purposes are to:

(1) protect insureds, creditors, and the public by providing adequate standards and an orderly procedure for the authorization of foreign insurers;

(2) subject foreign insurers doing an insurance business in Utah to the

jurisdiction of the Utah commissioner and courts; and

(3) provide Utah policyholders dealing with foreign insurers with regulatory protection equivalent to that provided to Utah policyholders dealing with domestic insurers.

Enacted by Chapter 242, 1985 General Session

31A-14-102. Documents as evidence.

Section 31A-5-105 applies to foreign insurers in Utah proceedings with respect to the use of documents as evidence.

Amended by Chapter 204, 1986 General Session

31A-14-104. Reservation and registration of corporate name.

Section 31A-5-201 applies to foreign corporations with respect to the reservation and registration of corporate names.

Amended by Chapter 204, 1986 General Session

31A-14-105. Authorized nondomestic insurers.

Except as otherwise provided, beginning July 1, 1986, this chapter applies to nondomestic insurers authorized under former Title 31.

Enacted by Chapter 242, 1985 General Session

31A-14-106. Applicability of corporation provisions.

Except to the extent made applicable by reference under this title, Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to insurers licensed under this chapter.

Amended by Chapter 340, 2011 General Session

31A-14-201. Application.

(1) (a) An incorporated person, other than a foreign health maintenance organization, authorized as an insurer in another jurisdiction in the United States may apply under this section for a certificate of authority as an insurer in this state.

(b) An alien insurer that is incorporated may apply under this section for a certificate of authority as an insurer in this state.

(2) An applicant for a certificate of authority under this section shall:

(a) use the forms prescribed by the commissioner; and

(b) provide the information and documents the commissioner requests, including the following:

(i) a copy of the applicant's articles and bylaws;

(ii) financial statements for the most recent complete fiscal year, with an explanation of the bases of all valuations and computations, in the detail reasonably required by the commissioner;

(iii) a summary, as detailed as the commissioner reasonably requires, of the applicant's financial history for:

(A) the preceding 10 years; or

(B) the entire period of the applicant's existence if less than 10 years;

(iv) for each of the applicant's current or proposed directors and principal officers:

(A) the name of the director or principal officer;

(B) the address of the director or principal officer; and

(C) the occupation for the preceding 10 years of the director or principal officer;

(v) for an alien insurer:

(A) the name of its United States manager, the manager's addresses and occupations for the preceding 10 years; and

(B) if the manager is a corporation, the names, addresses, and occupations of its directors and principal officers, and its most recent detailed financial statements;

(vi) a schedule listing:

(A) all jurisdictions in which applicant has done or has been authorized to conduct an insurance business during the preceding 10 years;

(B) all jurisdictions in which the applicant has applied for authorization to conduct an insurance business during the preceding 10 years, and the dates and results of those applications;

(C) all jurisdictions from which the applicant has withdrawn from conducting an insurance business during the preceding 10 years, and the reasons for its withdrawals; and

(D) the name of and the circumstances surrounding any officer, director, or controlling shareholder of the corporation ever being subject to a:

(I) felony indictment or conviction; or

(II) civil, criminal, or administrative action alleging fraud;

(vii) a summary description of the applicant's present business operations, including the coverages written and the states and countries in which it does business;

(viii) a list of any statements, reports, or other documents that have, within the last five years, been generally transmitted or distributed to or among the insurer's creditors, shareholders, members, subscribers, or policyholders;

(ix) if the applicant has been in the insurance business for less than 10 years, a summary of the past and a projection of the anticipated operating results at the end of each year of the first 10 years of operation, based, where known, on actual data and otherwise on reasonable assumptions of loss experience, premium and other income, operating expenses, and acquisition costs;

(x) a statement that organizational and promotional expenses have been paid, and that organizational procedures required by the insurer's domiciliary authority are complete;

(xi) a statement from the domiciliary regulatory authority and the state of entry into the United States, if any, that so far as known, the applicant is sound and there are no legitimate objections to its proposed operations in this state;

(xii) the plan for conducting an insurance business in this state, including:

(A) the geographical area where business is to be conducted;

(B) the types of insurance to be written;

(C) the proposed general marketing methods;
(D) the proposed method for establishing premium rates; and
(E) copies of the policy and application forms to be used in this state;
(xiii) any other information the commissioner reasonably requires;
(xiv) authorization to the commissioner to make inquiry of any person about the applicant, its manager under a management contract, its attorney in fact, its general agents, and any of the officers, directors, or shareholders of any of them designated by the commissioner; and
(xv) written agreement by the applicant and any other designated persons that in the absence of actual malice, no communication made in response to any inquiry under Subsection (2)(b)(xiv) will subject the person making it to an action for damages for defamation brought by the applicant, the designated person, or a legal representative of either.
(3) No action for damages for defamation lies even in the absence of this agreement.
(4) Notwithstanding Subsection (2), the commissioner may exempt an applicant for a certificate of authority from providing the information described in Subsection (2) if the commissioner finds that the information will not be helpful in making the decision of whether to issue a certificate of authority.

Amended by Chapter 116, 2001 General Session

31A-14-202. Certificate of authority.
(1) The commissioner shall either issue a certificate of authority to an applicant under Section 31A-14-201 or issue an order refusing the certificate which explains why he finds that:
(a) not all specific requirements of the law have been met, including the requirements of Section 31A-14-209 for an alien insurer;
(b) the applicant is not sound, reliable, entitled to public confidence, or cannot reasonably be expected to perform its obligations continuously in the future;
(c) the applicant's directors and officers or, in the case of an alien insurer, its United States manager, are not sufficiently trustworthy and competent to engage in the proposed business in this state and to comply with the laws of this state; or
(d) the applicant has not been in existence long enough to demonstrate its competence to engage in the proposed business in this state.
(2) If the commissioner finds that the applicant does not comply with all requirements of the law, the commissioner may, after a hearing under Section 31A-2-301, issue a certificate of authority if the purposes of each unsatisfied requirement and the protection of insureds, creditors, and the public in this state are otherwise achieved by:
(a) a deposit in trust to be established and maintained under Section 31A-2-206;
(b) a bond acceptable to the commissioner conditioned on the satisfaction of the purposes of the requirement;
(c) special limits on the applicant's business or methods of operation in this state or elsewhere; or
(d) other protective devices satisfactory to the commissioner.

(3) The certificate of authority shall specify the terms of any deposit or bond required as a condition for authorization, any limits placed on the insurer's business or methods of operation in this state, and any other conditions imposed under Subsection (2).

(4) An insurer may apply to the commissioner for a new certificate of authority, removing, altering, or adding limits on its business or methods of operation. The application shall be accompanied by the information specified in Section 31A-14-201 that the commissioner reasonably requires. The commissioner shall issue the new certificate as requested if he would do so if an initial application were being made.

Amended by Chapter 204, 1986 General Session

31A-14-203. Admission of foreign fraternals.

(1) A foreign fraternal may apply for authorization to transact business in Utah, by filing with the commissioner:

(a) a certified copy of its articles and bylaws;

(b) a power of attorney to the commissioner to receive service of process and other papers;

(c) a certificate from the commissioner in its domiciliary jurisdiction that the fraternal is authorized to transact business in that jurisdiction;

(d) a copy of each of its contract forms;

(e) a statement of its business in the form required by the commissioner, showing that the business of the fraternal substantially complies with all the provisions of law relating to similar domestic fraternals; and

(f) other information the commissioner may reasonably request.

(2) The commissioner shall examine the applicant fraternal.

(3) The commissioner shall grant a certificate of authority to do business in Utah if the fraternal's condition and practices protect the interests of potential insureds, creditors, and the public.

Enacted by Chapter 242, 1985 General Session

31A-14-204. Registered agent and registered office.

(1) Title 16, Chapter 17, Model Registered Agents Act, applies to the registered agent and service of process on all foreign insurers authorized to do business in this state. Whenever the words "Division of Corporations and Commercial Code" or "division" are used, they mean "insurance commissioner."

(2) The principal office shall have sufficient personnel to provide information and assistance to Utah insureds, unless the insurer informs policyholders on the policy or on other written communications of a toll-free telephone connection accessible at normal business hours in this state.

Amended by Chapter 364, 2008 General Session

31A-14-205. Requirements from other applicable chapters.

(1) A foreign insurer may not be authorized to do business in this state, unless it

strictly complies with the following requirements:

(a) Foreign insurers shall comply with the solvency standard set forth in Chapter 17, Part 6, Risk-Based Capital, including maintenance of minimum capital or permanent surplus under Section 31A-5-211.

(b) A foreign insurer proposing to market securities in this state shall comply with Sections 31A-5-301, 31A-5-302, and 31A-5-305, unless this marketing is subject to United States Securities and Exchange Commission regulation.

(c) Section 16-10a-1506 applies to the corporate name and the change of name of foreign stock insurers. Section 16-6a-1507 applies to the change of name of foreign mutual insurers.

(d) Subsection 31A-5-203(2)(c) applies to other business of foreign mutual insurers.

(e) Subsection 31A-5-404(2), as modified by Subsection 31A-5-404(4), applies to communications to shareholders, policyholders, or voting members of mutuals by foreign insurers.

(f) Section 31A-5-413 applies to interlocking directorates of foreign insurers.

(g) Subsection 31A-5-203(2)(d) applies to assessment liability in foreign insurers issuing assessable policies in any state.

(2) The commissioner may issue orders imposing and eliminating restrictions to foreign insurers under Section 31A-5-103.

(3) After a hearing, the commissioner may by order apply any of the provisions of Sections 31A-5-307, 31A-5-414, 31A-5-418 to a foreign corporation after finding that it is necessary for the protection of the interests of its insureds, creditors, or the public in this state. This Subsection (3) may be applied to a foreign insurer without a hearing if done under a reciprocal agreement with the domiciliary regulatory authority.

(4) If any provision made applicable to a foreign insurer under this section conflicts with the law of the insurer's domicile so that it is impossible for the corporation to comply with both laws, the law of the domicile governs.

(5) This section does not excuse or exempt any foreign insurer from complying with the provisions of this title which are otherwise applicable to a foreign insurer.

(6) This section does not apply to foreign fraternal insurers.

(7) If a licensed foreign insurer is in rehabilitation or liquidation proceedings or is found to be insolvent in its state of domicile, the commissioner may, without hearing, suspend the insurer's certificate of authority to do business in this state.

Amended by Chapter 300, 2000 General Session

31A-14-206. Commercially domiciled insurers.

(1) As used in this section, and except as to title insurers, the commissioner may consider a foreign insurer to be "commercially domiciled" in this state if:

(a) during the three immediately preceding calendar years, the foreign insurer wrote more insurance premiums in this state than it wrote in its state of domicile during the same period; or

(b) during the same three-year period, the foreign insurer's gross premiums written in this state constituted 15% or more of the insurer's total gross premiums written in the United States.

(2) Subject to Subsection (3), an insurer determined by the commissioner to be commercially domiciled in this state may be subjected to Chapters 16, 17, 18, 27, and 27a, and Chapter 5, Parts 4, 5, and 6 in the same manner and to the same extent as domestic insurers. The commissioner shall, by order, notify any commercially domiciled insurer not exempt under Subsection (3) of the extent to which the insurer is subject to the provisions listed under this Subsection (2).

(3) The commissioner may exempt from the provisions of this section any commercially domiciled insurer if the commissioner determines that the insurer has assets physically located in this state or an asset to liability ratio sufficient to justify the conclusion that there is no reasonable danger that the operations or conduct of the business of the insurer could present a danger of loss to Utah policyholders.

(4) Subsection 31A-14-205(4) applies to the conflict of the laws of this state with the laws of the insurer's domicile for foreign insurers, including commercially domiciled insurers, under this section.

(5) This section does not excuse or exempt any foreign insurer from complying with the provisions under this title which are otherwise applicable to a foreign insurer.

Amended by Chapter 309, 2007 General Session

31A-14-207. Exclusive agency and management contracts.

(1) No foreign insurer licensed under this chapter may enter into or be subject to a contract that grants or surrenders the control or management of the insurer, unless the commissioner gives express approval of the contract. If amended, a contract previously approved under this subsection must again receive the commissioner's express approval.

(2) No nondomestic insurer may enter into any contract giving a person the exclusive or dominant right to produce the entire insurance business for the insurer in this state unless the contract is filed with and approved by the commissioner. The contract is considered approved unless disapproved by the commissioner within 30 days after the date of filing. The commissioner's disapproval shall be delivered to the insurer in writing, stating the grounds for the disapproval.

(3) The commissioner may not approve an exclusive management or exclusive agency contract under Subsection (1) or (2) which:

(a) subjects the insurer to excessive charges for expenses;

(b) vests in a person any control over the general affairs of the insurer to the exclusion of its board of directors or officers;

(c) extends for an unreasonable length of time; or

(d) contains other inequitable provisions which may jeopardize the security of Utah policyholders.

Amended by Chapter 91, 1987 General Session

31A-14-208. Requirements for foreign reciprocals.

(1) No foreign reciprocal may be authorized to do business in this state unless:

(a) under the laws of its domicile, the provisions of its power of attorney, or otherwise, it can sue and be sued in its own name;

(b) the assets resulting from the exchange of insurance contracts can be reached by its creditors; and

(c) either:

(i) if it issues only nonassessable policies, it meets all the financial requirements for a mutual corporation in similar circumstances, including unallocated surplus that is at least as great as the level required under Chapter 17, Part 6, Risk-Based Capital; or

(ii) if it issues any assessable policies, it meets all the requirements for a mutual corporation issuing assessable policies in similar circumstances and its subscribers are liable to the exchange to the limit of their assessability without regard to the validity or collectibility of any assessment levied against other subscribers.

(2) Any reciprocal admitted to Utah shall have a name that includes the word "reciprocal," "interinsurer," "interinsurance exchange," "underwriters," or "association." The name may not suggest a corporate entity.

(3) The reciprocal may not be authorized to do business in Utah unless the contract with its attorney in fact satisfies the requirements for a management contract under Section 31A-14-207.

(4) To the extent they are consistent with the nature of a reciprocal, the provisions of Chapter 5 that are made applicable to foreign mutual corporations by Section 31A-14-205 apply to foreign reciprocals, and the provisions and requirements applicable to principal officers of corporations apply to the attorneys in fact of reciprocal insurers.

(5) Except for life insurance and annuities, an authorized reciprocal may transact any kind of insurance, including reinsurance subject to Section 31A-20-107.

Amended by Chapter 9, 1996 Special Session 2

31A-14-209. Requirements for incorporated alien insurers.

(1) No incorporated alien insurer may be authorized to do business in Utah unless, in addition to the requirements of Section 31A-14-201, it satisfies all of the following:

(a) It has operated for three years in its domicile or the commissioner finds other grounds for being confident that it will be solid during its formative period.

(b) It supplies and commits itself to maintain in the United States a deposit or bond in an amount the commissioner considers sufficient to protect the interests of insureds, creditors, and the public in Utah.

(c) It files an agreement with the commissioner as required by the commissioner regarding its records, reports, and submission to examinations. This agreement shall include a commitment to keep its records, reports, and other documents relevant to its United States business constantly available in full in the English language, and to keep these records and make its reports on its United States business in a form which satisfies the commissioner.

(2) A deposit under Subsection (1)(b) may be made as specified in Section 31A-2-206 or it may be made in another state with a custodian approved by the commissioner. The deposit shall be in trust for those persons the commissioner considers appropriate to protect the interests of insureds, creditors, and the public in Utah. The custodian shall supply a certificate of the deposit in the form and at the

intervals reasonably required by the commissioner.

(3) A bond satisfies Subsection (1)(b) if it is issued by an insurer authorized to do a surety business in Utah and is conditioned on nonperformance of any obligation to those persons the commissioner considers appropriate in protecting the interests of insureds, creditors, and the public in Utah. Each bond shall cover any claims that arise out of occurrences prior to the termination of the bond, and may not be terminable on any ground without at least 30 days notice to the commissioner. Each bond shall be in the form and be renewed at the intervals reasonably required by the commissioner.

Enacted by Chapter 242, 1985 General Session

31A-14-210. Requirements for foreign fraternals.

(1) A foreign fraternal may not be authorized to do business in this state under Section 31A-14-203, unless it strictly complies with:

(a) the financial requirements of Section 31A-9-209 and Chapter 17, Part 6, Risk-Based Capital;

(b) the requirements of Section 16-6a-1506 and Subsection 31A-5-410(1)(a), the reporting requirements of Subsection 31A-5-410(2), Section 31A-5-413 whenever removal is made involuntarily under the laws of the domicile, Section 31A-9-202, and Subsections 31A-9-204(1)(c), 31A-9-402(2), and 31A-9-602(1); and

(c) for five years after the initial issuance of a certificate of authority in its domiciliary jurisdiction, the requirements of Subsection 31A-9-213(2).

(2) (a) No foreign fraternal may be authorized to do business in this state unless it substantially complies with Sections 31A-5-217 and 31A-5-218, except that the approval requirement of Subsection 31A-5-217(2) does not apply.

(b) When any corporate reorganization, transformation, or liquidation of a foreign fraternal, or any levy to cover a deficiency under a law comparable to Subsection 31A-9-209(2), is formally initiated by the fraternal, by the official act of the domiciliary commissioner, or by any other official, the fraternal shall promptly give written notice to the commissioner.

(3) The commissioner may issue orders imposing and eliminating restrictions under Section 31A-9-103 that are applicable to foreign fraternals.

(4) (a) After a hearing, the commissioner may, by order, apply any of the provisions of Sections 31A-9-213, 31A-9-404, 31A-9-411, 31A-9-413, or Subsection 31A-5-415(2) to a foreign fraternal after finding that it is necessary for the protection of the interests of its members, creditors, or the public in this state.

(b) If any provision made applicable to the foreign fraternal under Subsection (4)(a) conflicts with a provision of the law of the domicile, so that it is impossible for the fraternal to comply with both, the law of the domicile governs.

Amended by Chapter 300, 2000 General Session

31A-14-211. Restrictions on foreign title insurers.

(1) An authorized foreign title insurer may only insure property in this state:

(a) through an agency title insurance producer who is a resident in Utah; or

(b) if the authorized foreign title insurer has a bona fide office in Utah:

(i) that is under the direction and control of the authorized foreign title insurer;
(ii) for which the authorized foreign title insurer pays the expenses, including compensation of the employees of the bona fide office;
(iii) at which a person may request information about title services related to a real estate transaction for which the person is a party;
(iv) at which a person may deliver written communications to the authorized foreign title insurer as required by the real estate transaction for which the person is a party; and
(v) at which a person may deliver escrow money related to a real estate transaction for which the person is a party.
(2) This section does not apply to reinsurance.

Amended by Chapter 319, 2013 General Session

31A-14-212. Changes in business plan.
(1) Within two years after the initial issuance of a certificate of authority to a foreign insurer by its domiciliary jurisdiction, the insurer may not substantially deviate from its business plan under Subsection 31A-14-201(2)(b)(xii) unless notice of the proposed action is filed with the commissioner 30 days in advance of the proposed effective date.
(2) If the commissioner believes that the change proposed under Subsection (1) would be contrary to Utah law or to the interests of insureds, creditors, or the public, he may prohibit the application of the change to Utah. In his prohibitory order he shall explain why he has prohibited the change.
(3) If the commissioner finds after a hearing that the application of the proposed change outside Utah would endanger the interests of insureds, creditors, or the public in Utah, the commissioner may revoke the insurer's certificate of authority unless the insurer agrees not to make the change.

Amended by Chapter 116, 2001 General Session

31A-14-213. Transfer of business.
(1) A foreign insurer that intends to transfer to another person all or a substantial part of its insurance business in Utah by means of an assumption reinsurance transaction, a sale, or otherwise, shall report the proposed transaction to the commissioner not less than 30 days before the proposed effective date. The commissioner may approve the transaction to take effect immediately. Alternatively, the commissioner may defer the effective date of the transaction for an additional period not exceeding 30 days, by written notice to the insurer before the expiration of the initial 30-day period.
(2) The commissioner may, within the 30-day period or its extension, prohibit the proposed action if it would be contrary to the law or to the interests of insureds, creditors, or the public in Utah.

Enacted by Chapter 242, 1985 General Session

31A-14-214. Amendment to articles and notice of corporate reorganization.

Sections 16-10a-1001 through 16-10a-1004 apply when a foreign insurer amends its articles of incorporation. If a foreign insurer plans to undergo any corporate reorganization of the kinds dealt with in Chapter 5, Part 5, Corporate Reorganization, the insurer shall notify the commissioner in writing, at the same time that the first formal step of the statutory procedure for achieving the reorganization is taken in the domiciliary jurisdiction or elsewhere. The insurer shall provide the details required by the commissioner, whether by rule or order.

Amended by Chapter 90, 2004 General Session

31A-14-215. Assessment by foreign company.

Every foreign mutual insurer authorized in this state shall notify the commissioner immediately after making an assessment upon any of its members in this state. The insurer shall attach to the notice a statement of the condition of the insurer, giving the facts showing the necessity for the assessment. Unless the commissioner orders otherwise under a Chapter 27, Part 5, Administrative Actions, proceeding, a foreign mutual insurer authorized in this state may not make or increase any assessment because of its inability to collect assessments from its members in other states.

Amended by Chapter 309, 2007 General Session

31A-14-216. Release from regulation.

(1) A foreign insurer authorized under this chapter is subject to regulation under the applicable provisions of the Insurance Code, unless it is released from regulation under this section.

(2) A foreign insurer may apply for release from regulation by filing with the commissioner:

(a) its certificate of authority;

(b) a schedule of its outstanding liabilities from policies issued in this state to residents of Utah or on risks located in Utah, and from other business transactions in Utah;

(c) a plan for securing the discharge of those outstanding liabilities; and

(d) any other information as reasonably required by the commissioner.

(3) The commissioner shall promptly release the insurer from regulation if he finds all the following:

(a) The insurer has stopped doing any new business in Utah.

(b) The discharge of existing liabilities to creditors in Utah is sufficiently secured.

(c) The release would not otherwise be prejudicial to the interests of insureds or creditors in Utah or, if the insurer is an alien insurer and Utah is the state of entry into the United States, of all insureds and creditors in the United States.

(4) Before deciding on the release, the commissioner may require the insurer to notify, at its own expense, all agents or other classes of potentially interested persons in a manner the commissioner prescribes, including publication of its withdrawal from

Utah. The notice shall advise affected persons to communicate to the commissioner any objections they may have to the insurer's release from regulation.

(5) As a prerequisite for releasing the insurer, the commissioner may require a deposit under Section 31A-2-206, a bond issued by a surety authorized in Utah, or other appropriate security or reinsurance in a sufficient amount to secure the proper discharge of the insurer's remaining liabilities in Utah. The commissioner may also require the insurer to sign an agreement to remain subject to the jurisdiction of the commissioner and the courts of Utah with respect to any matter arising out of business done in Utah prior to the release.

Enacted by Chapter 242, 1985 General Session

31A-14-217. Revocation of certificate of authority.

Whenever there would be grounds for delinquency proceedings under Chapter 27a, Insurer Receivership Act, against a foreign insurer, if the foreign insurer were a domestic insurer, the commissioner may, after any proceeding authorized by Title 63G, Chapter 4, Administrative Procedures Act, revoke, suspend, or limit the foreign insurer's certificate of authority. This action does not affect insurance which has already been issued. The insurer remains subject to regulation until released under Section 31A-14-216.

Amended by Chapter 382, 2008 General Session

31A-15-101. Purposes.

It is the purpose of this chapter to:

(1) prevent evasion by unauthorized insurers of the regulatory and tax laws of Utah and protect Utah and its residents against loss from that type of evasion;

(2) subject unauthorized insurers and other persons doing an insurance business in Utah to the jurisdiction of the Utah commissioner and courts;

(3) protect authorized insurers from unfair competition by unauthorized insurers; and

(4) provide an orderly method, under reasonable and practical safeguards, for procuring insurance from unauthorized insurers.

Enacted by Chapter 242, 1985 General Session

31A-15-102. Assisting unauthorized insurers.

(1) No person may do any act enumerated under Subsection (2) who knows or should know that the act may assist in the illegal placement of insurance with an unauthorized insurer or the subsequent servicing of an insurance policy illegally placed with an unauthorized insurer.

(2) An act performed by mail is performed both at the place of mailing and at the place of delivery. Any of the following acts, whether performed by mail or otherwise, fall within the prohibition of Subsection (1):

(a) soliciting, making, or proposing to make an insurance contract;

(b) taking, receiving, or forwarding an application for insurance;

(c) collecting or receiving, in full or in part, an insurance premium;

(d) issuing or delivering an insurance policy or other evidence of an insurance contract except as a messenger not employed by the insurer, or an insurance producer;

(e) doing any of the following in connection with the solicitation, negotiation, procuring, or effectuation of insurance coverage for another: inspecting risks, setting rates, advertising, disseminating information, or advising on risk management;

(f) publishing or disseminating any advertisement encouraging the placement or servicing of insurance that would violate Subsection (1); however this provision does not apply to publication or dissemination to an audience primarily outside Utah that also reaches persons in Utah unless the extension to persons inside Utah can be conveniently avoided without substantial expense other than loss of revenue; nor does it apply to regional or national network programs on radio or television unless they originate in Utah;

(g) investigating, settling, adjusting, or litigating claims; or

(h) representing or assisting any person to do an unauthorized insurance business or to procure insurance from an unauthorized insurer.

(3) Subsection (1) does not prohibit:

(a) an attorney acting for a client;

(b) a full-time salaried employee of an insured acting in the capacity of an insurance buyer or manager; or

(c) insurance activities described under Section 31A-15-103.

(4) Any act performed in Utah which is prohibited under this section constitutes appointment of the commissioner or the lieutenant governor as agent for service of process under Sections 31A-2-309 and 31A-2-310.

(5) Any person or entity who knows or should know that the person's or entity's actions assist in the illegal placement of insurance in violation of this section is guilty of a third degree felony.

Amended by Chapter 58, 2005 General Session

31A-15-103. Surplus lines insurance -- Unauthorized insurers.

(1) Notwithstanding Section 31A-15-102, a foreign insurer that has not obtained a certificate of authority to do business in this state under Section 31A-14-202 may negotiate for and make an insurance contract with a person in this state and on a risk located in this state, subject to the limitations and requirements of this section.

(2) (a) For a contract made under this section, the insurer may, in this state:

(i) inspect the risks to be insured;

(ii) collect premiums;

(iii) adjust losses; and

(iv) do another act reasonably incidental to the contract.

(b) An act described in Subsection (2)(a) may be done through:

(i) an employee; or

(ii) an independent contractor.

(3) (a) Subsections (1) and (2) do not permit a person to solicit business in this state on behalf of an insurer that has no certificate of authority.

(b) Insurance placed with a nonadmitted insurer shall be placed with a surplus

lines producer licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(c) The commissioner may by rule prescribe how a surplus lines producer may:

(i) pay or permit the payment, commission, or other remuneration on insurance placed by the surplus lines producer under authority of the surplus lines producer's license to one holding a license to act as an insurance producer; and

(ii) advertise the availability of the surplus lines producer's services in procuring, on behalf of a person seeking insurance, a contract with a nonadmitted insurer.

(4) For a contract made under this section, a nonadmitted insurer is subject to Sections 31A-23a-402, 31A-23a-402.5, and 31A-23a-403 and the rules adopted under those sections.

(5) A nonadmitted insurer may not issue workers' compensation insurance coverage to an employer located in this state, except for stop loss coverage issued to an employer securing workers' compensation under Subsection 34A-2-201(3).

(6) (a) The commissioner may by rule prohibit making a contract under Subsection (1) for a specified class of insurance if authorized insurers provide an established market for the class in this state that is adequate and reasonably competitive.

(b) The commissioner may by rule place a restriction or a limitation on and create special procedures for making a contract under Subsection (1) for a specified class of insurance if:

(i) there have been abuses of placements in the class; or

(ii) the policyholders in the class, because of limited financial resources, business experience, or knowledge, cannot protect their own interests adequately.

(c) The commissioner may prohibit an individual insurer from making a contract under Subsection (1) and all insurance producers from dealing with the insurer if:

(i) the insurer willfully violates:

(A) this section;

(B) Section 31A-4-102, 31A-23a-402, 31A-23a-402.5, or 31A-26-303; or

(C) a rule adopted under a section listed in Subsection (6)(c)(i)(A) or (B);

(ii) the insurer fails to pay the fees and taxes specified under Section 31A-3-301; or

(iii) the commissioner has reason to believe that the insurer is:

(A) in an unsound condition;

(B) operated in a fraudulent, dishonest, or incompetent manner; or

(C) in violation of the law of its domicile.

(d) (i) The commissioner may issue one or more lists of unauthorized foreign insurers whose:

(A) solidity the commissioner doubts; or

(B) practices the commissioner considers objectionable.

(ii) The commissioner shall issue one or more lists of unauthorized foreign insurers the commissioner considers to be reliable and solid.

(iii) In addition to the lists described in Subsections (6)(d)(i) and (ii), the commissioner may issue other relevant evaluations of unauthorized insurers.

(iv) An action may not lie against the commissioner or an employee of the department for a written or oral communication made in, or in connection with the

issuance of, a list or evaluation described in this Subsection (6)(d).

(e) A foreign unauthorized insurer shall be listed on the commissioner's "reliable" list only if the unauthorized insurer:

(i) delivers a request to the commissioner to be on the list;

(ii) establishes satisfactory evidence of good reputation and financial integrity;

(iii) (A) delivers to the commissioner a copy of the unauthorized insurer's current annual statement certified by the insurer; and

(B) continues each subsequent year to file its annual statements with the commissioner within 60 days of the day on which it is filed with the insurance regulatory authority where the insurer is domiciled;

(iv) (A) (I) is in substantial compliance with the solvency standards in Chapter 17, Part 6, Risk-Based Capital, or maintains capital and surplus of at least $15,000,000, whichever is greater; and

(II) maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, or maintains a deposit meeting the statutory deposit requirements for insurers in the state where it is made, which trust fund or deposit:

(Aa) shall be in an amount not less than $2,500,000 for the protection of all of the insurer's policyholders in the United States;

(Bb) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and

(Cc) may include as part of the trust arrangement a letter of credit that qualifies as acceptable security under Section 31A-17-404.1; or

(B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group of alien individual insurers, maintains a trust fund that:

(I) shall be in an amount not less than $50,000,000 as security to its full amount for all policyholders and creditors in the United States of each member of the group;

(II) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and

(III) may include as part of this trust arrangement a letter of credit that qualifies as acceptable security under Section 31A-17-404.1; and

(v) for an alien insurer not domiciled in the United States or a territory of the United States, is listed on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department.

(7) (a) Subject to Subsection (7)(b), a surplus lines producer may not, either knowingly or without reasonable investigation of the financial condition and general reputation of the insurer, place insurance under this section with:

(i) a financially unsound insurer;

(ii) an insurer engaging in unfair practices; or

(iii) an otherwise substandard insurer.

(b) A surplus line producer may place insurance under this section with an insurer described in Subsection (7)(a) if the surplus line producer:

(i) gives the applicant notice in writing of the known deficiencies of the insurer or the limitations on the surplus line producer's investigation; and

(ii) explains the need to place the business with that insurer.

(c) A copy of the notice described in Subsection (7)(b) shall be kept in the office of the surplus line producer for at least five years.

(d) To be financially sound, an insurer shall satisfy standards that are comparable to those applied under the laws of this state to an authorized insurer.

(e) An insurer on the "doubtful or objectionable" list under Subsection (6)(d) or an insurer not on the commissioner's "reliable" list under Subsection (6)(e) is presumed substandard.

(8) (a) A policy issued under this section shall:

(i) include a description of the subject of the insurance; and

(ii) indicate:

(A) the coverage, conditions, and term of the insurance;

(B) the premium charged the policyholder;

(C) the premium taxes to be collected from the policyholder; and

(D) the name and address of the policyholder and insurer.

(b) If the direct risk is assumed by more than one insurer, the policy shall state:

(i) the names and addresses of all insurers; and

(ii) the portion of the entire direct risk each assumes.

(c) A policy issued under this section shall have attached or affixed to the policy the following statement: "The insurer issuing this policy does not hold a certificate of authority to do business in this state and thus is not fully subject to regulation by the Utah insurance commissioner. This policy receives no protection from any of the guaranty associations created under Title 31A, Chapter 28."

(9) Upon placing a new or renewal coverage under this section, a surplus lines producer shall promptly deliver to the policyholder or the policyholder's agent evidence of the insurance consisting either of:

(a) the policy as issued by the insurer; or

(b) if the policy is not available upon placing the coverage, a certificate, cover note, or other confirmation of insurance complying with Subsection (8).

(10) If the commissioner finds it necessary to protect the interests of insureds and the public in this state, the commissioner may by rule subject a policy issued under this section to as much of the regulation provided by this title as is required for a comparable policy written by an authorized foreign insurer.

(11) (a) A surplus lines transaction in this state shall be examined to determine whether it complies with:

(i) the surplus lines tax levied under Chapter 3, Department Funding, Fees, and Taxes;

(ii) the solicitation limitations of Subsection (3);

(iii) the requirement of Subsection (3) that placement be through a surplus lines producer;

(iv) placement limitations imposed under Subsections (6)(a), (b), and (c); and

(v) the policy form requirements of Subsections (8) and (10).

(b) The examination described in Subsection (11)(a) shall take place as soon as practicable after the transaction. The surplus lines producer shall submit to the examiner information necessary to conduct the examination within a period specified by rule.

(c) (i) The examination described in Subsection (11)(a) may be conducted by the commissioner or by an advisory organization created under Section 31A-15-111 and authorized by the commissioner to conduct these examinations. The commissioner is not required to authorize an additional advisory organization to conduct an examination under this Subsection (11)(c).

(ii) The commissioner's authorization of one or more advisory organizations to act as examiners under this Subsection (11)(c) shall be:

(A) by rule; and

(B) evidenced by a contract, on a form provided by the commissioner, between the authorized advisory organization and the department.

(d) (i) (A) A person conducting the examination described in Subsection (11)(a) shall collect a stamping fee of an amount not to exceed 1% of the policy premium payable in connection with the transaction.

(B) A stamping fee collected by the commissioner shall be deposited in the General Fund.

(C) The commissioner shall establish a stamping fee by rule.

(ii) A stamping fee collected by an advisory organization is the property of the advisory organization to be used in paying the expenses of the advisory organization.

(iii) Liability for paying a stamping fee is as required under Subsection 31A-3-303(1) for taxes imposed under Section 31A-3-301.

(iv) The commissioner shall adopt a rule dealing with the payment of stamping fees. If a stamping fee is not paid when due, the commissioner or advisory organization may impose a penalty of 25% of the stamping fee due, plus 1-1/2% per month from the time of default until full payment of the stamping fee.

(v) A stamping fee relative to a policy covering a risk located partially in this state shall be allocated in the same manner as under Subsection 31A-3-303(4).

(e) The commissioner, representatives of the department, advisory organizations, representatives and members of advisory organizations, authorized insurers, and surplus lines insurers are not liable for damages on account of statements, comments, or recommendations made in good faith in connection with their duties under this Subsection (11)(e) or under Section 31A-15-111.

(f) An examination conducted under this Subsection (11) and a document or materials related to the examination are confidential.

Amended by Chapter 62, 2011 General Session

31A-15-104. Direct placement of insurance.

(1) Subject to this section, any person seeking insurance may obtain it from an unauthorized insurer if no producer resident doing business in Utah is involved and if negotiations occur primarily outside Utah. Negotiations by mail occur within Utah if a letter or other document containing insurance-related solicitations or negotiations is sent from or to a Utah address. Negotiations by telephone take place within Utah if one of the parties to the conversation is in Utah.

(2) Each policyholder who procures or renews insurance otherwise subject to this code from any insurer not authorized to do business in Utah, other than insurance procured under Section 31A-15-103 and the renewal of guaranteed renewable

insurance lawfully issued outside Utah, shall within 60 days after the insurance is procured or renewed, report to the commissioner in the form required by the commissioner and pay the taxes specified by Section 31A-3-301.

(3) (a) Any insurance on personal property sold on the installment plan, under a conditional sales contract, or an equivalent security agreement under the Uniform Commercial Code which charges the buyer, as a part of the consideration in the agreement of sale for insurance on the property, shall be placed with an insurer authorized to do business in Utah.

(b) Whenever the law of Utah requires a person to purchase insurance on risks in Utah, it shall be obtained from an insurer authorized to do business in Utah, or under Section 31A-15-103.

Amended by Chapter 298, 2003 General Session

31A-15-105. Effect of contracts illegal because insurer was unauthorized.

(1) An insurance contract entered into in violation of this chapter is unenforceable by, but enforceable against, the insurer. In an action against the insurer on the contract, the insured is bound by the terms of the contract as affected by this title and rules adopted under this title.

(2) An insurance policy entered into in violation of this chapter is voidable by the policyholder who entered into the transaction without knowing it was illegal. The policyholder may avoid the contract by notice to the insurer, if no insured has enforced the contract by an action under Subsection (1), and may recover any consideration paid under the contract.

(3) Any person who assisted in the procurement of an illegal contract under this chapter, and who knew or should have known the transaction was illegal, is liable to the insured for the full amount of a claim or loss payable under the contract, if the insurer does not pay it. The receiver appointed under Chapter 27a, Insurer Receivership Act, may assert the claims of insureds if the insurer is the subject of a proceeding under Chapter 27a.

Amended by Chapter 309, 2007 General Session

31A-15-106. Servicing of contracts made out of state.

(1) A foreign insurer that does not have a certificate of authority to do business in this state under Section 31A-14-202 may, in this state, collect premiums and adjust losses and do all other acts reasonably incidental to contracts made outside this state without violating this chapter. Any premiums collected under this section are subject to Section 31A-3-301.

(2) Subsection (1) does not permit a renewal, extension, increase, or other substantial change in the terms of any contract under Subsection (1) unless:

(a) it is permitted under Section 31A-15-103;

(b) the contract is for life or accident and health insurance or annuities; or

(c) a rule adopted by the commissioner permits this action when the interests of the policyholder and the public appear to be sufficiently protected.

Amended by Chapter 116, 2001 General Session

31A-15-107. Defense of action by unauthorized person.

(1) Except under Subsection (3), no pleading, notice, order, or process in any action in court or in any administrative proceeding before the commissioner instituted against an unauthorized person under Sections 31A-2-309 and 31A-2-310 may be filed by or on behalf of the unauthorized person unless one of the following conditions exists:

(a) The unauthorized person deposits with the clerk of the court in which the action or proceeding is pending, or with the commissioner in administrative proceedings, cash, securities, or a bond with sureties in an amount fixed by the court or the commissioner, sufficient to secure the payment or performance of any probable final judgment or order.

(b) That person procures proper authorization to do an insurance business in Utah.

(c) The commissioner, after a hearing, issues an order stating that he is satisfied the person has funds or securities, in a state of the United States, in trust or otherwise, which are readily available and adequate to satisfy any probable final judgment or to perform in accordance with any order.

(2) The court in any action or proceeding under this section, or the commissioner in any administrative proceeding under this section, may order any postponement he considers necessary to give the unauthorized person a reasonable opportunity to comply with Subsection (1).

(3) Subsection (1) does not prevent an unauthorized person from filing a motion to quash a writ or to set aside service on the ground that the person has not done any of the acts specified under Subsection 31A-15-102(2).

Enacted by Chapter 242, 1985 General Session

31A-15-108. Attorney fees.

In an action against an unauthorized person upon a contract of insurance issued in violation of this chapter, if the unauthorized person fails to make payment in accordance with the contract for 30 days after the payment is due and demand is made, and it appears to the court that the failure was without just cause, the court may allow the plaintiff a reasonable attorney's fee and may include the fee in any judgment that may be rendered in the action. The unauthorized person's failure to defend this action is prima facie evidence that the failure to pay was without just cause.

Enacted by Chapter 242, 1985 General Session

31A-15-109. Investigation and disclosure of insurance contracts.

Whenever the commissioner has reason to believe that insurance has been effectuated by or for any person in Utah with an unauthorized insurer, the commissioner may, in writing, order the person to produce for examination all insurance contracts and other documents evidencing insurance with both authorized and unauthorized insurers and to disclose to the commissioner the amount of insurance, the name and address of each insurer, the gross amount of premium, and the name and address of any person

who has assisted in effecting the insurance.

Enacted by Chapter 242, 1985 General Session

31A-15-110. Reporting of illegal insurance.

(1) Every person investigating or adjusting any loss or claim on a subject of insurance in this state shall immediately report to the commissioner every insurance policy or contract connected with the investigation or settlement, which the person has reason to believe has been entered into illegally by any insurer not authorized to transact business in this state.

(2) Every person acting as an insurance consultant shall immediately report to the commissioner every insurance policy or contract covering a subject of insurance in this state, which the consultant has reason to believe has been entered into illegally by an insurer not authorized to transact that type of insurance in this state.

Amended by Chapter 204, 1986 General Session

31A-15-111. Surplus lines advisory organizations.

(1) Advisory organizations of surplus lines producers may be formed to:

(a) facilitate and encourage compliance by its members with the laws of this state and the rules of the commissioner relative to surplus lines insurance;

(b) if authorized by the commissioner, perform and report to the commissioner on the confidential examinations and assess and receive the stamping fees described in Subsection 31A-15-103(11);

(c) make recommendations to the commissioner concerning classes of insurance for which a rule under Subsection 31A-15-103(6)(a) is appropriate;

(d) investigate "abuses of placements," as described in Subsection 31A-15-103(6)(b), and provide recommendations to the commissioner concerning rules under Subsection 31A-15-103(6)(b);

(e) bring to the commissioner's attention the existence of grounds for issuing an order under Subsection 31A-15-103(6)(c) concerning a particular unauthorized insurer;

(f) provide recommendations to the commissioner concerning unauthorized insurers which should be listed on a "doubtful or objectionable" list under Subsection 31A-15-103(6)(d);

(g) provide comments to the commissioner concerning whether an unauthorized insurer has a good reputation and financial integrity under Subsection 31A-15-103(6)(d)(ii);

(h) provide recommendations to the commissioner concerning rules under Subsection 31A-15-103(10) necessary to protect the interests of insureds and the public; and

(i) receive and disseminate to its members information relative to surplus lines coverages.

(2) Every advisory organization formed under this section shall file with the commissioner:

(a) a copy of its constitution, articles of agreement or association or articles of incorporation, and any amendments to these documents;

(b) a copy of its bylaws and any other writing governing the organization's activities and any amendments to these documents;

(c) a list of the names and addresses of residents of this state upon whom notices or orders of the commissioner or processes issued at his direction may be served, with changes in this list to be filed within 10 days of a change; and

(d) an agreement, on a form provided by the commissioner and executed by the advisory organization, that the commissioner may examine the advisory organization in accordance with the provisions of Sections 31A-2-203, 31A-2-204, and 31A-2-205.

(3) The commissioner may by rule or order require each person licensed as a surplus lines producer under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, to be a member of one or more specified advisory organizations operating under this section. The commissioner may make compliance with the rule or order a condition to continued licensure as a surplus lines producer.

(4) The comments and recommendations given the commissioner under Subsection (1) are merely advisory. The formation of an advisory organization under this section does not alter the commissioner's authority under this chapter.

Amended by Chapter 298, 2003 General Session

31A-15-201. Short title.

This part shall be known as the "Risk Retention Groups Act."

Enacted by Chapter 258, 1992 General Session

31A-15-202. Definitions.

As used in this part:

(1) "Completed operations liability" means liability, including liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability, arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by:

(a) any person who performs that work; or

(b) any person who hires an independent contractor to perform that work.

(2) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:

(a) for a corporation, the state in which the purchasing group is incorporated; and

(b) for an unincorporated entity, the state of its principal place of business.

(3) "Hazardous financial condition" means that a risk retention group, based on its present or reasonably anticipated financial condition, although not yet financially impaired or insolvent, is unlikely to be able:

(a) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(b) to pay other obligations in the normal course of business.

(4) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk

which is determined to be insurance under the laws of this state.

(5) (a) "Liability" means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses because of injuries to other persons, damage to their property, or other damage or loss to other persons, resulting from or arising out of:

(i) any profit or nonprofit business, trade, product, professional or other services, premises, or operations; or

(ii) any activity of any state or local government or any agency or political subdivision of any state or local government.

(b) "Liability" does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the federal Employers' Liability Act.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities rather than from responsibilities or activities referred to in Subsection (5).

(8) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group, including:

(a) information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

(b) for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(c) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(d) pro forma financial statements and projections;

(e) appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(f) identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements;

(g) identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

(h) any other matters required by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

(9) (a) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including damages resulting from the loss of use of property, if the liability arises out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of

a product.

(b) "Product liability" does not include the liability of any person for those damages described in Subsection (9)(a) if the product involved was in the possession of the person when the incident giving rise to the claim occurred.

(10) "Purchasing group" means any group which:

(a) has as one of its purposes the purchase of liability insurance on a group basis;

(b) purchases liability insurance only for its group members and only to cover their similar or related liability exposure, as described in Subsection (10)(c);

(c) is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, products, services, premises, or operations; and

(d) is domiciled in any state.

(11) "Risk retention group" means any corporation or other limited liability association:

(a) whose primary activity consists of assuming and spreading all, or any portion of, the liability exposure of its group members;

(b) which is organized for the primary purpose of conducting the activity described under Subsection (11)(a);

(c) which:

(i) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) (A) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before January 1, 1985, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of that state;

(B) however, any such group as described in Subsection (11)(c)(ii)(A) shall be considered to be a risk retention group only if it has been engaged in business continuously since January 1, 1985, and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as these terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986;

(d) which does not exclude any person from membership in the group solely to provide for members of the group a competitive advantage over the excluded person;

(e) which:

(i) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group; or

(ii) has as its sole owner an organization which:

(A) has as its members only persons who comprise the membership of the risk retention group; and

(B) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group;

(f) whose members are engaged in businesses or activities similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business trade, products, services, premises or operations;

(g) whose activities do not include providing insurance other than:

(i) liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) reinsurance with respect to the liability of any other risk retention group, or any members of the other group, which is engaged in businesses or activities so that the group or member meets the requirement described in Subsection (11)(f) for membership in the risk retention group which provides the reinsurance; and

(h) the name of which includes the phrase "risk retention group."

Amended by Chapter 324, 2010 General Session

31A-15-203. Risk retention groups chartered in this state.

(1) (a) A risk retention group under this part shall be chartered and licensed to write only liability insurance pursuant to this part and, except as provided elsewhere in this part, shall comply with all of the laws, rules, and requirements that apply to liability insurers chartered and licensed in this state, and with Section 31A-15-204 to the extent the requirements are not a limitation on other laws, rules, or requirements of this state.

(b) Notwithstanding any other provision to the contrary, all risk retention groups chartered in this state shall file an annual statement with the department and the NAIC in a form prescribed by the commissioner, and completed in diskette form if required by the commissioner, completed in accordance with the statement instructions and the NAIC Accounting Practices and Procedures Manual.

(2) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the commissioner a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision of the plan or study in the event of any subsequent material change in any item of the plan or study within 10 days of any such change. The group may not offer any additional kinds of liability insurance, in this state or in any other state, until any revision of the plan or study is approved by the commissioner.

(3) (a) At the time of filing its application for charter, the risk retention group shall provide to the commissioner in summary form the following information:

(i) the identity of the initial members of the group;

(ii) the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group;

(iii) the amount and nature of initial capitalization;

(iv) the coverages to be afforded; and

(v) the states in which the group intends to operate.

(b) Upon receipt of this information the commissioner shall forward the information to the NAIC. Providing notification to the NAIC is in addition to, and may not be sufficient to satisfy, the requirements of Section 31A-15-204 or any other sections of this part.

Amended by Chapter 297, 2011 General Session

31A-15-204. Risk retention groups not chartered in this state -- Designation of commissioner as agent -- Compliance with unfair claims

settlement practices act -- Deceptive, false, or fraudulent practices -- Examination regarding financial condition -- Prohibitions -- Penalties -- Operation prior to enactment of this part.

(1) Risk retention groups chartered and licensed in other states and seeking to do business as a risk retention group in this state shall comply with the following:

(a) Before offering insurance in this state a risk retention group shall submit to the commissioner:

(i) a statement identifying the states in which the group is chartered and licensed as a liability insurance company, its charter date, its principal place of business, and any other information, including information on its membership, the commissioner may require to verify that the group is a qualified risk retention group as defined in Subsection 31A-15-202(11); and

(ii) a copy of its plan of operations or feasibility study and revisions of the plan or study submitted to the state in which the risk retention group is chartered and licensed, except a plan or study is not required for any line or classification of liability insurance that:

(A) was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(B) was offered before that date by any risk retention group that had been chartered and operating for not less than three years before that date.

(b) The risk retention group shall submit to the commissioner a copy of any revision to its plan or study required by Subsection 31A-15-203(2) at the same time it submits the revision of its chartering state.

(c) The risk retention group shall submit, on a form approved by the commissioner, a statement of registration and a notice designating the commissioner as agent for the purpose of receiving service of legal documents or process.

(d) The risk retention group shall pay annual license fees required by Section 31A-3-103.

(2) Any risk retention group doing business in this state shall submit to the commissioner:

(a) a copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed, which shall be certified by an independent public accountant and shall contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a loss reserve specialist qualified under criteria approved by the commissioner;

(b) a copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

(c) if the commissioner requests, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

(d) any other information required to verify the group's continuing qualification as a risk retention group within the definition in Subsection 31A-15-202(11).

(3) (a) Each risk retention group shall pay premium taxes and taxes on premiums of direct business for risks resident or located within this state, and shall report to the Utah State Tax Commission the net premiums written for risks resident or located within this state. Each risk retention group shall be subject to taxation, and any

applicable fines and penalties related to taxation, on the same basis as a foreign admitted insurer.

(b) To the extent licensed producers are utilized pursuant to Section 31A-15-212, they shall report to the commissioner the premiums for direct business for all risks resident or located within this state that the producers have placed with, or on behalf of, a risk retention group not chartered in this state.

(c) To the extent that insurance producers are utilized pursuant to Section 31A-15-212 they shall keep a complete and separate record of all policies procured from each risk retention group. The record shall be open to examination by the commissioner, as provided under Section 31A-23a-412. These records shall include the following for each policy and each kind of insurance provided under each policy:

(i) the limit of liability;

(ii) the time period covered;

(iii) the effective date;

(iv) the name of the risk retention group that issued the policy;

(v) the gross premium charged;

(vi) the amount of any returned premiums; and

(vii) additional information required by the insurance commissioner.

(4) Each risk retention group and its agents and representatives shall comply with the Unfair Claims Settlement Practices Act, including Section 31A-15-207, Title 31A, Chapter 26, Part 3, Claim Practices, and any other provision of law relating to claims settlement practices.

(5) Each risk retention group shall comply with the laws of this state regarding deceptive, false, and fraudulent acts, practices regulated under Title 31A, Chapter 23a, Part 4, Marketing Practices, and any other provision of law relating to deceptive, false, or fraudulent practices. The commissioner may only obtain an injunction regarding the conduct described in this subsection from a court of competent jurisdiction.

(6) If the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within 60 days after a request by the commissioner of this state, the risk retention group shall submit to an examination by the commissioner of this state to determine its financial condition. Any examination conducted under this subsection shall be coordinated to avoid unjustified repetition and shall be conducted in an expeditious manner and in accordance with the NAIC's Examiner Handbook.

(7) Each application form for insurance from a risk retention group and each policy and certificate issued by a risk retention group shall contain the following notice in ten-point type on its front and declaration pages:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

(8) The following acts by a risk retention group are prohibited:

(a) the solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in the group; and

(b) the solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

(9) A risk retention group may not do business in this state if an insurance company is directly or indirectly a member or owner of the risk retention group, unless all members of the group are insurance companies.

(10) The terms of any insurance policy issued by a risk retention group may not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the Utah Supreme Court.

(11) A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by any state's insurance commissioner if there has been a finding of financial impairment after an examination under Subsection (6).

(12) A risk retention group that violates any provision of this part is subject to fines and penalties applicable to licensed insurers generally, including revocation of its right to do business in this state.

(13) In addition to complying with the requirements of this section, each risk retention group operating in this state before the effective date of this part shall comply with Subsection (1)(a) within 30 days after the effective date of this part.

Amended by Chapter 298, 2003 General Session

31A-15-205. Guaranty associations.

(1) A risk retention group may not be required to join or contribute financially to the Insurance Guaranty Fund created under Title 31A, Chapter 28, Part 2, Property and Casualty Guaranty Association, nor may any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by the risk retention group.

(2) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or from a risk retention group, the risks, wherever resident or located, may not be covered by any insurance guaranty fund or similar mechanism in this state.

(3) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state shall be covered by the Utah Property and Casualty Insurance Guaranty Association created under Title 31A, Chapter 28, Guaranty Associations.

Enacted by Chapter 258, 1992 General Session

31A-15-207. Purchasing groups -- Exemption from certain laws.

A purchasing group and its insurers are subject to all applicable laws of this state, except that a purchasing group and its insurers are exempt, in regard to liability insurance for the purchasing group, from any law that would:

(1) prohibit the establishment of a purchasing group;

(2) make it unlawful for an insurer to provide, or offer to provide, to a purchasing group or its members insurance on a basis providing advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters;

(3) prohibit a purchasing group or its members from purchasing insurance on a

group basis described in Subsection (2);

(4) prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

(5) require that a purchasing group have a minimum number of members, common ownership or affiliation, or certain legal form;

(6) require that a certain percentage of a purchasing group obtain insurance on a group basis;

(7) otherwise discriminate against a purchasing group or any of its members; or

(8) require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance producer residing in this state.

Amended by Chapter 297, 2011 General Session

31A-15-208. Purchasing groups -- Filing and registration requirements.

(1) A purchasing group that intends to do business in this state shall, prior to doing business, furnish notice to the insurance commissioner:

(a) identifying the state in which the purchasing group is domiciled;

(b) identifying any state in which the purchasing group intends to do business;

(c) specifying the lines and classifications of liability insurance that the purchasing group intends to purchase;

(d) identifying the insurers from which the group intends to purchase its insurance and the domicile of the insurers;

(e) specifying the method by which, and any persons through whom, insurance will be offered to group members whose risks are resident or located in this state;

(f) identifying the principal place of business of the purchasing group; and

(g) providing any other information required by the commissioner to verify that the purchasing group is a "purchasing group," as defined in Section 31A-15-202.

(2) A purchasing group shall notify the commissioner of a change in an item listed in Subsection (1) within 10 days of the change.

(3) (a) A purchasing group shall annually register with the commissioner and pay a filing fee.

(b) A purchasing group shall designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process.

(c) The registration and fee requirements of this Subsection (3) do not apply to a purchasing group that only purchases insurance that was authorized under the Product Liability Risk Retention Act of 1981, and that:

(i) in any state of the United States:

(A) was domiciled before April 1, 1986; and

(B) is domiciled after October 27, 1986;

(ii) (A) before October 27, 1986, purchased insurance from an insurer licensed in any state; and

(B) since October 27, 1986, purchased its insurance from an insurer licensed in any state; or

(iii) was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986.

(4) A purchasing group that is required to give notice under Subsection (1) shall also furnish information required by the commissioner to:
(a) verify that the entity qualifies as a purchasing group;
(b) determine where the purchasing group is located; and
(c) determine appropriate tax treatment of the purchasing group.

Amended by Chapter 10, 2010 General Session

31A-15-209. Restrictions on purchasing groups.

(1) A purchasing group which obtains liability insurance from an insurer not admitted in this state or from a risk retention group shall inform each of the group members which have a risk resident or located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state, and that the risk retention group or insurer may not be subject to all insurance laws and regulations of this state.
(2) A purchasing group may not purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.
(3) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

Enacted by Chapter 258, 1992 General Session

31A-15-210. Purchasing group taxation.

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing groups are imposed and shall be paid as follows:
(1) If the insurer is an admitted insurer, taxes are imposed on the insurer at the same rate and in the same manner and subject to the same procedures, interest, and penalties that apply to premium taxes and other taxes imposed on other admitted liability insurers relative to coverage of risks resident or located in this state.
(2) If the insurer is an approved, nonadmitted surplus lines insurer, taxes are imposed on the licensed producer who effected coverage on risks resident or located in this state at the same rate and in the same manner and subject to the same procedures, interest, and penalties that apply to taxes imposed on other licensed producers effecting coverage with approved, nonadmitted surplus lines insurers on risks resident or located in this state.

Amended by Chapter 297, 2011 General Session

31A-15-211. Enforcement authority.

(1) The commissioner is authorized to use the powers established for the department under this title to enforce the laws of this state not specifically preempted by the Liability Risk Retention Act of 1986, including the commissioner's administrative authority to investigate, issue subpoena, conduct depositions and hearings, issue orders, impose monetary penalties and seek injunctive relief. With regard to any

investigation, administrative proceedings, or litigation, the commissioner shall rely on the procedural laws of this state.

(2) Whenever the commissioner determines that any person, risk retention group, purchasing group, or insurer of a purchasing group has violated, is violating, or is about to violate any provision of this part or any other insurance law of this state applicable to the person or entity, or that the person or entity has failed to comply with a lawful order of the commissioner, he may, in addition to any other lawful remedies or penalties, file a complaint in the Third District Court of Salt Lake County to enjoin and restrain any person, risk retention group, purchasing group, or insurer from engaging in the violation, or to compel compliance with the order of the commissioner. The court has jurisdiction of the proceeding and has the power to enter a judgment and order for injunctive or other relief. In any action by the commissioner under this subsection, service of process shall be made upon the director of the Division of Corporations and Commercial Code who shall forward the order, pleadings, or other process to the person, risk retention group, purchasing group, or insurer in accordance with the procedures specified in Section 31A-14-204. Nothing in this section may be construed to limit or abridge the authority of the commissioner to seek injunctive relief in any district court of the United States as provided in Section 31A-15-213.

Enacted by Chapter 258, 1992 General Session

31A-15-212. Duty of producers to obtain license -- Risk retention groups -- Purchasing groups.

(1) A person may do the following only if he is licensed as an insurance agent or broker or is exempt from licensure under Title 31A, Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries:

(a) solicit, negotiate, or procure liability insurance in this state from a risk retention group;

(b) solicit, negotiate, or procure liability insurance in this state for a purchasing group from an authorized insurer or a risk retention group; and

(c) solicit, negotiate, or procure liability insurance coverage in this state for any member of a purchasing group under a purchasing group's policy.

(2) A person may solicit, negotiate, or procure liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state only if he is licensed as a surplus lines producer or is exempt from licensure under Title 31A, Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(3) The requirement of residence in this state does not apply for purposes of acting as a producer for a risk retention group or purchasing group under Subsections (1) and (2).

(4) On business placed with a risk retention group or written through a purchasing group, each person licensed under this title shall provide to each prospective insured the notice required by Subsection 31A-15-204(7) in the case of a risk retention group, and by Subsection 31A-15-209(1) in the case of a purchasing group.

(5) Solicitation for membership in a purchasing group is not of itself a solicitation

for insurance.

Amended by Chapter 298, 2003 General Session

31A-15-213. Effect of orders issued in U.S. District Court.

An order issued by any district court of the United States shall be enforceable in the courts of this state to enjoin a risk retention group from soliciting or selling insurance, or operating in any state, in all states, or in any territory or possession of the United States, upon a finding that the group is in hazardous financial condition or financially impaired condition.

Enacted by Chapter 258, 1992 General Session

31A-15-214. Severability.

If any provision of this part, or the application of any provision to any person or circumstances, is held invalid, the remainder of this part shall be given effect without the invalid provision or application.

Enacted by Chapter 258, 1992 General Session

31A-16-101. Scope and purpose of chapter.

(1) This chapter applies to all persons doing an insurance business in Utah.

(2) The purposes of this chapter include:

(a) 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;

(b) 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;

(c) controlling the payment of dividends that might affect the solidity of insurers; and

(d) providing, in appropriate cases, recoupment of dividends paid.

Enacted by Chapter 242, 1985 General Session

31A-16-103. Acquisition of control of or merger with domestic insurer.

(1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless, at the time any offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of securities if no offer or agreement is involved:

(i) the person files with the commissioner a statement containing the information required by this section;

(ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the insurer; and

(iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.

(b) Unless the person complies with Subsection (1)(a), a person other than the

issuer may not make a tender offer for, a request or invitation for tenders of, 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 acquisition, the person would directly, indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

(c) Unless the person complies with Subsection (1)(a), a person may not enter into an agreement to merge with or otherwise to acquire control of:

(i) a domestic insurer; or

(ii) any person controlling a domestic insurer.

(d) (i) For purposes of this section, a domestic insurer includes any person controlling a domestic insurer unless the person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance.

(ii) The controlling person described in Subsection (1)(d)(i) shall file with the commissioner a preacquisition notification containing the information required in Subsection (2) 30 calendar days before the proposed effective date of the acquisition.

(iii) For the purposes of this section, "person" does not include any securities broker that in the usual and customary brokers function holds less than 20% of:

(A) the voting securities of an insurance company; or

(B) any person that controls an insurance company.

(iv) This section applies to all domestic insurers and other entities licensed under Chapters 5, 7, 8, 9, and 11.

(e) (i) An agreement for acquisition of control or merger as contemplated by this Subsection (1) is not valid or enforceable unless the agreement:

(A) is in writing; and

(B) includes a provision that the agreement is subject to the approval of the commissioner upon the filing of any applicable statement required under this chapter.

(ii) A written agreement for acquisition or control that includes the provision described in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).

(2) The statement to be filed with the commissioner under Subsection (1) shall be made under oath or affirmation and shall contain the following information:

(a) the name and address of the "acquiring party," which means each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to be effected; and

(i) if the person is an individual:

(A) the person's principal occupation;

(B) a listing of all offices and positions held by the person during the past five years; and

(C) any conviction of crimes other than minor traffic violations during the past 10 years; and

(ii) if the person is not an individual:

(A) a report of the nature of its business operations during:

(I) the past five years; or

(II) for any lesser period as the person and any of its predecessors has been in existence;

(B) an informative description of the business intended to be done by the person

and the person's subsidiaries;

(C) a list of all individuals who are or who have been selected to become directors or executive officers of the person, or individuals who perform, or who will perform functions appropriate to such positions; and

(D) for each individual described in Subsection (2)(a)(ii)(C), the information required by Subsection (2)(a)(i) for each individual;

(b) (i) the source, nature, and amount of the consideration used or to be used in effecting the merger or acquisition of control;

(ii) a description of any transaction in which funds were or are to be obtained for the purpose of effecting the merger or acquisition of control, including any pledge of:

(A) the insurer's stock; or

(B) the stock of any of the insurer's subsidiaries or controlling affiliates; and

(iii) the identity of persons furnishing the consideration;

(c) (i) fully audited financial information, or other financial information considered acceptable by the commissioner, of the earnings and financial condition of each acquiring party for:

(A) the preceding five fiscal years of each acquiring party; or

(B) any lesser period the acquiring party and any of its predecessors shall have been in existence; and

(ii) unaudited information:

(A) similar to the information described in Subsection (2)(c)(i); and

(B) prepared within the 90 days prior to the filing of the statement;

(d) any plans or proposals which each acquiring party may have to:

(i) liquidate the insurer;

(ii) sell its assets;

(iii) merge or consolidate the insurer with any person; or

(iv) make any other material change in the insurer's:

(A) business;

(B) corporate structure; or

(C) management;

(e) (i) the number of shares of any security referred to in Subsection (1) that each acquiring party proposes to acquire;

(ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection (1); and

(iii) a statement as to the method by which the fairness of the proposal was arrived at;

(f) the amount of each class of any security referred to in Subsection (1) that:

(i) is beneficially owned; or

(ii) concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) a full description of any contract, arrangement, or understanding with respect to any security referred to in Subsection (1) in which any acquiring party is involved, including:

(i) the transfer of any of the securities;

(ii) joint ventures;

(iii) loan or option arrangements;

(iv) puts or calls;
(v) guarantees of loans;
(vi) guarantees against loss or guarantees of profits;
(vii) division of losses or profits; or
(viii) the giving or withholding of proxies;
(h) a description of the purchase by any acquiring party of any security referred to in Subsection (1) during the 12 calendar months preceding the filing of the statement including:
(i) the dates of purchase;
(ii) the names of the purchasers; and
(iii) the consideration paid or agreed to be paid for the purchase;
(i) a description of:
(i) any recommendations to purchase by any acquiring party any security referred to in Subsection (1) made during the 12 calendar months preceding the filing of the statement; or
(ii) any recommendations made by anyone based upon interviews or at the suggestion of the acquiring party;
(j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection (1); and
(ii) if distributed, copies of additional soliciting material relating to the transactions described in Subsection (2)(j)(i);
(k) (i) 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 (1) for tender; and
(ii) the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard to any agreement, contract, or understanding described in Subsection (2)(k)(i); and
(l) any additional information the commissioner requires by rule, which the commissioner determines to be:
(i) necessary or appropriate for the protection of policyholders of the insurer; or
(ii) in the public interest.
(3) The department may request:
(a) (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, from the Bureau of Criminal Identification; and
(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.
(b) Information obtained by the department from the review of criminal history records received under Subsection (3)(a) shall be used by the department for the purpose of:
(i) verifying the information in Subsection (2)(a)(i);
(ii) determining the integrity of persons who would control the operation of an insurer; and
(iii) preventing persons who violate 18 U.S.C. Sections 1033 and 1034 from engaging in the business of insurance in the state.
(c) If the department requests the criminal background information, the

department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(a)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(a)(ii); and

(iii) charge the person required to file the statement referred to in Subsection (1) a fee equal to the aggregate of Subsections (3)(c)(i) and (ii).

(4) (a) If the source of the consideration under Subsection (2)(b)(i) 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 so requests.

(b) (i) Under Subsection (2)(e), the commissioner may require a statement of the adjusted book value assigned by the acquiring party to each security in arriving at the terms of the offer.

(ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's proportional interest in the capital and surplus of the insurer with adjustments that reflect:

(A) market conditions;

(B) business in force; and

(C) other intangible assets or liabilities of the insurer.

(c) The description required by Subsection (2)(g) shall identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(5) (a) If the person required to file the statement referred to in Subsection (1) is a partnership, limited partnership, syndicate, or other group, the commissioner may require that all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:

(i) partner of the partnership or limited partnership;

(ii) member of the syndicate or group; and

(iii) person who controls the partner or member.

(b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation, or if the person required to file the statement referred to in Subsection (1) is a corporation, the commissioner may require that the information called for by Subsection (2) shall be given with respect to:

(i) the corporation;

(ii) each officer and director of the corporation; and

(iii) each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

(6) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to Subsection (2), 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 filing person learns of such change.

(7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection (1) is proposed to be made by means of a registration statement under the Securities Act of 1933, or under circumstances requiring the disclosure of similar

information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, a person required to file the statement referred to in Subsection (1) may use copies of any registration or disclosure documents in furnishing the information called for by the statement.

(8) (a) The commissioner shall approve any merger or other acquisition of control referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the commissioner finds that:

(i) after the change of control, the domestic insurer referred to in Subsection (1) 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;

(ii) the effect of the merger or other acquisition of control would:

(A) substantially lessen competition in insurance in this state; or

(B) tend to create a monopoly in insurance;

(iii) the financial condition of any acquiring party might:

(A) jeopardize the financial stability of the insurer; or

(B) prejudice the interest of:

(I) its policyholders; or

(II) any remaining securityholders who are unaffiliated with the acquiring party;

(iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection (1) are unfair and unreasonable to the securityholders of the insurer;

(v) 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:

(A) unfair and unreasonable to policyholders of the insurer; and

(B) not in the public interest; or

(vi) the competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of the policyholders of the insurer and the public to permit the merger or other acquisition of control.

(b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not be considered unfair if the adjusted book values under Subsection (2)(e):

(i) are disclosed to the securityholders; and

(ii) determined by the commissioner to be reasonable.

(9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days after the statement required by Subsection (1) is filed.

(b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the person filing the statement.

(ii) Affected parties may waive the notice required by this Subsection (9)(b).

(iii) Not less than seven days notice of the public hearing shall be given by the person filing the statement to:

(A) the insurer; and

(B) any person designated by the commissioner.

(c) The commissioner shall make a determination within 30 days after the conclusion of the hearing.

(d) 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

by the hearing may:

(i) present evidence;

(ii) examine and cross-examine witnesses; and

(iii) offer oral and written arguments.

(e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery proceedings in the same manner as is presently allowed in the district courts of this state.

(ii) All discovery proceedings shall be concluded not later than three days before the commencement of the public hearing.

(10) (a) The commissioner may retain technical experts to assist in reviewing all, or a portion of, information filed in connection with a proposed merger or other acquisition of control referred to in Subsection (1).

(b) In determining whether any of the conditions in Subsection (8) exist, the commissioner may consider the findings of technical experts employed to review applicable filings.

(c) (i) A technical expert employed under Subsection (10)(a) shall present to the commissioner a statement of all expenses incurred by the technical expert in conjunction with the technical expert's review of a proposed merger or other acquisition of control.

(ii) At the commissioner's direction the acquiring person shall compensate the technical expert at customary rates for time and expenses:

(A) necessarily incurred; and

(B) approved by the commissioner.

(iii) The acquiring person shall:

(A) certify the consolidated account of all charges and expenses incurred for the review by technical experts;

(B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A); and

(C) file with the department as a public record a copy of the consolidated account described in Subsection (10)(c)(iii)(A).

(11) (a) (i) If a domestic insurer proposes to merge into another insurer, any securityholder electing to exercise a right of dissent may file with the insurer a written request for payment of the adjusted book value given in the statement required by Subsection (1) and approved under Subsection (8), in return for the surrender of the security holder's securities.

(ii) The request described in Subsection (11)(a)(i) shall be filed not later than 10 days after the day of the securityholders' meeting where the corporate action is approved.

(b) The dissenting securityholder is entitled to and the insurer is required to pay to the dissenting securityholder the specified value within 60 days of receipt of the dissenting security holder's security.

(c) Persons electing under this Subsection (11) to receive cash for their securities waive the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter 10a, Part 13, Dissenters' Rights.

(d) (i) This Subsection (11) provides an elective procedure for dissenting securityholders to resolve their objections to the plan of merger.

(ii) This section does not restrict the rights of dissenting securityholders under Title 16, Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this Subsection (11).

(12) (a) All statements, amendments, or other material filed under Subsection (1), and all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its securityholders within five business days after the insurer has received the statements, amendments, other material, or notices.

(b) (i) Mailing expenses shall be paid by the person making the filing.

(ii) As security for the payment of mailing expenses, that person shall file with the commissioner an acceptable bond or other deposit in an amount determined by the commissioner.

(13) This section does not apply to any offer, request, invitation, agreement, or acquisition that the commissioner by order exempts from the requirements of this section 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) as otherwise not comprehended within the purposes of this section.

(14) The following are violations of this section:

(a) the failure to file any statement, amendment, or other material required to be filed pursuant to Subsections (1), (2), and (5); or

(b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger with a domestic insurer unless the commissioner has given the commissioner's approval to the acquisition or merger.

(15) (a) The courts of this state are vested with jurisdiction over:

(i) a person who:

(A) files a statement with the commissioner under this section; and

(B) is not resident, domiciled, or authorized to do business in this state; and

(ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a violation of this section.

(b) A person described in Subsection (15)(a) is considered to have performed acts equivalent to and constituting an appointment of the commissioner by that person, to be that person's lawful agent upon whom may be served all lawful process in any action, suit, or proceeding arising out of a violation of this section.

(c) A copy of a lawful process described in Subsection (15)(b) shall be:

(i) served on the commissioner; and

(ii) transmitted by registered or certified mail by the commissioner to the person at that person's last-known address.

Amended by Chapter 2, 2004 General Session

31A-16-105. Registration of insurers.

(1) (a) Every insurer which is authorized to do business in this state and which 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, if the requirements and standards are substantially similar to those contained in this section,

Subsections 31A-16-106(1)(a) and (2) and either Subsection 31A-16-106(1)(b) or a statutory provision similar to the following: "Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition."

(b) Any insurer which is subject to registration under this section shall register within 15 days after it becomes subject to registration, and annually thereafter by May 1 of each year for the previous calendar year, unless the commissioner for good cause extends the time for registration and then at the end of the extended time period. The commissioner may require any insurer authorized to do business in the state, which is a member of a holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in Subsection (3), or any other information filed by the insurer with the insurance regulatory authority of domiciliary jurisdiction.

(2) 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:

(a) the capital structure, general financial condition, and ownership and management of the insurer and any person controlling the insurer;

(b) the identity and relationship of every member of the insurance holding company system;

(c) any of the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:

(i) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of securities of the insurer by its affiliates;

(ii) purchases, sales, or exchanges of assets;

(iii) transactions not in the ordinary course of business;

(iv) 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;

(v) all management agreements, service contracts, and all cost-sharing arrangements;

(vi) reinsurance agreements;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

(d) 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

(e) any other matters concerning transactions between registered insurers and any affiliates as may be included in any subsequent registration forms adopted or approved by the commissioner.

(3) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(4) No information need be disclosed on the registration statement filed

pursuant to Subsection (2) 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 1%, or less, of an insurer's admitted assets as of the next preceding December 31 may not be considered material for purposes of this section.

(5) Any person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer if the information is reasonably necessary to enable the insurer to comply with the provisions of this chapter.

(6) The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(7) The commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement.

(8) The commissioner may allow an insurer which is authorized to do business in this state, and which is part of an insurance holding company system, to register on behalf of any affiliated insurer which is required to register under Subsection (1) and to file all information and material required to be filed under this section.

(9) The provisions of this section do not apply to any insurer, information, or transaction if, and to the extent that, the commissioner by rule or order exempts the insurer from the provisions of this section.

(10) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or a disclaimer of affiliation may be filed by any 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.

(11) The failure to file a registration statement or any summary of the registration statement required by this section within the time specified for the filing is a violation of this section.

Amended by Chapter 306, 2007 General Session

31A-16-106. Standards and management of an insurer within a holding company system.

(1) (a) Transactions within a holding company system to which an insurer subject to registration is a party are subject to the following standards:

(i) the terms shall be fair and reasonable;

(ii) charges or fees for services performed shall be reasonable;

(iii) expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(iv) 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 necessary to support the reasonableness of the charges or fees to the respective parties; and

(v) the insurer's surplus held for policyholders, following any dividends or distributions to shareholder affiliates, shall be reasonable in relation to the insurer's outstanding liabilities and shall be adequate to its financial needs.

(b) 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 30 days prior to entering into the transaction, or within any shorter period the commissioner may permit, if the commissioner has not disapproved the transaction within the period:

(i) sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments if the transactions are equal to, or exceed as of the next preceding December 31:

(A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus held for policyholders;

(B) for life insurers, 3% of the insurer's admitted assets;

(ii) loans or extensions of credit made to any person who is not an affiliate, if 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 if the transactions are equal to, or exceed as of the next preceding December 31:

(A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus held for policyholders;

(B) for life insurers, 3% of the insurer's admitted assets;

(iii) reinsurance agreements or modifications to reinsurance agreements in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds 5% of the insurer's surplus held for policyholders, as of the next preceding December 31, 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 the nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(iv) all management agreements, service contracts, and all cost-sharing arrangements;

(v) any material transactions, specified by rule, which the commissioner determines may adversely affect the interests of the insurer's policyholders; and

(vi) this subsection may not be interpreted to authorize or permit any transactions which would be otherwise contrary to law in the case of an insurer not a member of the same holding company system.

(c) 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 the separate transactions is to avoid the statutory threshold amount and thus to avoid the review by the commissioner that would occur otherwise. If the commissioner determines that the separate transactions were entered into over any 12 month period for such a purpose, he may exercise his authority under Section 31A-16-110.

(d) The commissioner, in reviewing transactions pursuant to Subsection (1)(b), shall consider whether the transactions comply with the standards set forth in Subsection (1)(a) and whether they may adversely affect the interests of policyholders.

(e) The commissioner shall be notified within 30 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 10% of the corporation's voting securities.

(2) (a) A domestic insurer may not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(i) 30 days after the commissioner has received notice of the declaration of the dividend and has not within the 30-day period disapproved the payment; or

(ii) the commissioner has approved the payment within the 30-day period.

(b) For purposes of this subsection, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, fair market value of which, together with that of other dividends or distributions made within the preceding 12 months, exceeds the lesser of:

(i) 10% of the insurer's surplus held for policyholders as of the next preceding December 31; or

(ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the next preceding December 31;

(iii) an extraordinary dividend does not include pro rata distributions of any class of the insurer's own securities.

(c) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution, which is conditioned upon the commissioner's approval of the dividend or distribution, 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 30-day period referred to in Subsection (2)(a).

(3) (a) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer may not be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this chapter.

(b) Nothing in this section precludes 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 (1)(a).

Amended by Chapter 324, 2010 General Session

31A-16-108. Examination of registered insurers.

(1) Subject to the limitation contained in this section and the powers which the commissioner has under Chapter 2 relating to the examination of insurers, the commissioner has the power to order any insurer registered under Section 31A-16-105 to produce the records, books, or other informational papers in the possession of the insurer or its affiliates which the commissioner considers necessary to ascertain the financial condition or legality of conduct of the insurer. If an insurer fails to comply with this order, the commissioner may examine the affiliates to obtain the information.

(2) The commissioner shall exercise his power under Subsection (1) only if the examination of the insurer under Chapter 2 is inadequate, or the interests of the policyholders of the insurer may be adversely affected if the commissioner fails to exercise his power.

(3) 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, if they are necessary to assist in the conduct of the examination under Subsection (1). Any persons so retained are under the direction and control of the commissioner and shall act in a purely advisory capacity.

(4) Each registered insurer who produces records, books, and papers under Subsection (1) for examination is liable for and shall pay the expense of the examination under Section 31A-2-205.

Enacted by Chapter 242, 1985 General Session

31A-16-109. Confidentiality of information obtained by commissioner.

All information, documents, and copies of these which are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made under Section 31A-16-108, and all information reported under Section 31A-16-105, is confidential. It is not subject to subpoena and may not be made public by the commissioner or any other person, except it may be provided to the insurance departments of other states, without the prior written consent of the insurer to which it pertains. The confidentiality of this section does not apply if the commissioner, after giving the insurer and its affiliates who would be affected by the disclosure, proper notice and an opportunity to be heard, and determines that the interests of policyholders, shareholders, or the public will be served by the publication of the information. In this situation, the commissioner may publish all or any part of the information in any manner he considers appropriate.

Amended by Chapter 91, 1987 General Session

31A-16-110. Enjoining violations -- Voting securities acquired in violation of law or rule.

(1) Whenever it appears to the commissioner that any insurer or any director, officer, employee, or agent of an insurer has committed or is about to commit a violation of this chapter or any rule or order issued by the commissioner under this chapter, the commissioner may apply to the district court of the county in which the principal office of the insurer is located, or if the insurer has no principal office in this state, then to the

Third District Court of Salt Lake County, for an order enjoining the insurer or a director, officer, employee, or agent of the insurer from the violation. The commissioner may also request other equitable relief which the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public require.

(2) 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 chapter or any rule or order issued by the commissioner under this chapter, may be voted at any shareholders' meeting, or may be counted for quorum purposes. Any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though those securities were not issued and outstanding. However, no action taken at that shareholders' meeting is invalidated by the voting of those securities, unless the action would materially affect control of the insurer or unless the district court has ordered that voting invalidates the action. 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 chapter or any rule or order issued by the commissioner under this chapter, the insurer or the commissioner may apply to the Third District Court of Salt Lake County or to the district court for the county in which the insurer has its principal place of business, to enjoin any offer, request, invitation, or agreement of acquisition which is made in contravention of Section 31A-16-103 or any rule or order issued by the commissioner under this chapter to enjoin the voting of that acquired security. This court order may also void any vote of that security if the vote has already been cast at any meeting of shareholders, and the court may grant other equitable relief which the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public require.

(3) Upon the application of the insurer or the commissioner, if a person has acquired or is proposing to acquire any voting securities in violation of this chapter or of any rule or order issued by the commissioner under this chapter, the Third District Court of Salt Lake County or the district court for the county in which the insurer has its principal place of business may, upon the notice which the court deems appropriate, seize or sequester any voting securities of the insurer owned directly or indirectly by that person, and issue orders with respect to that person and those securities which the court considers appropriate to effectuate the provisions of this chapter. For the purposes of this chapter, the situs of the ownership of the securities of domestic insurers is considered to be in this state.

Amended by Chapter 204, 1986 General Session

31A-16-111. Required sale of improperly acquired stock -- Penalties.

(1) If the commissioner finds that the acquiring person has not substantially complied with the requirements of this chapter in acquiring control of a domestic insurer, the commissioner may require the acquiring person to sell the acquiring person's stock of the domestic insurer in the manner specified in Subsection (2).

(2) (a) The commissioner shall effect the sale required by Subsection (1) in the manner which, under the particular circumstances, appears most likely to result in the payment of the full market value for the stock by persons who have the collective competence, experience, financial resources, and integrity to obtain approval under

Subsection 31A-16-103(8).

(b) Sales made under this section are subject to approval by the Third Judicial District Court for Salt Lake County, which court has the authority to effect the terms of the sale.

(3) The proceeds from sales made under this section shall be distributed first to the person required by this section to sell the stock, but only up to the amount originally paid by the person for the securities. Additional sale proceeds shall be paid to the General Fund.

(4) The person required to sell and persons related to or affiliated with the seller may not purchase the stock at the sale conducted under this section.

(5) (a) A director or officer of an insurance holding company system violates this chapter if the director or officer knowingly:

(i) participates in or assents to a transaction or investment that:

(A) has not been properly reported or submitted pursuant to:

(I) Subsections 31A-16-105(1) and (2); or

(II) Subsection 31A-16-106(1)(b); or

(B) otherwise violates this chapter; or

(ii) permits any of the officers or agents of the insurer to engage in a transaction or investment described in Subsection (5)(a)(i).

(b) A director or officer in violation of Subsection (5)(a) shall pay, in the director's or officer's individual capacity, a civil penalty of not more than $20,000 per violation:

(i) upon a finding by the commissioner of a violation; and

(ii) after notice and hearing before the commissioner.

(c) In determining the amount of the civil penalty under Subsection (5)(b), the commissioner shall take into account:

(i) the appropriateness of the penalty with respect to the gravity of the violation;

(ii) the history of previous violations; and

(iii) any other matters that justice requires.

(6) (a) When it appears to the commissioner that any insurer or any director, officer, employee, or agent of the insurer, has committed a willful violation of this chapter, the commissioner may cause criminal proceedings to be instituted:

(i) (A) in the district court for the county in this state in which the principal office of the insurer is located; or

(B) if the insurer has no principal office in this state, in the Third District Court for Salt Lake County; and

(ii) against the insurer or the responsible director, officer, employee, or agent of the insurer.

(b) (i) An insurer that willfully violates this chapter may be fined not more than $20,000. (ii) Any individual who willfully violates this chapter is guilty of a third degree felony, and upon conviction may be:

(A) fined in that person's individual capacity not more than $5,000;

(B) imprisoned; or

(C) both fined and imprisoned.

(7) This section does not limit the other sanctions applicable to violations of this title under Section 31A-2-308.

Amended by Chapter 114, 2000 General Session

31A-17-101. Scope.

Except as otherwise provided under this code, this chapter and the rules adopted to implement it apply to all insurers, including reinsurers, authorized to do business in this state.

Enacted by Chapter 242, 1985 General Session

31A-17-102. Standards for accounting rules.

When adopting accounting rules, the commissioner shall consider recommendations made by the National Association of Insurance Commissioners. Accounting rules shall follow generally accepted accounting principles, except as modified by statutory insurance accounting principles.

Enacted by Chapter 242, 1985 General Session

31A-17-201. Qualified assets.

(1) Except as provided under Subsections (3) and (4), only the qualified assets listed in Subsection (2) may be used in determining the financial condition of an insurer, except to the extent an insurer has shown to the commissioner that the insurer has excess surplus, as defined in Section 31A-1-301.

(2) For purposes of Subsection (1), "qualified assets" means:

(a) any of the following acquired or held in accordance with Sections 31A-18-105 and 31A-18-106:

(i) an investment;

(ii) a security;

(iii) property; or

(iv) a loan;

(b) the income due and accrued on an asset listed in Subsection (2)(a);

(c) assets other than an asset listed in Subsection (2)(a) that are determined to be admitted in the Accounting Practices and Procedures Manual, published by the National Association of Insurance Commissioners; and

(d) other assets authorized by the commissioner by rule.

(3) (a) Subject to Subsection (5) and even if the assets could not otherwise be counted under this chapter, assets acquired in the bona fide enforcement of creditors' rights may be counted for the purposes of Subsection (1) and Sections 31A-18-105 and 31A-18-106:

(i) for five years after the acquisition of the assets if the assets are real property; and

(ii) for one year if the assets are not real property.

(b) (i) The commissioner may allow reasonable extensions of the periods described in Subsection (3)(a), if disposal of the assets within the periods given is not possible without substantial loss.

(ii) Extensions under Subsection (3)(b)(i) may not, as to any particular asset, exceed a total of five years.

(4) Subject to Subsection (5), and even though under this chapter the assets could not otherwise be counted, assets acquired in connection with mergers, consolidations, or bulk reinsurance, or as a dividend or distribution of assets, may be counted for the same purposes, in the same manner, and for the same periods as assets acquired under Subsection (3).

(5) Assets described under Subsection (3) or (4) may not be counted for the purposes of Subsection (1), except to the extent they are counted as assets in determining insurer solvency under the laws of the state of domicile of the creditor or acquired insurer.

Amended by Chapter 252, 2003 General Session

31A-17-202. Status of assets that are not "qualified assets."

(1) (a) Except as provided in Subsection (1)(b), if an insurer owns assets that are not qualified assets under Section 31A-17-201, the assets shall be disregarded in determining and reporting the financial condition of the insurer.

(b) An insurer may invest its funds in investments that are permitted under Section 31A-18-105 but in excess of the limits under Sections 31A-18-103 and 31A-18-106 or other assets approved by the commissioner and these assets may be recognized and reported in the financial condition of the insurer to the extent the insurer has excess surplus, as defined under Section 31A-1-301.

(2) Insurers bear the burden of establishing the extent to which they have excess surplus.

Amended by Chapter 131, 1999 General Session

31A-17-203. Encumbering of assets.

(1) No domestic insurer may pledge, hypothecate, or otherwise encumber its assets to secure the debt, guaranty, or obligation of any other person. This prohibition does not apply to obligations of the insurer under surety bonds or insurance contracts issued in the regular course of business.

(2) No domestic insurer may pledge, hypothecate, or otherwise encumber its assets in an amount in excess of the amount of its capital and surplus, without the prior written consent of the commissioner.

(3) The commissioner may grant a domestic insurer an exception to Subsection (2) for a reinsurance agreement which may cause assets of the domestic insurer to be held, deposited, pledged, hypothecated, or otherwise encumbered in an amount in excess of capital and surplus to secure, offset, protect, or meet reserves or liabilities of the insurer that are established, incurred, or required under the provisions of the reinsurance agreement. The domestic insurer shall first file with the commissioner a written request for this exception, accompanied by a copy of the proposed reinsurance agreement and specifically stating its purpose and the reasons the exception should be granted.

(4) Any person that accepts a pledge, hypothecation, or encumbrance of any asset of an insurer not in accordance with the terms and limitations of this section is considered to have accepted that asset subject to a superior, preferential, and

perfected lien in favor of owners, beneficiaries, assignees, certificate holders, or third party claimants or beneficiaries of any insurance benefit or right arising out of and within the coverage of any insurance policy issued by the insurer. The commissioner may bring or participate in an action in any court of competent jurisdiction to protect the interests of insureds or claimants under this section.

Enacted by Chapter 204, 1986 General Session

31A-17-401. Valuation of assets.

(1) The commissioner shall value the assets of insurers in accordance with then current insurance business practices, but not in a manner inconsistent with the provisions of this title. In valuing assets, the commissioner shall consider any method then current, formulated, or approved by the National Association of Insurance Commissioners.

(2) Assets that are not qualified assets under Subsection 31A-17-201(2) are considered to have no value in evaluating an insurer's compliance with Chapter 17, Part 6, Risk-Based Capital. Those assets may be used in evaluating the insurer's financial condition only to the extent the insurer has excess surplus.

(3) (a) Insurance subsidiaries are valued on the books of a parent insurer as follows:

(i) Except as provided under Subsections (3)(a)(iii) and (iv), common stock of the subsidiary is valued on the basis of the parent insurer's percentage of ownership of the common stock multiplied by the total of the subsidiary's capital and surplus, less amounts needed to liquidate all claims to the capital and surplus which are senior to common stock. Subsection 31A-18-106(1)(k) provides applicable limitations on investments in subsidiaries.

(ii) The value of securities other than common stock issued by a subsidiary is the lesser of the present value of the future income to be derived under the securities or the amount the parent insurer would receive as a result of the securities if the subsidiary were liquidated and all creditors of the subsidiary and holders of the subsidiary's securities with senior priority were paid in full. The present value of future income derived from securities is determined by rule adopted by the commissioner. A parent insurer may attribute value to a security of its subsidiary only if the parent insurer is being paid dividends or interest on the security, and only if the parent insurer can reasonably anticipate that dividends or interest will continue to be paid on the security.

(iii) Except as provided under Subsection (3)(a)(iv), any portion of the subsidiary's value permitted under Subsection (3)(a) that is represented by assets other than assets listed under Section 31A-17-201, may only be classified as excess surplus of the parent insurer, and then only to the extent the parent insurer has established that it has excess surplus under Section 31A-17-202.

(iv) For the purposes of Subsection (3)(a)(iii), assets of a newly acquired subsidiary that are the equivalent of qualified assets in the subsidiary's domiciliary state, are, for the first five years after the subsidiary's acquisition, considered to be qualified assets under Section 31A-17-201. This assumption stands even if the assets are not otherwise qualified assets under Section 31A-17-201.

(b) A subsidiary formed or acquired to hold or manage investments that the

parent insurance company might hold or manage directly, shall be valued as if the assets of the subsidiary were owned directly by the insurer in a percentage equal to the insurer's percentage of ownership of the subsidiary. The subsidiary investment limitation of Subsection 31A-18-106(1)(k) does not apply to these subsidiaries.

(c) Subsidiaries other than those described in Subsections (3)(a) and (b) shall be valued in accordance with Subsection (1). The subsidiary investment limitation under Subsection 31A-18-106(1)(k) applies to these subsidiaries in the same manner as to subsidiaries described in Subsection (3)(a).

(d) In determining an insurer's financial condition, no value is given to:

(i) any interest held by the insurer in its own stock, including debts due the insurer that are secured by the insurer's own stock; or

(ii) any proportionate interest in the insurer's own stock, including debts that are secured by the insurer's own stock, which is held by any corporation, partnership, business unit, firm, or person owned in whole or in part by the insurer.

(4) The commissioner shall adopt rules to implement the provisions of this section.

Amended by Chapter 116, 2001 General Session

31A-17-402. Valuation of liabilities.

(1) Subject to this section, the commissioner shall make rules:

(a) specifying the liabilities required to be reported by an insurer in a financial statement submitted under Section 31A-2-202; and

(b) the methods of valuing the liabilities described in Subsection (1)(a).

(2) For life insurance, the methods of valuing specified pursuant to Subsection (1)(b) shall be consistent with Part 5, Standard Valuation Law.

(3) Title insurance reserves are provided for under Section 31A-17-408.

(4) In determining the financial condition of an insurer, liabilities include:

(a) the estimated amount necessary to pay:

(i) all the insurer's unpaid losses and claims incurred on or before the date of statement, whether reported or unreported; and

(ii) the expense of adjustment or settlement of a loss or claim described in this Subsection (4)(a);

(b) for life, accident and health insurance, and annuity contracts:

(i) the reserves on life insurance policies and annuity contracts in force, valued according to appropriate tables of mortality and the applicable rates of interest;

(ii) the reserves for accident and health benefits, for both active and disabled lives;

(iii) the reserves for accidental death benefits; and

(iv) any additional reserves:

(A) that may be required by the commissioner by rule; or

(B) if no rule is applicable under Subsection (4)(b)(iv)(A), in a manner consistent with the practice formulated or approved by the National Association of Insurance Commissioners with respect to those types of insurance;

(c) subject to Subsection (6), for insurance other than life, accident and health, and title insurance, the amount of reserves equal to the unearned portions of the gross

premiums charged on policies in force, computed:

(i) on a daily or monthly pro rata basis; or

(ii) other basis approved by the commissioner;

(d) for ocean marine and other transportation insurance, reserves:

(i) equal to 50% of the amount of premiums upon risks covering not more than one trip or passage not terminated; and

(ii) computed:

(A) upon a pro rata basis; or

(B) with the commissioner's consent, in accordance with a method provided under Subsection (4)(c); and

(e) the insurer's other liabilities due or accrued at the date of statement including:

(i) taxes;

(ii) expenses; and

(iii) other obligations.

(5) (a) Except to the extent provided in Subsection (5)(b), in determining the financial condition of an insurer of workers' compensation insurance, the insurer's liabilities do not include any liability based on the liability of the Employer's Reinsurance Fund under Section 34A-2-702 for industrial accidents or occupational diseases occurring on or before June 30, 1994.

(b) Notwithstanding Subsection (5)(a), the liability of an insurer of workers' compensation insurance includes any premium assessment:

(i) imposed under Section 59-9-101; and

(ii) due at the date of statement.

(6) After adopting a method for computing the reserves described in Subsection (4)(c), an insurer may not change the method without the commissioner's written consent.

Amended by Chapter 306, 2007 General Session

31A-17-404. Credit allowed a domestic ceding insurer against reserves for reinsurance.

(1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), or (7), subject to the following:

(a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a kind or class of business that the assuming insurer is licensed or otherwise permitted to write or assume:

(i) in its state of domicile; or

(ii) in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

(b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of Subsection (8) are met.

(2) A domestic ceding insurer is allowed credit for reinsurance ceded:

(a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;

(b) only to the extent that the accounting:
(i) is consistent with the terms of the reinsurance contract; and
(ii) clearly reflects:
(A) the amount and nature of risk transferred; and
(B) liability, including contingent liability, of the ceding insurer;
(c) only to the extent the reinsurance contract shifts insurance policy risk from the ceding insurer to the assuming reinsurer in fact and not merely in form; and
(d) only if the reinsurance contract contains a provision placing on the reinsurer the credit risk of all dealings with intermediaries regarding the reinsurance contract.
(3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.
(4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state.
(b) An insurer is accredited as a reinsurer if the insurer:
(i) files with the commissioner evidence of the insurer's submission to this state's jurisdiction;
(ii) submits to the commissioner's authority to examine the insurer's books and records;
(iii) (A) is licensed to transact insurance or reinsurance in at least one state; or
(B) in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;
(iv) files annually with the commissioner a copy of the insurer's:
(A) annual statement filed with the insurance department of its state of domicile; and
(B) most recent audited financial statement; and
(v) (A) (I) has not had its accreditation denied by the commissioner within 90 days of the day on which the insurer submits the information required by this Subsection (4); and
(II) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; or
(B) (I) has its accreditation approved by the commissioner; and
(II) maintains a surplus with regard to policyholders in an amount less than $20,000,000.
(c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation is revoked by the commissioner after a notice and hearing.
(5) (a) A domestic ceding insurer is allowed a credit if:
(i) the reinsurance is ceded to an assuming insurer that is:
(A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or
(B) in the case of a United States branch of an alien assuming insurer, is entered through a state meeting the requirements of Subsection (5)(a)(ii);
(ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for reinsurance substantially similar to those applicable under this section; and
(iii) the assuming insurer or United States branch of an alien assuming insurer:
(A) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; and
(B) submits to the authority of the commissioner to examine its books and

records.

(b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

(6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund:

(i) created in accordance with rules made by the commissioner; and

(ii) in a qualified United States financial institution for the payment of a valid claim of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; and

(C) a successor in interest to the United States ceding insurer.

(b) To enable the commissioner to determine the sufficiency of the trust fund described in Subsection (6)(a), the assuming insurer shall:

(i) report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by a licensed insurer; and

(ii) (A) submit to examination of its books and records by the commissioner; and

(B) pay the cost of an examination.

(c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the form of the trust and any amendment to the trust is approved by:

(A) the commissioner of the state where the trust is domiciled; or

(B) the commissioner of another state who, pursuant to the terms of the trust instrument, accepts principal regulatory oversight of the trust.

(ii) The form of the trust and an amendment to the trust shall be filed with the commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.

(iii) The trust instrument shall provide that a contested claim is valid and enforceable upon the final order of a court of competent jurisdiction in the United States.

(iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; or

(C) a successor in interest to the United States ceding insurer.

(v) The trust and the assuming insurer are subject to examination as determined by the commissioner.

(vi) The trust shall remain in effect for as long as the assuming insurer has an outstanding obligation due under a reinsurance agreement subject to the trust.

(vii) No later than February 28 of each year, the trustee of the trust shall:

(A) report to the commissioner in writing the balance of the trust;

(B) list the trust's investments at the end of the preceding calendar year; and

(C) (I) certify the date of termination of the trust, if so planned; or

(II) certify that the trust will not expire prior to the following December 31.

(d) The following requirements apply to the following categories of assuming insurer:

(i) For a single assuming insurer:

(A) the trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and

(B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000.

(ii) For a group acting as assuming insurer, including incorporated and individual unincorporated underwriters:

(A) for reinsurance ceded under a reinsurance agreement with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group;

(B) for reinsurance ceded under a reinsurance agreement with an inception date on or before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the other provisions of this chapter, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States;

(C) in addition to a trust described in Subsection (6)(d)(ii)(A) or (B), the group shall maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group for all years of account;

(D) the incorporated members of the group:

(I) may not be engaged in a business other than underwriting as a member of the group; and

(II) are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner:

(I) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(II) if a certification is unavailable, a financial statement, prepared by an independent public accountant, of each underwriter member of the group.

(iii) For a group of incorporated underwriters under common administration, the group shall:

(A) have continuously transacted an insurance business outside the United States for at least three years immediately preceding the day on which the group makes application for accreditation;

(B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

(C) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group pursuant to a reinsurance contract issued in the name of the group;

(D) in addition to complying with the other provisions of this Subsection (6)(d)(iii), maintain a joint trusteed surplus of which $100,000,000 is held jointly for the

benefit of the one or more United States domiciled ceding insurers of a member of the group as additional security for these liabilities; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner:

(I) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and

(II) a financial statement of each underwriter member of the group prepared by an independent public accountant.

(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) Reinsurance credit may not be allowed a domestic ceding insurer unless the assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

(a) (i) being an admitted insurer; and

(ii) submitting to jurisdiction under Section 31A-2-309;

(b) having irrevocably appointed the commissioner as the domestic ceding insurer's agent for service of process in an action arising out of or in connection with the reinsurance, which appointment is made under Section 31A-2-309; or

(c) agreeing in the reinsurance contract:

(i) that if the assuming insurer fails to perform its obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of a court of competent jurisdiction in a state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of an appellate court in the event of an appeal; and

(ii) to designate the commissioner or a specific attorney licensed to practice law in this state as its attorney upon whom may be served lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding company.

(9) Submitting to the jurisdiction of Utah courts under Subsection (8) does not override a duty or right of a party under the reinsurance contract, including a requirement that the parties arbitrate their disputes.

(10) If an assuming insurer does not meet the requirements of Subsection (3), (4), or (5), the credit permitted by Subsection (6) may not be allowed unless the assuming insurer agrees in the trust instrument to the following conditions:

(a) (i) Notwithstanding any other provision in the trust instrument, if an event described in Subsection (10)(a)(ii) occurs the trustee shall comply with:

(A) an order of the commissioner with regulatory oversight over the trust; or

(B) an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(ii) This Subsection (10)(a) applies if:

(A) the trust fund is inadequate because the trust contains an amount less than

the amount required by Subsection (6)(d); or

(B) the grantor of the trust is:

(I) declared insolvent; or

(II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the laws of its state or country of domicile.

(b) The assets of a trust fund described in Subsection (10)(a) shall be distributed by and a claim shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of a domestic insurance company.

(c) If the commissioner with regulatory oversight determines that the assets of the trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust instrument.

(d) A grantor shall waive any right otherwise available to it under United States law that is inconsistent with this Subsection (10).

Amended by Chapter 257, 2008 General Session

31A-17-404.1. Asset or reduction from liability for reinsurance ceded by a domestic insurer to other assuming insurers.

(1) (a) An asset or a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer that does not meet the requirements of Section 31A-17-404 is allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) A reduction described in Subsection (1)(a) shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(i) that are held:

(A) under a reinsurance contract with the assuming insurer; and

(B) as security for the payment of obligations under the reinsurance contract; and

(ii) if the security is held:

(A) in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(B) in the case of a trust, in a qualified United States financial institution.

(2) Security described in Subsection (1) may be in the form of:

(a) cash;

(b) a security:

(i) listed by the Securities Valuation Office of the National Association of Insurance Commissioners; and

(ii) qualifying as an admitted asset;

(c) subject to Subsection (3), a clean, irrevocable, unconditional letter of credit, issued or confirmed by a qualified United States financial institution:

(i) effective no later than December 31 of the year for which the filing is being made; and

(ii) in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or

(d) another form of security acceptable to the commissioner.

(3) Notwithstanding an issuing or confirming institution's subsequent failure to meet an applicable standard of acceptability, a letter of credit described in Subsection (2) that meets the applicable standards of issuer acceptability as of the day on which it is issued or confirmed shall continue to be acceptable as security until the sooner of the day on which the letter of credit expires, is extended, is renewed, is modified, or is amended.

Enacted by Chapter 257, 2008 General Session

31A-17-404.2. Credit allowed a foreign ceding insurer.

(1) A foreign ceding insurer is allowed a credit for reinsurance or reduction from liability to the extent that credit is allowed by the ceding insurer's state of domicile if:

(a) the state of domicile is accredited by the National Association of Insurance Commissioners; or

(b) credit or reduction from liability would be allowed under this section if the foreign ceding insurer were domiciled in this state.

(2) Credit for reinsurance or reduction from liability may be disallowed a foreign ceding insurer upon a finding by the commissioner that one or more of the following do not satisfy the credit for reinsurance requirements of this chapter applicable to a ceding insurer domiciled in this state:

(a) the condition of the reinsurer; or

(b) the collateral or other security provided by the reinsurer.

Enacted by Chapter 257, 2008 General Session

31A-17-404.3. Rules.

In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and this chapter, the commissioner may make rules prescribing:

(1) the form of a letter of credit required under this chapter;

(2) the requirements for a trust or trust instrument required by this chapter;

(3) the procedures for licensing and accrediting; and

(4) minimum capital and surplus requirements.

Enacted by Chapter 257, 2008 General Session

31A-17-404.4. Transition -- Application to reinsurance agreement.

The amendments to this part made in Laws of Utah 2008, Chapter 257, apply to a cession made on or after July 1, 2008 under a reinsurance contract that has an inception, anniversary, or renewal date no sooner than January 1, 2009.

Enacted by Chapter 257, 2008 General Session

31A-17-405. Fraternal rates and reserves.

(1) A fraternal may be organized for the transaction of business on a plan set forth in the contract which provides for sufficient contributions by each member each year to pay the member's share of the actual death claims of the year, through advance payments graded according to a mortality table approved by the commissioner, without any reserve, or with a reserve which may accumulate from overpayments of individual members. If this type of reserve does accumulate, each member shall be informed each year of the member's credit and of the cost of the member's insurance.

(2) Each fraternal shall collect regular premiums for each coverage it provides at adequate rates that are approved by the commissioner or conform to standards set by rules adopted by the commissioner.

(3) The reserves of a fraternal are subject to the same requirements as those of Chapter 5 insurers writing the same coverages, except that the commissioner may authorize the use of suitable fraternal mortality tables or other appropriate tables instead of the tables used by Chapter 5 insurers.

Enacted by Chapter 242, 1985 General Session

31A-17-406. Adjustment of reserves.

The commissioner may order an insurer to adjust its reserves so the reserves bear a reasonable actuarial relationship to the insurer's obligations.

Enacted by Chapter 242, 1985 General Session

31A-17-407. Accounting for repurchased shares.

When a corporation acquires its own shares under Section 31A-5-306 or in any other way, the acquired shares are accounted as a deduction from capital and not as assets.

Enacted by Chapter 242, 1985 General Session

31A-17-408. Title insurance reserves.

(1) In addition to an adequate reserve for outstanding losses, a title insurance company shall either:

(a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for each $1,000 face amount of retained liability under each title insurance contract or policy on a single insurance risk issued; or

(b) have the commissioner review and approve a contract of reinsurance applicable to the title insurance company's policies, which contract adequately covers the exposure or risk which the unearned premium reserve would serve.

(2) The fund shall be maintained for the protection of policyholders and is not subject to the claims of stockholders or creditors other than policyholders.

Amended by Chapter 116, 2001 General Session

31A-17-501. Standard Valuation Law.

This part is known as the "Standard Valuation Law."

Enacted by Chapter 305, 1993 General Session

31A-17-502. Reserve valuation.

The commissioner shall annually value, or cause to be valued, the reserve liabilities (also called "reserves" in this part) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state, and 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 other) used in the calculation of such reserves. In calculating such reserves, he may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required in this part of any foreign or alien company, he may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard provided in this part, and if the official of such state or jurisdiction accepts as sufficient and for all valid legal purposes the certificate of valuation of the commissioner when such certificate 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.

Enacted by Chapter 305, 1993 General Session

31A-17-503. Actuarial opinion of reserves.

(1) This section becomes operative on December 31, 1993.

(2) General: Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered to be necessary to its scope.

(3) Actuarial analysis of reserves and assets supporting reserves:

(a) Every life insurance company, except as exempted by or pursuant to rule, shall also annually include in the opinion required by Subsection (2), an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including the benefits under the expenses associated with the policies and contracts.

(b) The commissioner may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may consider necessary in order to render the opinion required by this section.

(4) Requirement for opinion under Subsection (3): Each opinion required by Subsection (3) shall be governed by the following provisions:

(a) A memorandum, in form and substance acceptable to the commissioner as specified by rule, shall be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rule or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(5) Requirement for all opinions: Every opinion shall be governed by the following provisions:

(a) The opinion shall be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1993.

(b) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(c) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by rule prescribe.

(d) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(e) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth by department rule.

(f) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(g) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in rules by the commissioner.

(h) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, are considered protected records under Section 63G-2-305 and may not be made public and are not subject to subpoena under Subsection 63G-2-202(7), other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or rules promulgated under this section. However, the memorandum or other material may otherwise be released by the commissioner (i) with the written consent of the company or (ii) to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of

the confidential memorandum is cited in its marketing or is cited before any governmental agency other than the department or is released to the news media, all portions of the memorandum are no longer confidential.

Amended by Chapter 297, 2011 General Session

31A-17-504. Computation of minimum standard.

Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of all life insurance policies and annuity and pure endowment contracts issued prior to January 1, 1994, shall be that provided by the laws in effect immediately prior to that date. Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of all such policies and contracts issued on or after January 1, 1994, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-513, 3.5% interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after June 1, 1973, 4% interest for such policies issued prior to April 2, 1980, 5.5% interest for single premium life insurance policies, and 4.5% interest for all other such policies issued on and after April 2, 1980, and the following tables:

(1) For all ordinary policies of life insurance issued on the standard basis, excluding any accident and health and accidental death benefits in such policies: the National Association of Insurance Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the operative date of Subsection 31A-22-408(6)(a) (that is, the Standard Nonforfeiture Law for Life Insurance), the National Association of Insurance Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after the operative date of Subsection 31A-22-408(6)(a) and prior to the operative date of Subsection 31A-22-408(6)(d), 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 Subsection 31A-22-408(6)(d):

(a) the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table;

(b) at the election of the company for any one or more specified plans of life insurance, the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(c) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(2) For all industrial life insurance policies issued on the standard basis, excluding any accident and health and accidental death benefits in such policies: the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of Subsection 31A-22-408(6)(c), and for such policies issued on or after such operative date, the National Association of Insurance 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 rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(3) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies:

(a) the 1937 Standard Annuity Mortality Table;

(b) at the option of the company, the Annuity Mortality Table for 1949, Ultimate; or

(c) any modification of either of these tables approved by the commissioner.

(4) For group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits in such policies:

(a) the Group Annuity Mortality Table for 1951, any modification of such table approved by the commissioner; or

(b) at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued on or after January 1, 1966, 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 rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(6) For accidental death benefits in or supplementary to policies issued on or after January 1, 1966, 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 rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, 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 for calculating the reserves for life insurance policies.

(7) For group life insurance, life insurance issued on the substandard basis and other special benefits: such tables as may be approved by the commissioner.

Amended by Chapter 116, 2001 General Session

31A-17-505. Computation of minimum standard for annuities.

(1) Except as provided in Section 31A-17-506, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this section, as defined in Subsection (2), and for all annuities and

pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507 and 31A-17-508 and the following tables and interest rates:

(a) for individual annuity and pure endowment contracts issued prior to April 2, 1980, excluding any accident and health and accidental death benefits in the contracts:

(i) (A) the 1971 Individual Annuity Mortality Table; or

(B) any modification of the 1971 Individual Annuity Mortality Table approved by the commissioner;

(ii) 6% interest for single premium immediate annuity contracts; and

(iii) 4% interest for all other individual annuity and pure endowment contracts;

(b) for individual single premium immediate annuity contracts issued on or after April 2, 1980, excluding any accident and health and accidental death benefits in the contracts:

(i) (A) any individual annuity mortality table that is approved by rule by the commissioner for use in determining the minimum standard of valuation for such contracts; or

(B) any modification of a table described in Subsection (1)(b)(i)(A) approved by the commissioner; and

(ii) 7.5% interest;

(c) for individual annuity and pure endowment contracts issued on or after April 2, 1980, other than single premium immediate annuity contracts, excluding any accident and health and accidental death benefits in the contracts:

(i) (A) any individual annuity mortality table that is approved by rule by the commissioner for use in determining the minimum standard of valuation for such contracts; or

(B) any modification of a table described in Subsection (1)(c)(i)(A) approved by the commissioner;

(ii) 5.5% interest for single premium deferred annuity and pure endowment contracts; and

(iii) 4.5% interest for all other such individual annuity and pure endowment contracts;

(d) for all annuities and pure endowments purchased prior to April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under the contracts:

(i) (A) the 1971 Group Annuity Mortality Table; or

(B) any modification of the 1971 Group Annuity Mortality Table approved by the commissioner; and

(ii) 6.5% interest; and

(e) for all annuities and pure endowments purchased on or after April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under the contracts:

(i) (A) any group annuity mortality table that is approved by rule by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments; or

(B) any modification of a table described in Subsection (1)(e)(i)(A) approved by

the commissioner; and

(ii) 7.5% interest.

(2) (a) After June 1, 1973, any company may file with the commissioner a written notice of its election to comply with this section after a specified date before January 1, 1979, which shall be the operative date of this section for the company.

(b) If a company does not make an election under Subsection (2)(a), the operative date of this section for the company shall be January 1, 1979.

Amended by Chapter 308, 2002 General Session

31A-17-506. Computation of minimum standard by calendar year of issue.

(1) Applicability of Section 31A-17-506: The interest rates used in determining the minimum standard for the valuation shall be the calendar year statutory valuation interest rates as defined in this section for:

(a) all life insurance policies issued in a particular calendar year, on or after the operative date of Subsection 31A-22-408(6)(d);

(b) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(c) all annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts.

(2) Calendar year statutory valuation interest rates:

(a) The calendar year statutory valuation interest rates, "I," shall be determined as follows and the results rounded to the nearer 1/4 of 1%:

(i) for life insurance:

$I = .03 + W(R1 - .03) + (W/2)(R2 - .09)$;

(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 R1 is the lesser of R and .09,

R2 is the greater of R and .09,

R is the reference interest rate defined in Subsection (4), and

W is the weighting factor defined in this section;

(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 Subsection (2)(a)(ii), the formula for life insurance stated in Subsection (2)(a)(i) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the formula for single premium immediate annuities stated in Subsection (2)(a)(ii) shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 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 Subsection (2)(a)(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 Subsection (2)(a)(ii) shall apply.

(b) 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 1% 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 in 1979, and shall be determined for each subsequent calendar year regardless of when Subsection 31A-22-408(6)(d) becomes operative.

(3) Weighting factors:

(a) The weighting factors referred to in the formulas stated in Subsection (2) are given in the following tables:

(i) (A) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less:	.50
More than 10, but less than 20:	.45
More than 20:	.35

(B) 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 Subsection (3)(a)(ii), shall be as specified in the tables in Subsections (3)(a)(iii)(A), (B), and (C), according to the rules and definitions in Subsection (3)(b):

(A) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factors 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

Plan Type

	A	B	C

(B) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in Subsection (3)(a)(iii)(A) increased by:

	.15	.25	.05

Plan Type

	A	B	C

(C) 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 12 months beyond the valuation date, the factors shown in Subsection (3)(a)(iii)(A) or derived in Subsection (3)(a)(iii)(B) increased by: .05 .05 .05.

(b) (i) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(ii) Plan type as used in the above tables is defined as follows:

(A) Plan Type A: At any time policyholder may withdraw funds only:

(I) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(II) without such adjustment but installments over five years or more;

(III) as an immediate life annuity; or

(IV) no withdrawal permitted.

(B) (I) Plan Type B: Before expiration of the interest rate guarantee, policyholder withdraw funds only:

(Aa) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(Bb) without such adjustment but in installments over five years or more; or

(Cc) no withdrawal permitted.

(II) 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.

(C) 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:

(I) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or

(II) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(iii) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options shall be valued on an issue year basis. As used in this 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.

(4) Reference interest rate: "Reference interest rate" referred to in Subsection (2)(a) is defined as follows:

(a) For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of the Monthly Average of the composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (4)(b), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (4)(b), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(e) For other annuities with no cash settlement options and for guaranteed

interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Subsection (4)(b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(5) Alternative method for determining reference interest rates: In the event that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds is no longer published by Moody's Investors Service, Inc. or in the event that the National Association of Insurance Commissioners determines that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by rule promulgated by the commissioner, may be substituted.

Amended by Chapter 297, 2011 General Session

31A-17-507. Reserve valuation method -- Life insurance and endowment benefits.

(1) Except as otherwise provided in Sections 31A-17-508, 31A-17-511, and 31A-17-513, reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits 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 such benefits provided for by the policy and the excess of Subsection (1)(a) over Subsection (1)(b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium may not exceed the net level annual premium on the 19 year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(b) A net one year term premium for such benefits provided for in the first policy year.

(2) Provided that for any life insurance policy issued on or after January 1, 1997, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for 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 reserve according to the commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Section 31A-17-511, be the greater of the reserve as of such policy anniversary calculated as described in Subsection (1) and the reserve as of such policy anniversary calculated as described in that subsection, but with:

(a) the value defined in Subsection (1)(a) being reduced by 15% of the amount of such excess first year premium;

(b) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;

(c) the policy being assumed to mature on such date as an endowment; and

(d) 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 Sections 31A-17-504 and 31A-17-506 shall be used.

(3) Reserves according to the commissioner's reserve valuation method 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, Internal Revenue Code;

(c) accident and health 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 principles of Subsections (1) and (2).

Amended by Chapter 297, 2011 General Session

31A-17-508. Reserve valuation method -- Annuity and pure endowment benefits.

(1) This section 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, Internal Revenue Code.

(2) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any accident and health 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.

Amended by Chapter 116, 2001 General Session

31A-17-509. Minimum reserves.

(1) In no event shall a company's aggregate reserves for all life insurance policies, excluding accident and health and accidental death benefits, issued on or after January 1, 1994, be less than the aggregate reserves calculated in accordance with the methods set forth in Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-512 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(2) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by Section 31A-17-503.

Amended by Chapter 116, 2001 General Session

31A-17-510. Optional reserve calculation.

(1) Reserves for all policies and contracts issued prior to January 1, 1994, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to that date. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after January 1, 1994, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided therein.

(2) Any such company which at any time shall have 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; provided, however, that, for the purposes of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by Section 31A-17-502 may not be considered to be the adoption of a higher standard of valuation.

Amended by Chapter 297, 2011 General Session

31A-17-511. Reserve calculation -- Valuation net premium exceeding the gross premium charged.

(1) If in any contract year the gross premium charged by any life insurance company 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 but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in Sections 31A-17-504 and 31A-17-506.

(2) Provided that for any life insurance policy issued on or after January 1, 1997, 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 section shall be applied as if the method actually used in calculating the reserve for such policy were the method described in Section 31A-17-507, ignoring Subsection 31A-17-507(2). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with Section 31A-17-507, including Subsection 31A-17-507(2), and the minimum reserve calculated in accordance with this section.

Enacted by Chapter 305, 1993 General Session

31A-17-512. Reserve calculation -- Indeterminate premium plans.

(1) 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 Sections 31A-17-507, 31A-17-508, and 31A-17-511, the reserves which are held under any such plan shall:

(a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) be computed by a method which is consistent with the principles of this part, as determined by rules promulgated by the commissioner.

Amended by Chapter 297, 2011 General Session

31A-17-513. Minimum standards for accident and health plans.

The commissioner shall promulgate a rule containing the minimum standards applicable to the valuation of accident and health plans.

Amended by Chapter 116, 2001 General Session

31A-17-601. Definitions.

As used in this part:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with Subsection 31A-17-602(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective action that the commissioner determines is required.

(3) "Health organization" means:

(a) an entity that is authorized under Chapter 7 or 8; and

(b) that is:

(i) a health maintenance organization;

(ii) a limited health service organization;

(iii) a dental or vision plan;

(iv) a hospital, medical, and dental indemnity or service corporation; or

(v) other managed care organization.

(4) "Life or accident and health insurer" means:

(a) an insurance company licensed to write life insurance, disability insurance, or both; or

(b) a licensed property casualty insurer writing only disability insurance.

(5) "Property and casualty insurer" means any insurance company licensed to write lines of insurance other than life but does not include a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer.

(6) "RBC" means risk-based capital.

(7) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the department by rule.

(8) "RBC level" means an insurer's or health organization's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(9) (a) "RBC plan" means a comprehensive financial plan containing the elements specified in Subsection 31A-17-603(2).

(b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

(i) the commissioner rejects the RBC plan; and

(ii) the plan is revised by the insurer or health organization, with or without the commissioner's recommendation.

(10) "RBC report" means the report required in Section 31A-17-602.

Amended by Chapter 116, 2001 General Session

31A-17-602. RBC reports -- RBC of life and accident and health insurers -- RBC of property and casualty insurers.

(1) Every domestic life or accident and health insurer, every domestic property and casualty insurer, and every domestic health organization shall:

(a) on or before March 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information as is required by the RBC instructions;

(b) file its RBC report with the insurance commissioner in any state in which the insurer or health organization is authorized to do business, if the insurance commissioner of that state notifies the insurer or health organization of its request in writing, in which case the insurer or health organization may file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) March 1; and

(c) file the documents described in Subsections (1)(a) and (b) with the National Association of Insurance Commissioners in accordance with RBC instructions.

(2) A life and accident and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

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

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

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

(d) all other business risks and other relevant risks as set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and the other relevant risks as set forth in the RBC instructions.

(4) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and such other relevant risks as are set forth in the RBC instructions.

(5) (a) If a domestic insurer files an RBC report that the commissioner

determines is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment.

(b) The notice under Subsection (5)(a) shall contain a statement of the reason for the adjustment.

(6) The commissioner may make rules to assist in applying the provisions of this part to health organizations.

Amended by Chapter 116, 2001 General Session

31A-17-603. Company action level event.

(1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer or health organization that indicates that:

(i) the insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) if a life or accident and health insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the life or fraternal RBC instructions; or

(iii) if a property and casualty insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC, but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) In the event of a company action level event, the insurer or health organization shall prepare and submit to the commissioner an RBC plan that shall:

(i) identify the conditions that contribute to the company action level event;

(ii) contain proposals of corrective actions that the insurer or health organization intends to take and that are expected to result in the elimination of the company action level event;

(iii) provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of:

(A) statutory operating income;

(B) net income;

(C) capital;

(D) surplus; and

(E) RBC levels;

(iv) identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(v) identify the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(3) The RBC plan shall be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607, within 45 days after notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(4) (a) Within 60 days after the submission by an insurer or health organization of an RBC plan to the commissioner, the commissioner shall notify the insurer or health organization whether the RBC plan:

(i) shall be implemented; or

(ii) is unsatisfactory.

(b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination, and may propose revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the insurer or health organization shall:

(i) prepare a revised RBC plan that incorporates any revision proposed by the commissioner; and

(ii) submit the revised RBC plan to the commissioner:

(A) within 45 days after the notification from the commissioner; or

(B) if the insurer challenges the notification from the commissioner under Section 31A-17-607, within 45 days after a notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(5) In the event of a notification by the commissioner to an insurer or health organization that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event subject to the insurer's or health organization's right to a hearing under Section 31A-17-607.

(6) Every domestic insurer or health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer or health organization is authorized to do business if:

(a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1); and

(b) the insurance commissioner of that state notifies the insurer or health

organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and (4).

Amended by Chapter 319, 2013 General Session

31A-17-604. Regulatory action level event.

(1) "Regulatory action level event" means with respect to any insurer or health organization, any of the following events:

(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) the notification by the commissioner to an insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge;

(d) the failure of the insurer or health organization to file an RBC report by March 1, unless the insurer or health organization has:

(i) provided an explanation for the failure that is satisfactory to the commissioner; and

(ii) cured the failure within 10 days after March 1;

(e) the failure of the insurer or health organization to submit an RBC plan to the commissioner within the time period set forth in Subsection 31A-17-603(3);

(f) notification by the commissioner to the insurer or health organization that:

(i) the RBC plan or revised RBC plan submitted by the insurer or health organization is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization, provided the insurer has not challenged the determination under Section 31A-17-607;

(g) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a determination by the commissioner under Subsection (1)(f), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge; or

(h) notification by the commissioner to the insurer or health organization that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan, but only if:

(i) the failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event in accordance with its

RBC plan or revised RBC plan; and

(ii) the commissioner has so stated in the notification, provided the insurer or health organization has not challenged the determination under Section 31A-17-607; or

(iii) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a determination by the commissioner under Subsection (1)(h), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge.

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

(a) require the insurer or health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) perform any examination or analysis the commissioner considers necessary of the assets, liabilities, and operations of the insurer or health organization, including a review of its RBC plan or revised RBC plan; and

(c) subsequent to the examination or analysis, issue a corrective order specifying the corrective action the commissioner determines is required.

(3) In determining a corrective action, the commissioner may take into account such factors the commissioner considers relevant with respect to the insurer or health organization based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer or health organization, including the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) within 45 days after the occurrence of the regulatory action level event;

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge; or

(c) if the insurer or health organization challenges a revised RBC plan pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

Amended by Chapter 116, 2001 General Session

31A-17-605. Authorized control level event.

(1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner to the insurer or health organization that after a

hearing the commissioner rejects the insurer's or health organization's challenge;

(d) the failure of the insurer or health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the insurer or health organization has not challenged the corrective order under Section 31A-17-607; or

(e) if the insurer or health organization has challenged a corrective order under Section 31A-17-607 and the commissioner after a hearing rejects the challenge or modifies the corrective order, the failure of the insurer or health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) (a) In the event of an authorized control level event with respect to an insurer or health organization, the commissioner shall:

(i) take any action required under Section 31A-17-604 regarding an insurer or health organization with respect to which a regulatory action level event has occurred; or

(ii) take any action as is necessary to cause the insurer or health organization to be placed under regulatory control under Chapter 27, Part 5, Administrative Actions, if the commissioner considers it to be in the best interests of:

(A) the policyholders or members;

(B) creditors of the insurer or health organization; and

(C) the public.

(b) If the commissioner takes an action described in Subsection (2)(a), the authorized control level event is sufficient grounds for the commissioner to take action under Chapter 27, Part 5, Administrative Actions, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health organization set forth in Chapter 27, Part 5, Administrative Actions.

(c) If the commissioner takes an action under Subsection (2)(a) pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections afforded to an insurer or health organization under Section 31A-27-504 pertaining to an action by the commissioner.

Amended by Chapter 309, 2007 General Session

31A-17-606. Mandatory control level event.

(1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's or health organization's total adjusted capital is less than its mandatory control level RBC;

(b) notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) In the event of a mandatory control level event with respect to an insurer or health organization, the commissioner shall take any actions necessary to place the

insurer under regulatory control under Chapter 27, Part 5, Administrative Actions.

(b) The mandatory control level event is sufficient grounds for the commissioner to take action under Chapter 27, Part 5, Administrative Actions, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health organization as are set forth in Chapter 27, Part 5, Administrative Actions.

(c) If the commissioner takes an action pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections of Section 31A-27-504 pertaining to summary proceedings.

(d) Notwithstanding the other provisions of Subsection (2), the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

Amended by Chapter 309, 2007 General Session

31A-17-607. Hearings.

(1) (a) Following receipt of a notice described in Subsection (2), the insurer or health organization shall have the right to a confidential departmental hearing at which the insurer or health organization may challenge any determination or action by the commissioner.

(b) The insurer or health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under Subsections 31A-17-604(1), (2), and (3).

(c) Upon receipt of the insurer's or health organization's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after the date of the insurer's or health organization's request.

(2) An insurer or health organization has the right to a hearing under Subsection (1) after:

(a) notification to an insurer or health organization by the commissioner of an adjusted RBC report;

(b) notification to an insurer or health organization by the commissioner that:

(i) the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization;

(c) notification to any insurer or health organization by the commissioner that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event with respect to the insurer or health organization in accordance with its RBC plan or revised RBC plan; or

(d) notification to an insurer or health organization by the commissioner of a corrective order with respect to the insurer or health organization.

Amended by Chapter 116, 2001 General Session

31A-17-608. Confidentiality -- Prohibition on announcements -- Prohibition

on use in ratemaking.

(1) (a) The commissioner shall keep confidential to the extent that information in a report or plan is not required to be included in a publicly available annual statement schedule, any detail in an RBC report or RBC plan including the results or report of any examination or analysis of an insurer or health organization performed pursuant to this part, that is filed by a domestic or foreign insurer or health organization with the commissioner or any corrective order issued by the commissioner pursuant to examination or analysis.

(b) Information kept confidential under Subsection (1)(a) may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this part or any other provision of the insurance laws of this state.

(2) (a) Except as otherwise required under this part, any insurer or health organization, producer, or other person engaged in any manner in the insurance business may not publish, disseminate, circulate or place before the public, or cause, directly or indirectly, the publishing, disseminating, circulating or placing before the public including, in a newspaper, magazine, other publication, a notice, circular, pamphlet, letter, or poster, or over any radio or television station, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or health organization, or of any component derived in the calculation.

(b) If any materially false statement with respect to the comparison regarding an insurer's or health organization's total adjusted capital to its RBC levels, or an inappropriate comparison of any other amount to the insurer's or health organization's RBC levels is published in any written publication and the insurer or health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement or the inappropriateness, the insurer or health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement or inappropriate comparison.

(3) The commissioner may not use an RBC instruction, report, plan, or revised plan:

(a) for ratemaking;

(b) as evidence in any rate proceeding; or

(c) to calculate or derive any element of an appropriate premium level or rate of return for any line of insurance or coverage that an insurer or health organization or any affiliate is authorized to write or cover.

Amended by Chapter 298, 2003 General Session

31A-17-609. Alternate adjusted capital.

(1) Except as provided in Section 31A-17-602, an insurer or health organization licensed under Chapters 5, 7, 8, 9, and 14 shall maintain total adjusted capital as defined in Section 31A-1-301 in an amount equal to the greater of:

(a) 175% of the minimum required capital, or of the minimum permanent surplus in the case of nonassessable mutuals, required by Section 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, or 31A-14-205; or

(b) the net total of:
(i) 10% of net insurance premiums earned during the year; plus
(ii) 5% of the admitted value of common stocks and real estate; plus
(iii) 2% of the admitted value of all other invested assets, exclusive of cash deposits, short-term investments, policy loans, and premium notes; less
(iv) the amount of any asset valuation reserve being maintained by the insurer or health organization, but not to exceed the sum of Subsections (1)(b)(ii) and (iii).
(2) As used in Subsection (1)(b), "premiums earned" means premiums and other consideration earned for insurance in the 12-month period ending on the date the calculation is made.
(3) The commissioner may consider an insurer or health organization to be financially hazardous under Subsection 31A-27a-207(1)(i), if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and the total adjusted capital required by Subsection (1).
(4) The commissioner shall consider an insurer or health organization to be financially hazardous under Subsection 31A-27a-207(1)(i) if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and 70% of the total adjusted capital required by Subsection (1).

Amended by Chapter 309, 2007 General Session

31A-17-610. Foreign insurers or health organizations.
(1) (a) Any foreign insurer or health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the most recent calendar year by the later of:
(i) the date an RBC report would be required to be filed by a domestic insurer or health organization under this part; or
(ii) 15 days after the request is received by the foreign insurer or health organization.
(b) Any foreign insurer or health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.
(2) (a) The commissioner may require a foreign insurer or health organization to file an RBC plan with the commissioner if:
(i) there is a company action level event, regulatory action level event, or authorized control level event with respect to the foreign insurer or health organization as determined under:
(A) the RBC statute applicable in the state of domicile of the insurer or health organization; or
(B) if no RBC statute is in force in that state, under this part; and
(ii) the insurance commissioner of the state of domicile of the foreign insurer or health organization fails to require the foreign insurer or health organization to file an RBC plan in the manner specified under:
(A) that state's RBC statute; or

(B) if no RBC statute is in force in that state, under Section 31A-17-603.

(b) If the commissioner requires a foreign insurer or health organization to file an RBC plan, the failure of the foreign insurer or health organization to file the RBC plan with the commissioner is grounds to order the insurer or health organization to cease and desist from writing new insurance business in this state.

(3) The commissioner may make application to the Third District Court for Salt Lake County permitted under Section 31A-27a-901 with respect to the liquidation of property of a foreign insurer or health organization found in this state if:

(a) a mandatory control level event occurs with respect to any foreign insurer or health organization; and

(b) no domiciliary receiver has been appointed with respect to the foreign insurer or health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer or health organization.

Amended by Chapter 309, 2007 General Session

31A-17-611. Immunity.

There may be no liability on the part of, and no cause of action may arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this part.

Enacted by Chapter 9, 1996 Special Session 2

31A-17-612. Severability clause.

If any provision of this part, or the application of the part to any person or circumstance, is held invalid, the determination may not affect the provisions or applications of this part that can be given effect without the invalid provision or application, and to that end the provisions of this part are severable.

Enacted by Chapter 9, 1996 Special Session 2

31A-17-613. Effective date of notice.

A notice by the commissioner to an insurer or health organization that may result in regulatory action under this chapter is effective the sooner of:

(1) the date the insurer or health organization receives the notice; or

(2) three days after mailing the notice.

Amended by Chapter 116, 2001 General Session

31A-18-101. Scope -- Definitions.

(1) Except as otherwise provided in this title, this chapter and the rules adopted to implement it apply to all insurers authorized to do business in this state, including a reinsurer.

(2) As used in this chapter, "cash" means a medium of exchange that a depository institution, as defined in Section 7-1-103, accepts for deposit and allows an immediate credit to an account in the depository institution, including the following in a

depository institution:

(a) a savings account; or

(b) a certificate of deposit with a maturity date within one year or less from the day on which the certificate of deposit is acquired.

Amended by Chapter 257, 2008 General Session

31A-18-102. Separate account investments.

(1) Except as provided under Subsection (2), each separate account established under Section 31A-5-217 shall be evaluated as a separate insurer to determine whether the account complies with Chapters 17 and 18.

(2) Except as provided under Subsection (3), the amounts allocated to each separate account, and accumulations thereon, may be invested and reinvested without regard to any requirements or limitations prescribed by Chapter 18.

(3) To the extent that the corporation's reserve liability, with regard to benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest, is maintained in any separate account, a portion of the assets of the account at least equal to the reserve liability shall be invested in accordance with this chapter, or in accordance with such requirements as the commissioner prescribes by rule.

(4) Assets allocated to a separate account shall be valued at market value on the date of valuation, or, if there is no readily available market, then in accordance with the applicable contract. However, a portion of the assets of the account at least equal to the corporation's reserve liability with regard to the guaranteed benefits and funds referred to in Subsection (3), if any, shall be reported separately and valued in accordance with the rules otherwise applicable to the corporation's assets or in accordance with rules adopted under Subsection (3). No securities valuation reserve or other reserve for fluctuation in the value of securities is required for assets that do not have to comply with this chapter.

Enacted by Chapter 242, 1985 General Session

31A-18-103. Protection against currency fluctuations.

Any insurer whose business requires it to make payment in different currencies may have investments in securities in each of those currencies in an amount that, independently of all other investments, meets the requirements of the Insurance Code as applied separately to the insurer's obligations in each currency. The commissioner may by order require an insurer, or by rule require a class of insurers, to maintain these separate currency investments if the obligations in other currencies are large enough to present a problem of financial stability if there are substantial fluctuations in relative currency values.

Enacted by Chapter 242, 1985 General Session

31A-18-105. Permitted classes of investments.

The following classes of investment may be counted for the purposes specified

under Chapter 17, Part 6, Risk-Based Capital:

(1) a bond or other evidence of indebtedness of:

(a) a governmental unit in the United States or Canada;

(b) an instrumentality of a governmental unit described in Subsection (1)(a); or

(c) a private corporation domiciled in the United States;

(2) an equipment trust obligation or certificate that is an adequately secured instrument:

(a) evidencing an interest in transportation equipment that is located wholly or in part within the United States; and

(b) with a right to receive determined portions of the rental, or to purchase other fixed obligatory payments for the use or purchase of the transportation equipment;

(3) a loan secured by:

(a) one or more mortgages;

(b) one or more trust deeds; or

(c) another statutorily authorized type of security interest in real estate located in the United States;

(4) a loan secured by a pledged security or evidence of debt eligible for investment under this section;

(5) a preferred stock of a United States corporation;

(6) (a) a common stock of a United States corporation; or

(b) an American depository receipt if traded on one of the following exchanges:

(i) New York;

(ii) American; or

(iii) NASDAQ;

(7) real estate that is used as the home office or branch office of the insurer;

(8) real estate in the United States that produces substantial income;

(9) a loan upon the security of the insurer's own policies in an amount that:

(a) is adequately secured by the policies; and

(b) does not exceed the surrender value of the policies;

(10) a financial futures contract used for hedging and not for speculation, as approved under rules adopted by the commissioner;

(11) an investment in a foreign security of a class permitted under this section as required for compliance with Section 31A-18-103;

(12) an investment permitted under Subsection 31A-18-102(2);

(13) an American depository receipt not traded on one of the following exchanges:

(a) New York;

(b) American; or

(c) NASDAQ;

(14) an investment other than those listed in Subsections (1) through (13) that is determined to be admitted in the Accounting Practices and Procedures Manual, published by the National Association of Insurance Commissioners;

(15) cash; and

(16) another investment the commissioner authorizes by rule.

Amended by Chapter 257, 2008 General Session

31A-18-106. Investment limitations generally applicable.

(1) The investment limitations listed in Subsections (1)(a) through (m) apply to an insurer.

(a) For an investment authorized under Subsection 31A-18-105(1) that is not amortizable under applicable valuation rules, the limitation is 5% of assets.

(b) For an investment authorized under Subsection 31A-18-105(2), the limitation is 10% of assets.

(c) For an investment authorized under Subsection 31A-18-105(3), the limitation is 50% of assets.

(d) For an investment authorized under Subsection 31A-18-105(4) that is considered to be an investment in a kind of security or evidence of debt pledged, the investment is subject to the class limitations applicable to the pledged security or evidence of debt.

(e) For an investment authorized under Subsection 31A-18-105(5), the limitation is 35% of assets.

(f) For an investment authorized under Subsection 31A-18-105(6), the limitation is:

(i) 20% of assets for a life insurer; and

(ii) 50% of assets for a nonlife insurer.

(g) For an investment authorized under Subsection 31A-18-105(7), the limitation is:

(i) 5% of assets; or

(ii) for an insurer organized and operating under Chapter 7, Nonprofit Health Service Insurance Corporations, 25% of assets.

(h) For an investment authorized under Subsection 31A-18-105(8), the limitation is:

(i) 20% of assets, inclusive of home office and branch office properties; or

(ii) for an insurer organized and operating under Chapter 7, Nonprofit Health Service Insurance Corporations, 35% of assets, inclusive of home office and branch office properties.

(i) For an investment authorized under Subsection 31A-18-105(10), the limitation is 1% of assets.

(j) For an investment authorized under Subsection 31A-18-105(11), the limitation is the greater of that permitted or required for compliance with Section 31A-18-103.

(k) Except as provided in Subsection (1)(l), an insurer's investments in subsidiaries is limited to 50% of the insurer's total adjusted capital. An investment by an insurer in a subsidiary includes:

(i) a loan, advance, or contribution to a subsidiary by an insurer; and

(ii) an insurer holding a bond, note, or stock of a subsidiary.

(l) Under a plan of merger approved by the commissioner, the commissioner may allow an insurer any portion of its assets invested in an insurance subsidiary. The approved plan of merger shall require the acquiring insurer to conform its accounting for investments in subsidiaries to Subsection (1)(k) within a specified period that may not exceed five years.

(m) For an investment authorized under Subsections 31A-18-105(13) and (14),

the aggregate limitation is 10% of assets.

(2) The limits on investments listed in Subsections (2)(a) through (e) apply to each insurer.

(a) (i) For all investments in a single entity, its affiliates, and subsidiaries, the limitation is 10% of assets, except that the limit imposed by this Subsection (2)(a) does not apply to:

(A) an investment in the government of the United States or its agencies;

(B) an investment guaranteed by the government of the United States;

(C) an investment in the insurer's insurance subsidiaries; or

(D) a cash deposit that:

(I) is cash;

(II) is held by a depository institution, as defined in Section 7-1-103, that:

(Aa) is solvent;

(Bb) is federally insured; and

(Cc) subject to Subsection (2)(a)(ii), has a Tier 1 leverage ratio of at least 5%, if the depository institution is a bank as defined in Section 7-1-103, or a ratio of Tier 1 capital to total assets of at least 5%, if the depository institution is not a bank; and

(III) does not exceed the greater of:

(Aa) .4 times the Tier 1 capital of the depository institution; or

(Bb) the amount insured by a federal deposit insurance agency.

(ii) The commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, shall:

(A) define "Tier 1 leverage ratio";

(B) define "Tier 1 capital"; and

(C) proscribe the method to calculate Tier 1 capital.

(b) An investment authorized by Subsection 31A-18-105(3) shall comply with the requirements listed in this Subsection (2)(b).

(i) (A) Except as provided in this Subsection (2)(b)(i), the amount of a loan secured by a mortgage or deed of trust may not exceed 80% of the value of the real estate interest mortgaged, unless the excess over 80%:

(I) is insured or guaranteed by:

(Aa) the United States;

(Bb) a state of the United States;

(Cc) an instrumentality, agency, or political subdivision of the United States or a state; or

(Dd) a combination of entities described in this Subsection (2)(b)(i)(A)(I); or

(II) is insured by an insurer approved by the commissioner and qualified to insure that type of risk in this state.

(B) A mortgage loan representing a purchase money mortgage acquired from the sale of real estate is not subject to the limitation of Subsection (2)(b)(i)(A).

(ii) Subject to Subsection (2)(b)(v), a loan or evidence of debt secured by real estate may only be secured by:

(A) unencumbered real property that is located in the United States; or

(B) an unencumbered interest in real property that is located in the United States.

(iii) Evidence of debt secured by a first mortgage or deed of trust upon a

leasehold estate shall require that:

(A) the leasehold estate exceed the maturity of the loan by not less than 10% of the lease term;

(B) the real estate not be otherwise encumbered; and

(C) the mortgagee is entitled to be subrogated to all rights under the leasehold.

(iv) Subject to Subsection (2)(b)(v):

(A) participation in a mortgage loan shall:

(I) be senior to other participants; and

(II) give the holder substantially the rights of a first mortgagee; or

(B) the interest of the insurer in the evidence of indebtedness shall be of equal priority, to the extent of the interest, with other interests in the real property.

(v) A fee simple or leasehold real estate or an interest in a fee simple or leasehold is not considered to be encumbered within the meaning of this chapter by reason of a prior mortgage or trust deed held or assumed by the insurer as a lien on the property, if:

(A) the total of the mortgages or trust deeds held does not exceed 70% of the value of the property; and

(B) the security created by the prior mortgage or trust deed is a first lien.

(c) A loan permitted under Subsection 31A-18-105(4) may not exceed 75% of the market value of the collateral pledged, except that a loan upon the pledge of a United States government bond may be equal to the market value of the pledge.

(d) For an equity interest in a single real estate property authorized under Subsection 31A-18-105(8), the limitation is 5% of assets.

(e) An investment authorized under Subsection 31A-18-105(10) shall be in connection with a potential change in the value of specifically identified:

(i) asset that the insurer owns; or

(ii) liability that the insurer has incurred.

(3) The restrictions on investments listed in Subsections (3)(a) and (b) apply to each insurer.

(a) Except for a financial futures contract and real property acquired and occupied by the insurer for home and branch office purposes, a security or other investment is not eligible for purchase or acquisition under this chapter unless it is:

(i) interest bearing or income paying; and

(ii) not then in default.

(b) A security is not eligible for purchase at a price above its market value.

(4) Computation of percentage limitations under this section:

(a) is based only upon the insurer's total qualified invested assets described in Section 31A-18-105 and this section, as these assets are valued under Section 31A-17-401; and

(b) excludes investments permitted under Section 31A-18-108 and Subsections 31A-17-203(2) and (3).

(5) An insurer may not make an investment that, because the investment does not conform to Section 31A-18-105 and this section, has the result of rendering the insurer, under Chapter 17, Part 6, Risk-Based Capital, subject to proceedings under Chapter 27a, Insurer Receivership Act.

(6) A pattern of persistent deviation from the investment diversification

standards set forth in Section 31A-18-105 and this section may be grounds for a finding that the one or more persons with authority to make the insurer's investment decisions are "incompetent" as used in Subsection 31A-5-410(3).

(7) Section 77r-1 of the Secondary Mortgage Market Enhancement Act of 1984 does not apply to the purchase, holding, investment, or valuation limitations of assets of insurance companies subject to this chapter.

Amended by Chapter 297, 2011 General Session

31A-18-107. Disposal of nonqualified assets.

(1) The commissioner may allow a reasonable time, not longer than 10 years, for disposal of any investment which was a qualified asset when made, but which, because of changes in valuation or changes in the insurer's asset mix, is no longer a qualified asset under Section 31A-17-201.

(2) The commissioner may allow a reasonable time during which an investment which is not a qualified asset may be characterized as one, but only if the investment was made by mistake or if the forced sale of the asset would be contrary to the interests of insureds, creditors, or the Utah public.

Enacted by Chapter 242, 1985 General Session

31A-18-108. Investment of excess surplus.

(1) If an insurer has excess surplus, as defined under Section 31A-1-301, then to the extent of its excess surplus, the insurer may invest in a manner inconsistent with the limitations of Section 31A-18-106 or in other assets approved by the commissioner.

(2) This section does not empower any insurer to make investments that are:

(a) illegal; or

(b) prohibited under Section 31A-4-107.

(3) Each insurer has the burden of establishing the extent of its excess surplus.

Amended by Chapter 131, 1999 General Session

31A-18-110. Investment valuation reserves.

(1) The commissioner may by rule, applicable to all or any specified classes of insurers, provide for the establishment, in reasonable amounts, of investment valuation reserves that are necessary to lessen the impact on surplus of the fluctuation of the values of specific classes of assets. In formulating these rules, the commissioner shall consider:

(a) similar rules used in other states or recommended for use by the National Association of Insurance Commissioners;

(b) the propensities of the various types and classes of investments to fluctuate in value; and

(c) the present and anticipated investment climate, as measured by economic indicators such as interest rates, price-level changes, market volatility, and economic growth or decline.

(2) The commissioner may by order require an individual insurer to establish

investment valuation reserves in addition to those required for other insurers of the class to which the insurer belongs, to the extent that the financial condition of the insurer and the nature of its assets and liabilities or business require that those reserves be established to adequately protect its insureds.

(3) Where reasonably possible, reserves required under Subsection (1) shall correspond with those generally required in other states.

Enacted by Chapter 242, 1985 General Session

31A-19a-101. Title -- Scope and purposes.

(1) This chapter is known as the "Utah Rate Regulation Act."

(2) (a) (i) Except as provided in Subsection (2)(a)(ii), this chapter applies to all kinds and lines of direct insurance written on risks or operations in this state by an insurer authorized to do business in this state.

(ii) This chapter does not apply to:

(A) life insurance;

(B) credit life insurance;

(C) variable and fixed annuities;

(D) health and accident and health insurance;

(E) credit accident and health insurance; and

(F) reinsurance.

(b) This chapter applies to all insurers authorized to do any line of business, except those specified in Subsection (2)(a)(ii).

(3) It is the purpose of this chapter to:

(a) protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory rates;

(b) encourage independent action by and reasonable price competition among insurers so that rates are responsive to competitive market conditions;

(c) provide formal regulatory controls for use if independent action and price competition fail;

(d) provide regulatory procedures for the maintenance of appropriate data reporting systems;

(e) authorize cooperative action among insurers in the rate-making process, and regulate that cooperation to prevent practices that bring about a monopoly or lessen or destroy competition;

(f) encourage the most efficient and economic marketing practices; and

(g) regulate the business of insurance in a manner that, under the McCarran-Ferguson Act, 15 U.S.C. Secs. 1011 through 1015, will preclude application of federal antitrust laws.

(4) Rate filings made prior to July 1, 1986, under former Title 31, Chapter 18, are continued. Rate filings made after July 1, 1986, are subject to the requirements of this chapter.

Amended by Chapter 308, 2002 General Session

31A-19a-102. Definitions.

As used in this chapter:

(1) "Classification system" or "classification" means the process of grouping risks with similar risk characteristics so that differences in anticipated costs may be recognized.

(2) (a) "Developed losses" means losses adjusted using standard actuarial techniques to eliminate the effect of differences between:

(i) current payment or reserve estimates; and

(ii) payments or reserve estimates that are anticipated to provide actual ultimate loss payments.

(b) For purposes of Subsection (2)(a), losses includes loss adjustment expense.

(3) "Dividend" means money paid to a policyholder from the remaining portion of the premium paid for a policy:

(a) based on the participating class of business; and

(b) after the insurer has made deductions for:

(i) losses;

(ii) expenses;

(iii) additions to reserves; and

(iv) profit and contingencies.

(4) "Expenses" means that portion of a rate attributable to:

(a) acquisition;

(b) field supervision;

(c) collection expenses;

(d) general expenses;

(e) taxes;

(f) licenses; and

(g) fees.

(5) "Experience rating" means a rating procedure that:

(a) uses the past insurance experience of an individual policyholder to forecast the future losses of the policyholder by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification; and

(b) produces a prospective premium credit, debit, or unity modification.

(6) "Joint underwriting" means a voluntary arrangement established to provide insurance coverage for a risk pursuant to which two or more insurers jointly contract with the insured at a price and under policy terms agreed upon between the insurers.

(7) "Loss adjustment expense" means the expenses incurred by the insurer in the course of settling claims.

(8) (a) "Market" means the interaction between buyers and sellers consisting of a:

(i) product component; and

(ii) geographic component.

(b) A product component consists of identical or readily substitutable products if the products are compared as to factors including:

(i) coverage;

(ii) policy terms;

(iii) rate classifications; and

(iv) underwriting.

(c) A geographic component is a geographical area in which buyers seek access to the insurance product through sales outlets and other distribution mechanisms or patterns.

(9) "Mass marketed plan" means a method of selling insurance when:

(a) the insurance is offered to:

(i) employees of a particular employer;

(ii) members of a particular association or organization; or

(iii) persons grouped in a manner other than described in Subsection (8)(a)(i) or (ii), except groupings formed principally for the purpose of obtaining insurance; and

(b) the employer, association, or other organization, if any, has agreed to, or otherwise affiliated itself with, the sale of insurance to its employees or members.

(10) "Prospective loss costs" means the same as pure premium rate.

(11) "Pure premium rate" means that portion of a rate that:

(a) does not include provisions for profit or expenses, other than loss adjustment expenses; and

(b) is based on historical aggregate losses and loss adjustment expenses that are:

(i) adjusted through development to their ultimate value; and

(ii) projected through trending to a future point in time.

(12) (a) "Rate" means that cost of insurance per exposure unit either expressed as:

(i) a single number; or

(ii) as a pure premium rate, adjusted before any application of individual risk variations, based on loss or expense considerations to account for the treatment of:

(A) expenses;

(B) profit; and

(C) individual insurer variation in loss experience.

(b) "Rate" does not include a minimum premium.

(13) "Rating tiers" means an underwriting and rating plan designed to categorize insurance risks that have common characteristics related to potential insurance loss into broad groups for the purpose of establishing a set of rating levels that reflect definable levels of potential hazard or risk.

(14) "Riskiness" means the variability of results around the average expected result.

(15) "Supplementary rate information" includes one or more of the following needed to determine the applicable rate in effect or to be in effect:

(a) a manual or plan of rates;

(b) a statistical plan;

(c) a classification;

(d) a rating schedule;

(e) a minimum premium;

(f) a policy fee;

(g) a rating rule;

(h) a rate-related underwriting rule;

(i) a rate modification plan; or

(j) any other similar information prescribed by rule of the commissioner as

supplementary rate information.

(16) "Supporting information" includes one or more of the following:

(a) data demonstrating actuarial justification for the basic rate factors, classifications, expenses, and profit factors used by the filer;

(b) the experience and judgment of the filer;

(c) the experience or data of other insurers or rate service organizations relied upon by the filer;

(d) the interpretation of any other data relied upon by the filer;

(e) descriptions of methods used in making the rates; or

(f) any other information defined by rule as supporting information that is required to be filed.

(17) "Trending" means any procedure for projecting, for the period during which the policies are to be effective:

(a) losses to the average date of loss; or

(b) premiums or exposures to the average date of writing.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-103. Exemptions.

(1) The commissioner may by rule exempt from any or all of the provisions of this chapter:

(a) any person;

(b) a class of persons; or

(c) a market segment.

(2) The exemption described in Subsection (1) shall be given only if and to the extent that the commissioner finds the application of the provisions of this chapter to that person or group is unnecessary to achieve the purposes of this chapter.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-201. Rate standards.

(1) Rates may not be excessive, inadequate, or unfairly discriminatory.

(2) (a) Rates are not excessive if a reasonable degree of price competition exists at the consumer level with respect to the class of business to which they apply. In determining whether a reasonable degree of price competition exists, the commissioner shall consider:

(i) relevant tests of workable competition pertaining to:

(A) market structure;

(B) market performance; and

(C) market conduct; and

(ii) the practical opportunities available to consumers in the market to:

(A) acquire pricing and other consumer information; and

(B) compare and obtain insurance from competing insurers.

(b) The tests described in Subsection (2)(a) include:

(i) the size and number of insurers actively engaged in the market and class of business;

(ii) the market shares of insurers actively engaged in the market and changes in market shares;

(iii) the existence of rate differentials in that class of business;

(iv) ease of entry and latent competition of insurers capable of easy entry;

(v) availability of consumer information concerning the product and sales outlets or other sales mechanisms; and

(vi) efforts of insurers to provide consumer information.

(c) If reasonable price competition does not exist, rates are excessive if:

(i) rates are likely to produce a long-term profit that is unreasonably high in relation to the riskiness of the class of business; or

(ii) expenses are unreasonably high in relation to the services rendered.

(3) Rates are inadequate if:

(a) they are clearly insufficient, when combined with the investment income attributable to them, to sustain the projected losses and expenses in the class of business to which they apply; and

(b) the use of such rates has or, if continued, will have:

(i) the effect of substantially lessening competition; or

(ii) the tendency to create a monopoly in any market.

(4) (a) A rate is unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses after allowing for practical limitations.

(b) A rate is not unfairly discriminatory if it is averaged broadly among persons insured under a:

(i) group, franchise, or blanket policy; or

(ii) mass marketed plan.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-202. Rating methods.

(1) To determine whether rates comply with the standards under Section 31A-19a-201, the commissioner shall consider the:

(a) criteria listed in Subsection (2);

(b) classifications, if any, permitted under Subsection (3);

(c) expenses described in Subsection (4); and

(d) profits described in Subsection (5).

(2) In determining rates the commissioner shall consider within and outside of Utah:

(a) past and prospective loss experience;

(b) catastrophe hazards;

(c) trends;

(d) loadings for leveling premium rates over time;

(e) reasonable margin for profit and contingencies;

(f) dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders; and

(g) other relevant factors.

(3) (a) Risks may be grouped by classifications for the establishment of rates and minimum premiums.

(b) (i) A classification rate may be modified to produce rates for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards or expense provisions.

(ii) The standards described in Subsection (3)(b)(i) may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(c) Notwithstanding Subsection (3)(b), risk classification may not be based upon race, color, creed, national origin, or the religion of the insured.

(4) The expense provisions included in the rates to be used by an insurer shall reflect:

(a) the operating methods of the insurer; and

(b) its anticipated expenses.

(5) The rates may contain provision for contingencies and an allowance permitting a profit that is not unreasonable in relation to the riskiness of the class of business. In determining the reasonableness of the profit, consideration may be given to investment income.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-203. Rate filings.

(1) (a) Except as provided in Subsections (4) and (5), every authorized insurer and every rate service organization licensed under Section 31A-19a-301 that has been designated by any insurer for the filing of pure premium rates under Subsection 31A-19a-205(2) shall file with the commissioner the following for use in this state:

(i) all rates;

(ii) all supplementary information; and

(iii) all changes and amendments to rates and supplementary information.

(b) An insurer shall file its rates by filing:

(i) its final rates; or

(ii) either of the following to be applied to pure premium rates that have been filed by a rate service organization on behalf of the insurer as permitted by Section 31A-19a-205:

(A) a multiplier; or

(B) (I) a multiplier; and

(II) an expense constant adjustment.

(c) Every filing under this Subsection (1) shall state:

(i) the effective date of the rates; and

(ii) the character and extent of the coverage contemplated.

(d) Except for workers' compensation rates filed under Sections 31A-19a-405 and 31A-19a-406, each filing shall be within 30 days after the rates and supplementary information, changes, and amendments are effective.

(e) A rate filing is considered filed when it has been received:

(i) with the applicable filing fee as prescribed under Section 31A-3-103; and

(ii) pursuant to procedures established by the commissioner.

(f) The commissioner may by rule prescribe procedures for submitting rate filings by electronic means.

(2) (a) To show compliance with Section 31A-19a-201, at the same time as the filing of the rate and supplementary rate information, an insurer shall file all supporting information to be used in support of or in conjunction with a rate.

(b) If the rate filing provides for a modification or revision of a previously filed rate, the insurer is required to file only the supporting information that supports the modification or revision.

(c) If the commissioner determines that the insurer did not file sufficient supporting information, the commissioner shall inform the insurer in writing of the lack of sufficient supporting information.

(d) If the insurer does not provide the necessary supporting information within 45 calendar days of the date on which the commissioner mailed notice under Subsection (2)(c), the rate filing may be:

(i) considered incomplete and unfiled; and

(ii) returned to the insurer as:

(A) not filed; and

(B) not available for use.

(e) Notwithstanding Subsection (2)(d), the commissioner may extend the time period for filing supporting information.

(f) If a rate filing is returned to an insurer as not filed and not available for use under Subsection (2)(d), the insurer may not use the rate filing for any policy issued or renewed on or after 60 calendar days from the date the rate filing was returned.

(3) At the request of the commissioner, an insurer using the services of a rate service organization shall provide a description of the rationale for using the services of the rate service organization, including the insurer's:

(a) own information; and

(b) method of use of the rate service organization's information.

(4) (a) An insurer may not make or issue a contract or policy except in accordance with the rate filings that are in effect for the insurer as provided in this chapter.

(b) Subsection (4)(a) does not apply to contracts or policies for inland marine risks for which filings are not required.

(5) Subsection (1) does not apply to inland marine risks, which, by general custom, are not written according to standardized manual rules or rating plans.

(6) (a) The insurer may file a written application, stating the insurer's reasons for using a higher rate than that otherwise applicable to a specific risk.

(b) If the application described in Subsection (6)(a) is filed with and not disapproved by the commissioner within 10 days after filing, the higher rate may be applied to the specific risk.

(c) The rate described in this Subsection (6) may be disapproved without a hearing.

(d) If disapproved, the rate otherwise applicable applies from the effective date of the policy, but the insurer may cancel the policy pro rata on 10 days' notice to the policyholder.

(e) If the insurer does not cancel the policy under Subsection (6)(d), the insurer shall refund any excess premium from the effective date of the policy.

(7) (a) Agreements may be made between insurers on the use of reasonable

rate modifications for insurance provided under Section 31A-22-310.

(b) The rate modifications described in Subsection (7)(a) shall be filed immediately upon agreement by the insurers.

Amended by Chapter 117, 2004 General Session

31A-19a-204. Rates open to inspection.

(1) Rates and supplementary rate information filed under this chapter shall be open to public inspection at any reasonable time.

(2) The commissioner shall supply copies to any person on:

(a) request; and

(b) payment of a reasonable charge.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-205. Delegation of rate making and rate filing obligation.

(1) An insurer may:

(a) itself establish rates and supplementary rate information for any market segment based on the factors in Section 31A-19a-202; or

(b) use rates, pure premium rates, and supplementary rate information prepared by a rate service organization that the insurer selects, with:

(i) average expense factors determined by the rate service organization; or

(ii) any modification for its own expense and loss experience as the credibility of that experience allows.

(2) An insurer may discharge its obligation under Subsection 31A-19a-203(1) by filing with the commissioner:

(a) notification that the insurer uses pure premium rates and supplementary rate information prepared by a licensed rate service organization that the insurer selects; and

(b) any information about modifications the insurer has made to those rates or that information as is necessary fully to inform the commissioner.

(3) If an insurer has discharged its obligation in accordance with Subsection (2), the insurer's rates and supplementary rate information shall be those, including any amendments, filed at intervals by the rate service organization, subject to any modifications filed by the insurer.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-206. Disapproval of rates.

(1) (a) Except for a conflict with the requirements of Section 31A-19a-201 or 31A-19a-202, the commissioner may disapprove a rate at any time that the rate directly conflicts with:

(i) this title; or

(ii) any rule made under this title.

(b) The disapproval under Subsection (1)(a) shall:

(i) be in writing;

(ii) specify the statute or rule with which the filing conflicts; and

(iii) state when the rule is no longer effective.

(c) (i) If an insurer's or rate service organization's rate filing is disapproved under Subsection (1)(a), the insurer or rate service organization may request a hearing on the disapproval within 30 calendar days of the date on which the order described in Subsection (1)(a) is issued.

(ii) If a hearing is requested under Subsection (1)(c)(i), the commissioner shall schedule the hearing within 30 calendar days of the date on which the commissioner receives the request for a hearing.

(iii) After the hearing, the commissioner shall issue an order:

(A) approving the rate filing; or

(B) disapproving the rate filing.

(2) (a) If within 90 calendar days of the date on which a rate filing is filed the commissioner finds that the rate filing does not meet the requirements of Section 31A-19a-201 or 31A-19a-202, the commissioner shall send a written order disapproving the rate filing to the insurer or rate organization that made the filing.

(b) The order described in Subsection (2)(a) shall specify how the rate filing fails to meet the requirements of Section 31A-19a-201 or 31A-19a-202.

(c) (i) If an insurer's or rate service organization's rate filing is disapproved under Subsection (2)(a), the insurer or rate service organization may request a hearing on the disapproval within 30 calendar days of the date on which the order described in Subsection (2)(a) is issued.

(ii) If a hearing is requested under Subsection (2)(c)(i), the commissioner shall schedule the hearing within 30 calendar days of the date on which the commissioner receives the request for a hearing.

(iii) After the hearing, the commissioner shall issue an order:

(A) approving the rate filing; or

(B) (I) disapproving the rate filing; and

(II) stating when, within a reasonable time from the date on which the order is issued, the rate is no longer effective.

(d) In a hearing held under this Subsection (2), the insurer or rate service organization bears the burden of proving compliance with the requirements of Section 31A-19a-201 or 31A-19a-202.

(3) (a) If the order described in Subsection (2)(a) is issued after the implementation of the rate filing, the commissioner may order that use of the rate filing be discontinued for any policy issued or renewed on or after a date not less than 30 calendar days from the date the order was issued.

(b) If an insurer or rate service organization requests a hearing under Subsection (2), the order to discontinue use of the rate filing is stayed:

(i) beginning on the date the insurer or rate service organization requests a hearing; and

(ii) ending on the date the commissioner issues an order after the hearing that addresses the stay.

(4) If the order described in Subsection (2)(a) is issued before the implementation of the rate filing:

(a) an insurer or rate service organization may not implement the rate filing; and

(b) the rates of the insurer or rate service organization at the time of disapproval continue to be in effect.

(5) (a) If after a hearing the commissioner finds that a rate that has been previously filed and has been in effect for more than 90 calendar days no longer meets the requirements of Section 31A-19a-201 or 31A-19a-202, the commissioner may order that use of the rate by any insurer or rate service organization be discontinued.

(b) The commissioner shall give any insurer that will be affected by an order that may be issued under Subsection (5)(a) notice of the hearing at least 10 business days prior to the hearing.

(c) The order issued under Subsection (5)(a) shall:

(i) be in writing;

(ii) state the grounds for the order; and

(iii) state when, within a reasonable time from the date on which the order is issued, the rate is no longer effective.

(d) The order issued under Subsection (5)(a) may not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(e) The order issued under Subsection (5)(a) may include a provision for a premium adjustment for contracts or policies made or issued after the effective date of the order.

(6) (a) When an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall, on the insurer's request, specify interim rates for the insurer.

(b) An interim rate described in Subsection (6)(a):

(i) shall be high enough to protect the interests of all parties; and

(ii) may, when necessary to protect the policyholders, order that a specified portion of the premiums be placed in an escrow account approved by the commissioner.

(c) When the new rates become effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that minimal refunds to policyholders need not be distributed.

Amended by Chapter 297, 2011 General Session

31A-19a-207. Delayed effect of rates.

(1) (a) The commissioner may by rule require that insurers in a market segment file with the commissioner any changes in rates or supplementary rate information at least 30 calendar days before they become effective if the commissioner finds, after a hearing, that in that market segment:

(i) competition is not an effective regulator of the rates charged;

(ii) that a substantial number of companies are competing irresponsibly through the rates charged; or

(iii) that there are widespread violations of this chapter.

(b) The commissioner may extend the waiting period under Subsection (1)(a) for not to exceed 30 additional calendar days by written notice to the filer before the first 30-day period expires.

(c) In determining whether competition is an effective regulator of the rates

charged, the commissioner shall consider, as to the particular market segment:

(i) the number of insurers actively engaged in providing coverage;

(ii) the respective market shares of insurers providing coverage;

(iii) the volatility of market share fluctuations;

(iv) the ease of entry into the market; and

(v) any other known relevant factors.

(2) (a) If the commissioner finds that a market segment is noncompetitive under Subsection (1), all rates previously filed and in use may continue to be used until disapproved.

(b) After a finding of a noncompetitive market under Subsection (1), for purposes of disapproval, the commissioner shall treat the filing of existing rates as having been filed as of the date of the rule under Subsection (1).

(3) A competitive market is presumed to exist, unless the commissioner makes a contrary finding under Subsection (1).

(4) (a) A rule issued under Subsection (1) expires no later than one year from the date on which the rule was adopted, unless the commissioner, after a hearing, renews the rule.

(b) A renewal hearing for a rule issued under Subsection (1) may not be held earlier than nine months after the date on which the rule was issued or last renewed.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-208. Special restrictions on individual insurers.

(1) The commissioner may require by order that a particular insurer file any or all of its rates and supplementary rate information 30 calendar days prior to their effective date, if the commissioner finds, after a hearing, that to protect the interests of the insurer's insureds and the public in Utah, the commissioner shall exercise closer supervision of the insurer's rates, because of the insurer's financial condition or rating practices.

(2) The commissioner may extend the waiting period described in Subsection (1) for any filing for not to exceed 30 additional calendar days, by written notice to the insurer before the first 30-day period expires.

(3) A filing that has not been disapproved before the expiration of the waiting period is considered to meet the requirements of this chapter, subject to the possibility of subsequent disapproval under Section 31A-19a-206.

Amended by Chapter 297, 2011 General Session

31A-19a-209. Special provisions for title insurance.

(1) (a) (i) The Title and Escrow Commission shall adopt rules subject to Section 31A-2-404, establishing rate standards and rating methods for individual title insurance producers and agency title insurance producers.

(ii) The commissioner shall determine compliance with rate standards and rating methods for title insurance insurers, individual title insurance producers, and agency title insurance producers.

(b) In addition to the considerations in determining compliance with rate

standards and rating methods as set forth in Sections 31A-19a-201 and 31A-19a-202, including for title insurers, the commissioner and the Title and Escrow Commission shall consider the costs and expenses incurred by title insurance insurers, individual title insurance producers, and agency title insurance producers peculiar to the business of title insurance including:

(i) the maintenance of title plants; and

(ii) the searching and examining of public records to determine insurability of title to real redevelopment property.

(2) (a) Every title insurance insurer or agency title insurance producer, and every individual title insurance producer who is not designated by an agency title insurance producer, shall file with the commissioner:

(i) a schedule of the escrow charges that the title insurance insurer, individual title insurance producer, or agency title insurance producer proposes to use in this state for services performed in connection with the issuance of policies of title insurance; and

(ii) any changes to the schedule of the escrow charges described in Subsection (2)(a)(i).

(b) Except for a schedule filed by a title insurance insurer under this Subsection (2), a schedule filed under this Subsection (2) is subject to review by the Title and Escrow Commission.

(c) (i) The schedule of escrow charges required to be filed by Subsection (2)(a)(i) takes effect on the day on which the schedule of escrow charges is filed.

(ii) Any changes to the schedule of the escrow charges required to be filed by Subsection (2)(a)(ii) take effect on the day specified in the change to the schedule of escrow charges except that the effective date may not be less than 30 calendar days after the day on which the change to the schedule of escrow charges is filed.

(3) A title insurance insurer, individual title insurance producer, or agency title insurance producer may not file or use any rate or other charge relating to the business of title insurance, including rates or charges filed for escrow that would cause the title insurance company, individual title insurance producer, or agency title insurance producer to:

(a) operate at less than the cost of doing:

(i) the insurance business; or

(ii) the escrow business; or

(b) fail to adequately underwrite a title insurance policy.

(4) (a) All or any of the schedule of rates or schedule of charges, including the schedule of escrow charges, may be changed or amended at any time, subject to the limitations in this Subsection (4).

(b) Each change or amendment shall:

(i) be filed with the commissioner, subject to review by the Title and Escrow Commission; and

(ii) state the effective date of the change or amendment, which may not be less than 30 calendar days after the day on which the change or amendment is filed.

(c) Any change or amendment remains in force for a period of at least 90 calendar days from the change or amendment's effective date.

(5) While the schedule of rates and schedule of charges are effective, a copy of each shall be:

(a) retained in each of the offices of:
(i) the title insurance insurer in this state;
(ii) the title insurance insurer's individual title insurance producers or agency title insurance producers in this state; and
(b) upon request, furnished to the public.
(6) Except in accordance with the schedules of rates and charges filed with the commissioner, a title insurance insurer, individual title insurance producer, or agency title insurance producer may not make or impose any premium or other charge:
(a) in connection with the issuance of a policy of title insurance; or
(b) for escrow services performed in connection with the issuance of a policy of title insurance.

Amended by Chapter 319, 2013 General Session

31A-19a-210. Dividend and participating plans.
(1) (a) This part does not prohibit the distribution by an insurer to a policyholder of any of the following allowed or returned by the insurer:
(i) dividends;
(ii) savings; or
(iii) unabsorbed premium deposits.
(b) Notwithstanding Subsection (1)(a), an insurer may not distribute dividends, savings, or unabsorbed premium deposits to an entity that has no insurable interest in the insurance.
(2) An insurer may not unfairly discriminate between policyholders in the payment of dividends, savings, or unabsorbed premium deposits.
(3) (a) A declaration of dividends or schedule explaining the basis for the distribution of dividends, savings, or unabsorbed premium deposits allowed or returned by an insurer to its policyholders is not a rating plan or system if the insurer:
(i) determines and declares the declaration or schedule after a specified policy accounting period; and
(ii) files the declaration or schedule pursuant to Section 31A-21-310.
(b) A declaration or schedule described under Subsection (3)(a) is not required to be filed with the commissioner under this chapter.
(4) (a) A dividend or participating plan developed by insurers establishing given criteria for eligibility and the general basis for distribution for a dividend, if declared, is considered a rating plan if the plan is to be applicable to an insurance policy from its inception.
(b) A plan described in Subsection (4)(a) shall be filed with the commissioner pursuant to this part.
(5) An insurer may not make the distribution of a dividend or any portion of a dividend conditioned upon renewal of the policy or contract.

Enacted by Chapter 130, 1999 General Session

31A-19a-211. Premium rate reduction for seniors -- Motor vehicle accident prevention course -- Curriculum -- Certificate -- Exception.

(1) (a) Each rate, rating schedule, and rating manual for the liability, personal injury protection, and collision coverages of private passenger motor vehicle insurance policies submitted to or filed with the commissioner shall provide for an appropriate reduction in premium charges for those coverages if the principal operator of the covered vehicle:

(i) is a named insured who is 55 years of age or older; and

(ii) has successfully completed a motor vehicle accident prevention course as outlined in Subsection (2).

(b) Any premium reduction provided by an insurer under this section is presumed to be appropriate unless credible data demonstrates otherwise.

(2) (a) The curriculum for a motor vehicle accident prevention course under this section shall include:

(i) how impairment of visual and audio perception affects driving performance and how to compensate for that impairment;

(ii) the effects of fatigue, medications, and alcohol on driving performance, when experienced alone or in combination, and precautionary measures to prevent or offset ill effects;

(iii) updates on rules of the road and equipment, including safety belts and safe, efficient driving techniques under present day road and traffic conditions;

(iv) how to plan travel time and select routes for safety and efficiency; and

(v) how to make crucial decisions in dangerous, hazardous, and unforeseen situations.

(b) (i) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the Department of Public Safety may make rules to establish and clarify standards pertaining to the curriculum and teaching methods of a course under this section.

(ii) These rules may include provisions allowing the department to conduct on-site visits to ensure compliance with agency rules and this chapter.

(iii) These rules shall be specific as to time and manner of visits and provide for methods to prohibit or remedy forcible visits.

(3) (a) The premium reduction required by this section shall be effective for a named insured for a three-year period after successful completion of the course outlined in Subsection (2).

(b) The insurer may require, as a condition of maintaining the premium reduction, that the named insured not be convicted or plead guilty or nolo contendere to a moving traffic violation for which points may be assessed against the named insured's driver license except for a violation under Subsection 53-3-221(12).

(4) Each person who successfully completes the course outlined in Subsection (2) shall be issued a certificate by the organization offering the course. The certificate qualifies the person for the premium reduction required by this section.

(5) This section does not apply if the approved course outlined in Subsection (2) is attended as a penalty imposed by a court or other governmental entity for a moving traffic violation.

Amended by Chapter 382, 2008 General Session

31A-19a-212. Premium increases prohibited for certain claims or inquiries.

(1) Each rate, rating schedule, and rating manual filed for personal lines insurance may not permit a premium increase due to:

(a) a telephone call or other inquiry that does not result in the insured requesting the payment of a claim; or

(b) a claim under a policy of insurance covering a motor vehicle or the operation of a motor vehicle resulting from any incident, including acts of vandalism, in which the person named in the policy or any other person using the insured motor vehicle with the express or implied permission of the named insured is not at fault.

(2) Subsection (1) prohibits a premium increase when:

(a) a policy is issued; or

(b) a policy is renewed.

(3) This section is an exception to Section 31A-19a-201.

Amended by Chapter 117, 2004 General Session
Amended by Chapter 266, 2004 General Session

31A-19a-213. Joint underwriting.

Notwithstanding Subsection 31A-19a-306(2)(a), insurers participating in joint underwriting associations or joint reinsurance pursuant to Section 31A-20-102 or other arrangements for risk sharing may in connection with such activity act in cooperation with each other in the making of one or more of the following:

(1) rates;

(2) rating systems;

(3) policy forms;

(4) underwriting rules;

(5) surveys;

(6) inspections and investigations;

(7) the furnishing of loss and expense statistics or other information; or

(8) research.

Enacted by Chapter 130, 1999 General Session

31A-19a-214. Rating tiers.

(1) An insurer may file with the commissioner a rate filing that provides for a program with more than one rate level in the same company or group of companies if:

(a) the program is based, to the extent feasible, upon mutually exclusive underwriting rules per tier;

(b) the underwriting rules are based on clear, objective criteria that would lead to a logical distinguishing of potential risk; and

(c) in filing to establish tiers, the insurer provides supporting information that evidences a clear distinction between the expected losses and expenses for each tier.

(2) A rating tier may not be continued if premium, loss, and expense data fail to show a continued clear distinction between the tiers.

Enacted by Chapter 130, 1999 General Session

31A-19a-215. False or misleading information.

A person or organization may not:

(1) willfully withhold from the commissioner, any rate service organization, or any insurer information that will affect the rates or premiums chargeable under this chapter; or

(2) knowingly give false or misleading information to the commissioner, any rate service organization, or any insurer.

Enacted by Chapter 130, 1999 General Session

31A-19a-216. Charging of rates.

An authorized insurer, licensed insurance producer, employee, other representative of an authorized insurer may not knowingly:

(1) charge or demand a rate or receive a premium that departs from the rates, rating plans, classifications, schedules, rules, and standards in effect on behalf of the insurer; or

(2) issue or make any policy or contract involving a violation of Subsection (1).

Amended by Chapter 298, 2003 General Session

31A-19a-217. Grievance procedures.

(1) (a) An insured affected by a rate may submit a written request for information to the rate service organization or insurer that made the rate.

(b) The rate service organization or insurer shall answer a request made under Subsection (1)(a) within 45 calendar days from the date it received the request by furnishing all pertinent rating information to:

(i) the insured; or

(ii) the insured's authorized representative.

(2) (a) A person aggrieved by the manner in which a rate service organization or an insurer has applied its rating system in connection with the insurance afforded to that person may submit a written request for review to the rate service organization or insurer.

(b) If a request for review is filed under Subsection (2)(a), the rate service organization or insurer shall provide a reasonable review procedure within Utah.

(c) The review shall examine the application of the rating system in connection with the insurance afforded the person that requested review.

(d) The person that requested review may be heard in person or through an authorized representative.

(e) If the rate service organization or insurer fails to grant the request for review within 30 calendar days from the date the request is made, the applicant may appeal in writing to the commissioner.

(f) If an appeal is filed under Subsection (2)(e), the commissioner may order the rate service organization or insurer to provide the review in accordance with this Subsection (2).

(3) After a review under Subsection (2), the person that requested review may request the commissioner to confirm that the insurance afforded was rated according to

filed rates and rating plans.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-218. Appeal from filing.

(1) (a) A person aggrieved by a filing that is in effect may apply to the commissioner in writing for a hearing.

(b) The application described under Subsection (1)(a) shall:

(i) specify the grounds upon which the applicant intends to rely to establish the grievance; and

(ii) state why the filing does not meet the requirements of law.

(2) On receipt of an application for hearing under Subsection (1), the commissioner shall grant the requested hearing if the commissioner finds that:

(a) the application was made in good faith;

(b) the grievance is justified, assuming the applicant's grounds can be established; and

(c) the grounds otherwise justify holding such a hearing.

(3) A hearing granted under Subsection (2) shall be held:

(a) within 30 calendar days from the date of receipt of the application; and

(b) not less than 10 days after written notice to:

(i) the applicant;

(ii) each insurer that made the filing; and

(iii) each rate service organization that made the filing.

(4) (a) If after the hearing the commissioner finds that the filing is defective, the commissioner shall issue an order:

(i) specifying the respects in which the filing fails to meet the requirements of the law; and

(ii) setting a date after which the filing ceases to be effective.

(b) A copy of the order shall be sent to each party to the dispute.

(c) The order may not affect any contract or policy made or issued before the date set forth in the order.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-301. Operation and control of rate service organizations.

(1) (a) A rate service organization may not provide any service relating to statistical collection or the rates of any insurance subject to this chapter unless the organization is licensed under Section 31A-19a-302.

(b) An insurer may not use the services of the organization for the purposes described in Subsection (1)(a), unless the organization is licensed under Section 31A-19a-302.

(2) A rate service organization may not refuse to supply any services for which it is licensed in this state to any insurer:

(a) authorized to do business in this state; and

(b) that offers to pay the fair and usual compensation for the services.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-302. Licensing of rate service organizations.

(1) A rate service organization applying for a license shall include with its application:

(a) a copy of its constitution, charter, articles of organization, agreement, association, or incorporation, and a copy of its bylaws, plan of operation, and any other rules or regulations governing the conduct of its business;

(b) a list of its members and subscribers;

(c) the name and address of one or more residents of Utah upon whom notices, processes affecting it, or orders of the commissioner may be served;

(d) a statement explaining in what capacity it plans to function and showing its technical qualifications for acting in the capacity for which it seeks a license;

(e) biographical information, as defined by the department, of the officers and directors of the organization; and

(f) any other relevant information and documents that the commissioner requires.

(2) A rate service organization that applies for a license under Subsection (1) shall promptly notify the commissioner of every material change in the facts or in the documents on which its application was based.

(3) (a) The commissioner shall issue a license specifying the authorized activity of an applicant, if the commissioner finds that:

(i) the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed; and

(ii) all the requirements of law are met.

(b) The commissioner may not issue a license if the proposed activity would tend to:

(i) create a monopoly; or

(ii) lessen or substantially lessen the competition in any market.

(4) (a) Any license issued under this chapter shall be subject to annual renewal.

(b) A fee shall be charged for the initial license and for renewal. The fee shall be set by the Legislature under Section 31A-3-103.

(5) Any amendment to a document filed under Subsection (1)(a) shall be filed within at least 30 calendar days after the day the document becomes effective. Failure to comply with this Subsection (5) is a ground for revocation of the license granted under Subsection (3).

(6) The license of each rate service organization licensed under former Title 31, Chapter 18, is continued under this chapter.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-303. Termination of license.

(1) A license issued under this chapter remains in force until:

(a) revoked, suspended, or limited under Subsection (2);

(b) lapsed under Subsection (3); or

(c) surrendered to and accepted by the commissioner.

(2) (a) After a hearing, the commissioner may revoke, suspend, or limit in whole or in part, the license of any person licensed under this part, if:

(i) the licensee is found to be unqualified;

(ii) the licensee is found to have violated:

(A) an insurance statute;

(B) a valid rule under Subsection 31A-2-201(3); or

(C) a valid order under Subsection 31A-2-201(4); or

(iii) the licensee's methods and practices in the conduct of business endanger the legitimate interests of policyholders, insurers, or the public.

(b) An order suspending a license issued under this chapter shall specify the period of suspension, but in no event may the suspension period exceed 12 months.

(3) (a) Any license issued under this chapter shall lapse if the licensee fails to pay a fee when due.

(b) A license that lapses under this Subsection (3) may be reinstated if the licensee, within 90 calendar days from the day the license lapsed, pays twice the usual license renewal fee.

(4) A licensee whose license is suspended or revoked, but who continues to act as a licensee is subject to the penalties applicable to violating Subsection 31A-19a-301(1).

(5) (a) An order revoking a license under Subsection (2) may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If under Subsection (5)(a) no time is specified, the former licensee may not apply for five years, without the express approval of the commissioner.

(6) (a) Any person whose license is suspended or revoked shall, when the suspension ends or a new license is issued, pay all fees that would have been payable if the license had not been suspended or revoked, unless the commissioner, by order, waives the payment of the interim fees.

(b) If a new license is issued more than three years after the revocation of a similar license, Subsection (6)(a) applies only to the fees that would have accrued during the three years immediately following the revocation.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-304. Probation.

(1) (a) In any circumstances that would justify a suspension under Section 31A-19a-303, instead of a suspension, the commissioner may, after a hearing, put the licensee on probation for a specified period not to exceed 12 months from the date of probation.

(b) The probation order shall state the conditions for retention of the license, which shall be reasonable.

(2) Violation of the probation constitutes grounds for revocation pursuant to a proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 382, 2008 General Session

31A-19a-305. Anti-competitive agreements prohibited.

(1) (a) An insurer may not assume any obligation to any person other than a policyholder or other company under common control, to use or adhere to certain rates or rating procedures.

(b) Except for a policyholder or other company under common control, a person may not impose any penalty or other adverse consequence for failure of an insurer to adhere to certain rates or rating procedures.

(2) This section does not apply to rates used:

(a) by a joint underwriting group;

(b) by a pool;

(c) under quota share reinsurance treaties; or

(d) by a residual market mechanism.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-306. Insurers and rate service organizations -- Prohibited activity.

(1) An insurer or rate service organization may not:

(a) attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market; or

(b) engage in a boycott of an insurance market on a concerted basis.

(2) (a) Except as provided in Subsection (2)(c), an insurer may not agree with any other insurer or with a rate service organization to mandate adherence to or to mandate use of any:

(i) rate;

(ii) prospective loss cost;

(iii) rating plan;

(iv) rating schedule;

(v) rating rule;

(vi) policy or bond form;

(vii) rate classification;

(viii) rate territory;

(ix) underwriting rule;

(x) survey;

(xi) inspection; or

(xii) material similar to those described in Subsections (2)(a)(i) through (xi).

(b) The fact that two or more insurers, whether or not members or subscribers of a rate service organization, use consistently or intermittently the same materials described in Subsection (2)(a) is not sufficient in itself to support a finding that an agreement exists.

(c) An insurer may enter into an agreement prohibited by Subsection (2)(a):

(i) to the extent needed to facilitate the reporting of statistics to:

(A) a rate service organization;

(B) a statistical agent; or

(C) the commissioner; or

(ii) as provided in Part 4.

(3) Two or more insurers having a common ownership or operating in this state under common management or control may act in concert between or among

themselves with respect to any matters pertaining to those activities authorized in this section as if they constituted a single insurer.

(4) An insurer or rate service organization may not make any arrangement with any other insurer, rate service organization, or other person that has the purpose or effect of unreasonably restraining trade or unreasonably lessening competition in the business of insurance.

Enacted by Chapter 130, 1999 General Session

31A-19a-307. Rate service organizations -- Permitted activity.

A rate service organization may on behalf of its members and subscribers:

(1) develop statistical plans including territorial and class definitions;

(2) collect statistical data from:

(a) members;

(b) subscribers; or

(c) any other source;

(3) prepare, file, and distribute prospective loss costs which may include provisions for special assessments;

(4) prepare, file, and distribute:

(a) factors;

(b) calculations;

(c) formulas pertaining to classification; or

(d) territory, increased limits, and other variables;

(5) prepare, file, and distribute supplementary rating information;

(6) distribute information that is required or directed to be filed with the commissioner;

(7) conduct research and on-site inspections to prepare classifications of public fire defenses;

(8) consult with public officials regarding public fire protection as it would affect members, subscribers, and others;

(9) conduct research and onsight inspections to discover, identify, and classify information relating to causes or prevention of losses;

(10) conduct research relating to the impact of statutory changes upon prospective loss costs;

(11) prepare, file, and distribute policy forms and endorsements;

(12) consult with members, subscribers, and others concerning use and application of the policy forms and endorsements described in Subsection (11);

(13) conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;

(14) conduct on-site inspections to determine rating classifications for individual insureds;

(15) collect, compile, and publish past and current prices of individual insurers, provided the information is also made available to the general public at a reasonable cost;

(16) collect and compile exposure and loss experience for the purpose of individual risk experience ratings;

(17) furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section; and
(18) engage in any other activity not prohibited by this title.

Enacted by Chapter 130, 1999 General Session

31A-19a-308. Rate service organizations -- Filing requirements.
(1) A rate service organization shall file with the commissioner any of the following that is used in this state:
(a) any statistical plan;
(b) all prospective loss costs;
(c) provisions for special assessments;
(d) all supplementary rating information; and
(e) any change, amendment, or modification of an item described in Subsections (1)(a) through (d).
(2) The filings required under Subsection (1) shall be subject to Sections 31A-19a-203 and 31A-19a-206 and other provisions of this chapter relating to filings made by insurers.

Enacted by Chapter 130, 1999 General Session

31A-19a-309. Recording and reporting of experience.
(1) (a) The commissioner may adopt rules for the development of statistical plans, for use by all insurers in recording and reporting their loss and expense experience, in order that the experience of those insurers may be made available to the commissioner.
(b) The rules provided for in Subsection (1) may include:
(i) the data that shall be reported by an insurer;
(ii) definitions of data elements;
(iii) the timing and frequency of data reporting by an insurer;
(iv) data quality standards;
(v) data edit and audit requirements;
(vi) data retention requirements;
(vii) reports to be generated; and
(viii) the timing of reports to be generated.
(c) Except for workers' compensation insurance under Section 31A-19a-404, an insurer may not be required to record or report its experience on a classification basis that is inconsistent with its own rating system.
(2) (a) The commissioner may designate one or more rate service organizations to assist the commissioner in gathering that experience and making compilations of the experience.
(b) The compilations developed under Subsection (2)(a) shall be made available to the public.
(3) The commissioner may make rules and plans for the interchange of data necessary for the application of rating plans.
(4) To further uniform administration of rate regulatory laws, the commissioner

and every insurer and rate service organization may:

(a) exchange information and experience data with insurance supervisory officials, insurers, and rate service organizations in other states; and

(b) consult with the persons described in Subsection (4)(a) with respect to the application of rating systems and the reporting of statistical data.

Amended by Chapter 297, 2011 General Session

31A-19a-401. Scope of part.

(1) This part applies to workers' compensation insurance and employers' liability insurance written in connection with it.

(2) All insurers writing workers' compensation coverage, including the Workers' Compensation Fund created under Chapter 33, are subject to this part.

Amended by Chapter 222, 2000 General Session

31A-19a-402. Purpose.

It is the purpose of this part to:

(1) establish specific provisions for the filing of workers' compensation rates in addition to those provided in Part 2;

(2) provide for review by the department of workers' compensation rate-making and the results of it; and

(3) provide for a designated rate service organization to perform certain functions on behalf of the commissioner.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-403. Definitions.

As used in this part:

(1) "Uniform classification plan," in addition to the definition of "classification system" in Section 31A-19a-102, means a plan:

(a) that is consistent between all insurers of classification codes and descriptions; and

(b) by which like workers' compensation exposures are grouped for the purposes of underwriting, rating, and statistical reporting.

(2) "Uniform experience rating plan" means a plan that is consistent between all insurers for experience rating entities insured for workers' compensation insurance.

(3) "Uniform statistical plan" means a plan that is consistent between all insurers that is used for the reporting of workers' compensation insurance statistical data.

Amended by Chapter 90, 2004 General Session

31A-19a-404. Designated rate service organization.

(1) For purposes of workers' compensation insurance, the commissioner shall designate one rate service organization to:

(a) develop and administer the uniform statistical plan, uniform classification

plan, and uniform experience rating plan filed with and approved by the commissioner;

(b) assist the commissioner in gathering, compiling, and reporting relevant statistical information on an aggregate basis;

(c) develop and file manual rules, subject to the approval of the commissioner, that are reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan, and the uniform classification plan; and

(d) develop and file the prospective loss costs pursuant to Section 31A-19a-406.

(2) The uniform experience rating plan shall:

(a) contain reasonable eligibility standards;

(b) provide adequate incentives for loss prevention; and

(c) provide for sufficient premium differentials so as to encourage safety.

(3) Each workers' compensation insurer, directly or through its selected rate service organization, shall:

(a) record and report its workers' compensation experience to the designated rate service organization as set forth in the uniform statistical plan approved by the commissioner;

(b) adhere to a uniform classification plan and uniform experience rating plan filed with the commissioner by the rate service organization designated by the commissioner; and

(c) adhere to the prospective loss costs filed by the designated rate service organization.

(4) The commissioner may adopt rules for:

(a) the development and administration by the designated rate service organization of the:

(i) uniform statistical plan;

(ii) uniform experience rating plan; and

(iii) uniform classification plan;

(b) the recording and reporting of statistical data and experience rating data by the various insurers writing workers' compensation insurance;

(c) the selection, retention, and termination of the designated rate service organization; and

(d) providing for the equitable sharing and recovery of the expense of the designated rate service organization to develop, maintain, and provide the plans, services, and filings that are used by the various insurers writing workers' compensation insurance.

(5) (a) Notwithstanding Subsection (3), an insurer may develop directly or through its selected rate service organization subclassifications of the uniform classification system upon which a rate may be made.

(b) A subclassification shall be filed with the commissioner 30 days before its use.

(c) The commissioner shall disapprove subclassifications if the insurer fails to demonstrate that the data produced by the subclassifications can be reported consistently with the uniform statistical plan and uniform classification plan.

(6) Notwithstanding Subsection (3), an insurer may, directly or though its selected rate service organization, develop its own experience modifications based on

the uniform statistical plan, uniform classification plan, and uniform rating plan filed by the rate service organization designated by the commissioner under Subsection (1).

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-405. Filing of rates and other rating information.

(1) (a) All workers' compensation rates, supplementary rate information, and supporting information shall be filed at least 30 days before the effective date of the rate or information.

(b) Notwithstanding Subsection (1)(a), on application by the filer, the commissioner may authorize an earlier effective date.

(2) The loss and loss adjustment expense factors included in the rates filed under Subsection (1) shall be the prospective loss costs filed by the designated rate service organization under Section 31A-19a-406.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-406. Filing requirements for designated rate service organization.

(1) The rate service organization designated under Section 31A-19a-404 shall file with the commissioner the following items proposed for use in this state at least 30 calendar days before the date they are distributed to members, subscribers, or others:

(a) each prospective loss cost with its supporting information;

(b) the uniform classification plan and rating manual;

(c) the uniform experience rating plan manual;

(d) the uniform statistical plan manual; and

(e) each change, amendment, or modification of any of the items listed in Subsections (1)(a) through (d).

(2) (a) If the commissioner believes that prospective loss costs filed violate the excessive, inadequate, or unfair discriminatory standard in Section 31A-19a-201 or any other applicable requirement of this part, the commissioner may require that the rate service organization file additional supporting information.

(b) If, after reviewing the supporting information, the commissioner determines that the prospective loss costs violate these requirements, the commissioner may:

(i) require that adjustments to the prospective loss costs be made; or

(ii) call a hearing for any purpose regarding the filing.

Renumbered and Amended by Chapter 130, 1999 General Session

31A-19a-407. Cooperation among rating organizations and insurers

(1) Notwithstanding Section 31A-19a-305, rate service organizations and insurers may cooperate with each other in rate-making or in other matters within the scope of this part.

(2) (a) The commissioner may review the cooperative activities and practices permitted under Subsection (1).

(b) If, after a hearing, the commissioner finds any of the cooperative activities or practices permitted under Subsection (1) to be unfair, unreasonable, or otherwise

inconsistent with the law, the commissioner may issue an order:

(i) specifying in what respects the activity or practice is unfair, unreasonable, or otherwise inconsistent with the law; and

(ii) requiring the persons or entities involved to discontinue the activity or practice.

Enacted by Chapter 130, 1999 General Session

31A-19a-408. Procedures for workers' compensation tiered rate filings.

(1) Notwithstanding Section 31A-19a-214 and subject to the other provisions of this section, a workers' compensation insurer may file with the commissioner a rate filing for workers' compensation insurance that provides for a plan with more than one rate tier for a single insurer or an insurer group with common ownership if the filing shows that:

(a) each tier is established on underwriting rules that are based on criteria that would lead to a logical distinguishing of potential risk; and

(b) supporting actuarial analysis or other information that shows a clear distinction between the following for each tier:

(i) expected losses and expenses; and

(ii) actual losses and expenses.

(2) A workers' compensation insurer shall file with the commissioner an update of the actuarial analysis or other information required under Subsection (1)(b) at least every three years.

(3) A workers' compensation insurer may apply underwriting expertise and judgment in the tier placement process, except that underwriting expertise and judgment shall:

(a) be applied in a prudent manner; and

(b) when applied, be fair, reasonable, and fully documented.

Enacted by Chapter 242, 2011 General Session

31A-20-101. Underwriting limitations.

No insurer may insure or attempt to insure against:

(1) a wager or gaming risk;

(2) loss of an election;

(3) the penal consequences of a crime; or

(4) punitive damages.

Amended by Chapter 204, 1986 General Session

31A-20-102. Joint underwriting.

(1) Every group, association, or other organization of insurers that engages in joint underwriting or joint reinsurance shall file with the commissioner:

(a) a copy of its constitution, articles of incorporation, or agreement of association, and its bylaws or rules governing its activities, all certified by the custodian of the originals;

(b) a list of its members; and
(c) the name and address of its resident process agent.
(2) Every group, association, or other organization shall promptly notify the commissioner of every change in its constitution, articles of incorporation, agreement of association, bylaws, rules, its list of members, and its resident process agent.
(3) (a) If all members of a group of insurers under this section are authorized to do business in Utah, the business done by the group shall be allocated for regulatory purposes to individual members of the group.
(b) The group itself is subject only to:
(i) Chapter 1, General Provisions;
(ii) Chapter 2, Administration of the Insurance Laws;
(iii) Chapter 4, Insurers in General;
(iv) Chapter 20, Underwriting Restrictions;
(v) Chapter 21, Insurance Contracts in General;
(vi) Chapter 22, Contracts in Specific Lines;
(vii) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; and
(viii) Chapter 26, Insurance Adjusters.
(c) If any member of the group is not authorized to do business in Utah, the group shall obtain authorization to do business under Chapter 14, Foreign Insurers, and is subject to regulation under that chapter.

Amended by Chapter 340, 2011 General Session

31A-20-103. Classifications of insurance.
The commissioner may by rule define lines and classes of insurance which are not already defined under Section 31A-1-301. These definitions may be used for any purposes within the commissioner's regulatory power, including:
(1) providing instructions for reports and replies under Section 31A-2-202;
(2) controlling combinations of lines or classes of insurance; and
(3) determining which rules under Chapter 22 are applicable.

Amended by Chapter 91, 1987 General Session

31A-20-104. Combinations of policies.
Except as otherwise provided in this chapter, the commissioner may by rule establish standards for the combination of different coverages in policies and may specify whether premiums shall be separately stated for each.

Enacted by Chapter 242, 1985 General Session

31A-20-105. Indemnity agreements for surety corporation.
In assessing the financial condition of a surety insurer and its underwriting capacity and limits, the commissioner shall take into account the existence of a systematic underwriting practice of indemnity or security arrangements under Section 31A-22-104.

Enacted by Chapter 242, 1985 General Session

31A-20-106. Variable contracts.

(1) (a) An insurer may not deliver or issue for delivery within this state an insurance policy that provides a life or annuity benefit in a variable amount until the insurer:

(i) is licensed to do a life insurance or annuity business in this state; and

(ii) satisfies the commissioner that the insurer's condition and methods of operation in connection with those types of insurance policies do not render the insurer's operation hazardous to the public or its policyholders in this state.

(b) Notwithstanding any other provision of law, the commissioner has sole authority to:

(i) regulate the issuance and sale of a variable contract; and

(ii) make rules necessary and appropriate to carry out this chapter in relation to a variable contract.

(2) In determining the qualification of an insurer requesting authority to deliver an insurance policy described in Subsection (1) in this state, the commissioner shall consider:

(a) the history and financial condition of the insurer;

(b) the character, responsibility, and general fitness of the insurer's officers and directors; and

(c) in the case of a foreign insurer, whether the regulation provided by the state of its domicile or the jurisdiction in which its head office is located provides protection to policyholders and the public substantially equal to that provided by this title and the rules issued under this title.

(3) If an insurer is a subsidiary of an admitted life insurer, or affiliated with an admitted life insurer through common management or ownership, the commissioner may consider the insurer to have met the requirements of this section if:

(a) the insurer meets the requirements of this section; or

(b) the parent or the affiliated insurer meets the requirements of this section.

(4) This title applies to a separate account or a contract relating to the separate account, except:

(a) Sections 31A-22-402, 31A-22-407, and 31A-22-409, in the case of a variable annuity policy;

(b) Sections 31A-22-402, 31A-22-407, and 31A-22-408, in the case of a variable life insurance policy; and

(c) as otherwise provided in this title.

Amended by Chapter 10, 2010 General Session

31A-20-107. Reinsurance.

(1) (a) An authorized insurer writing a nonassessable policy may assume as a reinsurer a risk it may write directly.

(b) Subject to Chapters 5 through 14, Chapter 17, and to any limitation imposed on a foreign insurer by the law of its domicile, the commissioner may also authorize an

insurer to assume, as a reinsurer, one or more designated classes of risks it is not authorized to write directly.

(2) (a) Subject to Section 31A-5-508, an authorized insurer may cede or retrocede to:

(i) an insurer authorized to assume it under Subsection (1) a liability it has undertaken on a risk lawfully written under its certificate of authority; and

(ii) an authorized agency of the federal government or of this state.

(b) An authorized insurer may cede or retrocede reinsurance to an unauthorized insurer subject to:

(i) Sections 31A-17-404 and 31A-17-404.1;

(ii) a rule made by the commissioner under a section listed in Subsection (2)(b)(i); and

(iii) Subsection (3).

(3) A person may not knowingly cede reinsurance or permit or assist it to be ceded to a reinsurer not in sound financial condition. If a reinsurer satisfies one or more of the security factors under Section 31A-17-404.1, there is a rebuttable presumption that the reinsurer is in sound financial condition.

(4) (a) An authorized reinsurer who knowingly assumes from an unauthorized insurer, a risk that may lawfully be written only by an authorized insurer, shall immediately report the facts of the transaction to the commissioner.

(b) (i) Subject to Subsection (4)(b)(ii), an assuming reinsurer described in Subsection (4)(a):

(A) is liable for all taxes and penalties applicable under Sections 31A-3-301, 31A-3-302, and 31A-3-303; and

(B) may take credit for the payment of a tax or penalty lapse under Subsection (4)(b)(i) in its settlement of accounts with the unauthorized ceding insurer.

(ii) This Subsection (4)(b) does not apply if the assuming reinsurer's agreement with the ceding insurer takes the taxes described in Subsection (4)(b)(i) into account.

(5) (a) Except as provided under Subsection (5)(b), an authorized reinsurer proposing to withdraw from writing a class of its business in Utah, except by nonrenewal of an existing contract at its expiration, shall give the commissioner 60 days written notice of its intention. The authorized reinsurer may not withdraw until after those 60 days lapse.

(b) This Subsection (5) does not apply if the withdrawing reinsurer writes an insignificant market share of that class of business in Utah. The commissioner shall define "insignificant market share" by rule.

Amended by Chapter 257, 2008 General Session

31A-20-108. Single risk limitation.

(1) This section applies to all lines of insurance, including ocean marine and reinsurance, except:

(a) title insurance;

(b) workers' compensation insurance;

(c) occupational disease insurance;

(d) employers' liability insurance; and

(e) health insurance.

(2) (a) Except as provided under Subsections (3) and (4) and under Section 31A-20-109, an insurer authorized to do an insurance business in Utah may not expose itself to loss on a single risk in an amount exceeding 10% of its capital and surplus.

(b) The commissioner may adopt rules to calculate surplus under this section.

(c) An insurer may deduct the portion of a risk reinsured by a reinsurance contract worthy of a reserve credit under Sections 31A-17-404 through 31A-17-404.4 in determining the limitation of risk under this section.

(3) (a) The commissioner may adopt rules, after hearings held with notice provided under Section 31A-2-303, to specify the maximum exposure to which an assessable mutual may subject itself.

(b) The rules described in Subsection (3)(a) may provide for classifications of insurance and insurers to preserve the solidity of insurers.

(4) As used in this section, a "single risk" includes all losses reasonably expected as a result of the same event.

(5) A company transacting fidelity or surety insurance may expose itself to a risk or hazard in excess of the amount prescribed in Subsection (2), if the commissioner, after considering all the facts and circumstances, approves the risk.

Amended by Chapter 349, 2009 General Session

31A-20-109. Single risk limitation for title insurance.

(1) As used in this section:

(a) "Net retained liability" means the total potential liability retained by a title insurer for a single risk, after deducting liability reinsured for which credit may be taken under Section 31A-17-404.

(b) "Single risk" means the sum of the potential liabilities under all title insurance policies issued on any estates in the same real property.

(2) The net retained liability of a title insurer for a single risk, whether assumed directly or as reinsurance, may not exceed 50% of the capital and surplus of the insurer.

Enacted by Chapter 242, 1985 General Session

31A-20-110. Underwriting rules for title insurance.

(1) A title insurance policy may not be written until the title insurer or its individual title insurance producer or agency title insurance producer has conducted a reasonable search and examination of the title and has made a determination of insurability of title under sound underwriting principles. Evidence of this search and reasonable determination shall be retained in the files of the title insurer or its individual title insurance producer or agency title insurance producer for not less than 15 years after the policy has been issued, either in its original form or as recorded by any process which can accurately and reliably reproduce the original. This section does not apply to a company assuming liability through a contract of reinsurance, or to a company acting as coinsurer, if another coinsuring company has complied with this section.

(2) A title insurance policy may not be issued except by a title insurer, an individual title insurance producer who is appointed by an insurer, or agency title insurance producer licensed under Section 31A-23a-105.

(3) This section is enforceable only by the commissioner. It does not create, eliminate, or modify any private cause of action or remedy.

Amended by Chapter 319, 2013 General Session

31A-21-101. Scope of Chapters 21 and 22.

(1) Except as provided in Subsections (2) through (6), this chapter and Chapter 22, Contracts in Specific Lines, apply to all insurance policies, applications, and certificates:

(a) delivered or issued for delivery in this state;

(b) on property ordinarily located in this state;

(c) on persons residing in this state when the policy is issued; or

(d) on business operations in this state.

(2) This chapter and Chapter 22 do not apply to:

(a) an exemption provided in Section 31A-1-103;

(b) an insurance policy procured under Sections 31A-15-103 and 31A-15-104;

(c) an insurance policy on business operations in this state:

(i) if:

(A) the contract is negotiated primarily outside this state; and

(B) the operations in this state are incidental or subordinate to operations outside this state; and

(ii) except that insurance required by a Utah statute shall conform to the statutory requirements; or

(d) other exemptions provided in this title.

(3) (a) Sections 31A-21-102, 31A-21-103, 31A-21-104, Subsections 31A-21-107(1) and (3), and Sections 31A-21-306, 31A-21-308, 31A-21-312, and 31A-21-314 apply to ocean marine and inland marine insurance.

(b) Section 31A-21-201 applies to inland marine insurance that is written according to manual rules or rating plans.

(4) A group or blanket policy is subject to this chapter and Chapter 22, except:

(a) a group or blanket policy outside the scope of this title under Subsection 31A-1-103(3)(h); and

(b) other exemptions provided under Subsection (5).

(5) The commissioner may by rule exempt any class of insurance contract or class of insurer from any or all of the provisions of this chapter and Chapter 22 if the interests of the Utah insureds, creditors, or the public would not be harmed by the exemption.

(6) Workers' compensation insurance, including that written by the Workers' Compensation Fund created under Chapter 33, Workers' Compensation Fund, is subject to this chapter and Chapter 22.

(7) Unless clearly inapplicable, any provision of this chapter or Chapter 22 applicable to either a policy or a contract is applicable to both.

Amended by Chapter 297, 2011 General Session

31A-21-102. Oral contracts of insurance and binders.

(1) "Binder" means a writing which describes the subject and amount of insurance and temporarily binds insurance coverage pending the issuance of an insurance policy. "Binder" does not include conditional receipts by life insurance companies under which issuance of the policy or coverage under the policy is contingent upon the acceptability of the risk to the insurer.

(2) Binding oral contracts of insurance may only be made as to casualty insurance, liability insurance, property insurance, vehicle liability insurance, workers' compensation insurance, and as to combinations of these coverages. The insurer shall issue a policy or binder as soon as reasonably possible after negotiation of any oral contract under this subsection.

(3) No binder is valid beyond the issuance of the policy as to which the binder was given, or beyond 150 days from the binder's effective date, whichever occurs first.

(4) If a policy has not been issued as to a binder, the binder may be extended or renewed beyond 150 days, but only upon the commissioner's written approval, or under rules adopted by the commissioner.

(5) A binder may be cancelled by the insurer prior to its expiration date only in the same manner as and subject to the same restrictions that apply to insurance policies under Section 31A-21-303.

Amended by Chapter 261, 1989 General Session

31A-21-103. Capacity to contract.

Any person 16 years of age or older who is otherwise competent to contract under Utah law, and who is not subject to any legal disability, may contract for insurance. If there is a conservator appointed under Title 75, the conservator, rather than the person whose property is subject to the conservatorship, may contract for insurance to protect the property under conservatorship. In the case of a conservatorship over the person or property of a person under 16 years of age, the conservator may invest funds of the estate in life or accident and health insurance or annuity contracts, but only with the approval of the court having jurisdiction over the conservatorship.

Amended by Chapter 116, 2001 General Session

31A-21-104. Insurable interest and consent -- Scope.

(1) As used in this chapter:

(a) For purposes of this section, "exchange" means an exchange made pursuant to Section 1035, Internal Revenue Code, as may be amended.

(b) "Insurable interest" in a person means the following, including a circumstance described in Subsection (3):

(i) for a person closely related by blood or by law, a substantial interest engendered by love and affection; or

(ii) in the case of a person not described in Subsection (1)(b)(i), a lawful and

substantial interest in having the life, health, and bodily safety of the person insured continue.

(c) "Insurable interest" in property or liability means any lawful and substantial economic interest in the nonoccurrence of the event insured against.

(d) "Life settlement" is as defined in Section 31A-36-102.

(2) (a) An insurer may not knowingly provide insurance to a person who does not have or expect to have an insurable interest in the subject of the insurance.

(b) A person may not knowingly procure, directly, by assignment, or otherwise, an interest in the proceeds of an insurance policy unless that person has or expects to have an insurable interest in the subject of the insurance.

(c) In the case of life insurance, the insurable interest requirements of Subsections (2)(a) and (b):

(i) are satisfied if the requirements are met:

(A) at the effective date of the insurance policy; and

(B) at the time of a later procurement, if any, of an interest in the proceeds of an insurance policy; and

(ii) do not need to be met at the time that proceeds of an insurance policy are payable if the requirements are met at the times specified in Subsection (2)(c)(i).

(d) Except as provided in Subsections (7) and (8), insurance provided in violation of this Subsection (2) is subject to Subsection (6).

(e) A policy holder in a group insurance policy does not need an insurable interest if a certificate holder or a person other than the group policyholder who is specified by the certificate holder is the recipient of the proceeds of the group insurance policy.

(3) The following is a nonexhaustive list of insurable interests:

(a) A person has an unlimited insurable interest in that person's own life and health.

(b) A shareholder, member, or partner has an insurable interest in the life of another shareholder, member, or partner for purposes of an insurance contract that is an integral part of a legitimate buy-sell agreement respecting shares, membership interests, or partnership interests in the business.

(c) (i) A trust has an insurable interest in the subject of the insurance to the extent that all beneficiaries of the trust have an insurable interest.

(ii) A trust violates this section if the trust:

(A) is created to give the appearance of an insurable interest, but an insurable interest does not exist; and

(B) is used to initiate a policy for an investor or other person who has no insurable interest in the insured.

(d) (i) Subject to Subsection (3)(d)(v), an employer or an employer sponsored trust:

(A) has an insurable interest in the lives of the employer's:

(I) directors;

(II) officers;

(III) managers;

(IV) nonmanagement employees; and

(V) retired employees; and

(B) may insure a life listed in Subsection (3)(d)(i)(A):

(I) on an individual or group basis; and

(II) with the written consent of the insured.

(ii) (A) A trustee of a trust established by an employer for the sole benefit of the employer has the same insurable interest in the life and health of any person as does the employer.

(B) Without limiting the general principle in Subsection (3)(d)(ii)(A), a trustee of a trust established by an employer that provides life, health, disability, retirement, or similar benefits to an individual identified in Subsection (3)(d)(i)(A) has an insurable interest in the life of the individual described in Subsection (3)(d)(i)(A) for whom the benefits are provided.

(iii) (A) For the purpose of exchanging life insurance, an individual described in Subsection (3)(d)(i)(A) includes an individual who was formerly included under Subsection (3)(d)(i)(A) if the life insurance to be exchanged:

(I) is purchased or acquired while the individual is a current director, officer, manager, or employee; and

(II) is exchanged for life insurance in an amount that does not exceed the amount of the insurance being exchanged.

(B) Written consent of an individual described in this Subsection (3)(d)(iii) is not required at the time of the exchange of the life insurance.

(C) This Subsection (3)(d)(iii) shall be interpreted in a manner consistent with Subsection (2)(c).

(iv) (A) If an employer or trustee establishes an insurable interest as provided in this Subsection (3)(d) and all of the employer's business is acquired, purchased, merged into, or otherwise transferred to a subsequent employer, the insurable interest of the original employer or trustee in an individual described in Subsection (3)(d)(i)(A) is automatically transferred to:

(I) the subsequent employer; or

(II) the trustee of a trust established by the subsequent employer for the subsequent employer's sole benefit.

(B) A subsequent employer or a trustee of a trust described in Subsection (3)(d)(iv)(A)(II) may exchange life insurance that is purchased or acquired in an individual described in Subsection (3)(d)(i)(A) by the original employer or trustee without establishing a new insurable interest at the time of the exchange of the insurance.

(v) The extent of an employer's or employer sponsored trust's insurable interest for a nonmanagement or retired employee under Subsection (3)(d)(i) is limited to an amount commensurate with the employer's unfunded liabilities at the time insurance on the nonmanagement or retired employee is procured.

(4) (a) Except as provided in Subsection (5), an insurer may not knowingly issue an individual life or accident and health insurance policy to a person other than the one whose life or health is at risk unless that person:

(i) is 18 years of age or older;

(ii) is not under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property; and

(iii) gives written consent to the issuance of the policy.

(b) A person shall express consent:

(i) by signing an application for the insurance with knowledge of the nature of the document; or

(ii) in any other reasonable way.

(c) Insurance provided in violation of this Subsection (4) is subject to Subsection (6).

(5) (a) A life or accident and health insurance policy may be taken out without consent in a circumstance described in this Subsection (5)(a).

(i) A person may obtain insurance on a dependent who does not have legal capacity.

(ii) A creditor may, at the creditor's expense, obtain insurance on the debtor in an amount reasonably related to the amount of the debt.

(iii) A person may obtain life and accident and health insurance on an immediate family member who is living with or dependent on the person.

(iv) A person may obtain an accident and health insurance policy on others that would merely indemnify the policyholder against expenses the person would be legally or morally obligated to pay.

(v) The commissioner may adopt rules permitting issuance of insurance for a limited term on the life or health of a person serving outside the continental United States who is in the public service of the United States, if the policyholder is related within the second degree by blood or by marriage to the person whose life or health is insured.

(b) Consent may be given by another in a circumstance described in this Subsection (5)(b).

(i) A parent, a person having legal custody of a minor, or a guardian of a person under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, may consent to the issuance of a policy on a dependent child or on a person under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property.

(ii) A grandparent may consent to the issuance of life or accident and health insurance on a grandchild.

(iii) A court of general jurisdiction may give consent to the issuance of a life or accident and health insurance policy on an ex parte application showing facts the court considers sufficient to justify the issuance of that insurance.

(6) (a) An insurance policy is not invalid because:

(i) the insurance policy is issued or procured in violation of Subsection (2); or

(ii) consent has not been given.

(b) Notwithstanding Subsection (6)(a), a court with appropriate jurisdiction may:

(i) order the proceeds to be paid to some person who is equitably entitled to the proceeds, other than the one to whom the policy is designated to be payable; or

(ii) create a constructive trust in the proceeds or a part of the proceeds on behalf of a person who is equitably entitled to the proceeds, subject to all the valid terms and conditions of the policy other than those relating to insurable interest or consent.

(7) This section does not prevent an organization described under Section 501(c)(3), (e), or (f), Internal Revenue Code, as amended, and the regulations made under this section, and which is regulated under Title 13, Chapter 22, Charitable Solicitations Act, from soliciting and procuring, by assignment or designation as

beneficiary, a gift or assignment of an interest in life insurance on the life of the donor or assignor or from enforcing payment of proceeds from that interest.

(8) (a) Subsection (8)(b) applies if:

(i) an insurance policy is transferred pursuant to a life settlement in accordance with Chapter 36, Life Settlements Act; and

(ii) before the transfer described in Subsection (8)(a)(i) the insurable interest requirements of Subsection (2)(c)(i) are met for the insurance policy.

(b) An insurance policy described in Subsection (8)(a) is not subject to Subsection (6)(b) and nothing in this section prevents:

(i) an owner of life insurance, whether or not the owner is also the subject of the insurance, from entering into a life settlement;

(ii) a life settlement producer from soliciting a person to enter into a life settlement;

(iii) a person from enforcing payment of proceeds from the interest obtained under a life settlement; or

(iv) the execution:

(A) of any of the following with respect to the death benefit or ownership of any portion of a settled policy as provided for in Section 31A-36-109:

(I) an assignment;

(II) a sale;

(III) a transfer;

(IV) a devise; or

(V) a bequest; and

(B) by any of the following:

(I) a life settlement provider;

(II) a life settlement purchaser;

(III) a financing entity;

(IV) a related provider trust;

(V) a special purpose entity;

(VI) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A; or

(VII) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501.

(9) (a) The insurable interests described in this section:

(i) are not exclusive;

(ii) are cumulative of an insurable interest that is not expressly included in this section but exists in common law; and

(iii) are not in lieu of an insurable interest that is not expressly included in this section but exists in common law.

(b) The inclusion of an insurable interest in this section may not be considered to be excluding another insurable interest that is similar to the insurable interest included in this section.

(c) (i) The recognition of an insurable interest in this section by Chapter 89, Laws of Utah 2007, does not imply or create a presumption that the insurable interest did not exist before April 30, 2007.

(ii) An insurable interest shall be presumed with respect to a life insurance policy

issued before April 30, 2007 to a person whose insurable interest is recognized in this section by Chapter 89, Laws of Utah 2007.

Amended by Chapter 355, 2009 General Session

31A-21-105. Representations, warranties, and conditions.

(1) (a) No statement, representation, or warranty made by any person representing the insurer in the negotiation for an individual or franchise insurance contract affects the insurer's obligations under the policy unless it is stated in the policy or in a written application signed by the applicant. No person, except the applicant or another by his written consent, may alter the application, except for administrative purposes in a way which is clearly not ascribable to the applicant.

(b) No statement, representation, or warranty made by or on behalf of a particular certificate holder under a group policy affects the insurer's obligations under the certificate unless it is stated in the certificate or in a written document signed by the certificate holder, and a copy of it is supplied to the certificate holder.

(c) The policyholder, his assignee, the loss payee or mortgagee or lienholder under property insurance, and any person whose life or health is insured under a policy may request, in writing, from the company a copy of the application, if he did not receive the policy or a copy of it, or if the policy has been reinstated or renewed without the attachment of a copy of the original application. If the insurer does not deliver or mail a copy as requested within 30 days after receipt of the request by the insurer or its agent, or in the case of a group policy certificate holder, does not inform that person within the same period how he may inspect the policy or a copy of it and application or enrollment card or a copy of it during normal business hours at a place reasonably convenient to the certificate holder, nothing in the application or enrollment card affects the insurer's obligations under the policy to the person making the request. Each person whose life or health is insured under a group policy has the same right to request a copy of any document under Subsection (1)(b).

(2) Except as provided in Subsection (5), no misrepresentation or breach of an affirmative warranty affects the insurer's obligations under the policy unless:

(a) the insurer relies on it and it is either material or is made with intent to deceive; or

(b) the fact misrepresented or falsely warranted contributes to the loss.

(3) No failure of a condition prior to the loss and no breach of a promissory warranty affects the insurer's obligations under the policy unless it exists at the time of the loss and either increases the risk at the time of the loss or contributes to the loss. This Subsection (3) does not apply to failure to tender payment of premium.

(4) Nondisclosure of information not requested by the insurer is not a defense to an action against the insurer. Failure to correct within a reasonable time any representation that becomes incorrect because of changes in circumstances is misrepresentation, not nondisclosure.

(5) If after issuance of a policy the insurer acquires knowledge of sufficient facts to constitute a general defense to all claims under the policy, the defense is only available if the insurer notifies the insured within 60 days after acquiring the knowledge of its intention to defend against a claim if one should arise, or within 120 days if the

insurer considers it necessary to secure additional medical information and is actively seeking the information at the end of the 60 days. The insurer and insured may mutually agree to a policy rider in order to continue the policy in force with exceptions or modifications. For purposes of this Subsection (5), an insurer has acquired knowledge only if the information alleged to give rise to the knowledge was disclosed to the insurer or its agent in connection with communications or investigations associated with the insurance policy under which the subject claim arises.

(6) (a) An insurer that offers coverage to a small employer group as required by Pub. L. No. 104-191, 110 Stat. 1979, Sec. 2711(a), may not rescind a policy or individual certificate holder based on application misrepresentation unless the insurer would not have been required to issue the coverage in the absence of the misrepresentation.

(b) Subsection (6)(a) does not prevent an insurer from correcting rates if:

(i) in the absence of misrepresentation a different rate would have been required; and

(ii) the corrected rates are in compliance with Section 31A-30-106.

(7) No trivial or transitory breach of or noncompliance with any provision of this chapter is a basis for avoiding an insurance contract.

Amended by Chapter 131, 2003 General Session

31A-21-106. Incorporation by reference.

(1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain any agreement or incorporate any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery, unless the policy, application, or agreement accurately reflects the terms of the incorporated agreement, provision, or attached document.

(b) (i) A policy may by reference incorporate rate schedules and classifications of risks and short-rate tables filed with the commissioner.

(ii) By rule or order, the commissioner may authorize incorporation by reference of provisions for:

(A) administrative arrangements;

(B) premium schedules; and

(C) payment procedures for complex contracts.

(c) (i) A policy of title insurance insuring the mortgage or deed of trust of an institutional lender may, if requested by an institutional lender, incorporate by reference generally applicable policy terms that are contained in a specifically identified policy that has been filed with the commissioner.

(ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly engages in the business of making loans secured by real estate.

(d) A policy may incorporate by reference the following by citing in the policy:

(i) a federal law or regulation;

(ii) a state law or rule; or

(iii) a public directive of a federal or state agency.

(2) A purported modification of a contract during the term of the policy may not affect the obligations of a party to the contract:

(a) unless the modification is:
(i) in writing; and
(ii) agreed to by the party against whose interest the modification operates; and
(b) except:
(i) as provided in:
(A) Subsection (3) or (4);
(B) Subsection 31A-8-402.3(9);
(C) Subsection 31A-22-721(10); or
(D) Subsection 31A-30-107(8); or
(ii) as otherwise mandated by law.
(3) Subsection (2) does not prevent a change in coverage under group contracts resulting from:
(a) provisions of an employer eligibility rule;
(b) the terms of a collective bargaining agreement; or
(c) provisions in federal Employee Retirement Income Security Act plan documents.
(4) Subsection (2) does not prevent a premium increase at any renewal date that is applicable uniformly to all comparable persons.

Amended by Chapter 252, 2003 General Session

31A-21-107. Contract rights under noncomplying policies.
(1) Except as otherwise specifically provided by this title, a policy is enforceable against the insurer according to its terms, even if it exceeds the authority of the insurer.
(2) Any insurance policy, rider, or endorsement issued after July 1, 1986, and which is otherwise valid, which contains any condition or provision not in compliance with the requirements of this title, is not rendered invalid by this title. However, those conditions and provisions shall be construed and applied as if the policy, rider, or endorsement was in full compliance with this title.
(3) Upon written request of the policyholder or an insured whose rights under the policy are continuing and not transitory, an insurer shall reform and reissue or amend by a clearly stated rider its written policy to comply with the requirements of the law existing at the date of issuance of the policy. Subject to this section and Section 31A-21-102, a person seeking to reform a written insurance agreement by complaint or petition to a judicial authority shall show by clear and convincing evidence the existence of facts establishing the reformation.

Amended by Chapter 204, 1986 General Session

31A-21-108. Subrogation actions.
Subrogation actions may be brought by the insurer in the name of its insured.

Enacted by Chapter 204, 1986 General Session

31A-21-109. Debt cancellation agreements and debt suspension agreements.

(1) As used in this section:

(a) "Debt cancellation agreement" means a contract between a lender and a borrower where the lender, for a separately stated consideration, agrees to waive all or part of the debt in the event of a fortuitous event such as death, disability, or the destruction of the lender's collateral.

(b) "Debt suspension agreement" means a contract between a lender and a borrower where the lender, for a separately stated consideration, agrees to suspend scheduled installment payments for an agreed period of time in the event of a:

(i) fortuitous event such as involuntary unemployment or accident; or

(ii) fortuitous condition such as sickness.

(c) "Guaranteed asset protection waiver" is as defined in Section 31A-6b-102.

(d) "Institution" means:

(i) a bank as defined in Section 7-1-103;

(ii) a credit union as defined in Section 7-1-103;

(iii) an industrial bank as defined in Section 7-1-103; or

(iv) a savings and loan association as defined in Section 7-1-103.

(e) "Regulate the issuance" includes regulation of the following with respect to a debt cancellation agreement or a debt suspension agreement:

(i) terms;

(ii) conditions;

(iii) rates;

(iv) forms; and

(v) claims.

(f) "Subsidiary" is as defined in Section 7-1-103.

(2) Except as provided in Subsection (6), the commissioner has sole jurisdiction over the regulation of a debt cancellation agreement or debt suspension agreement.

(3) Subject to this section, the commissioner may by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(a) authorize an insurer to issue:

(i) a debt cancellation agreement; or

(ii) a debt suspension agreement; and

(b) regulate the issuance of:

(i) a debt cancellation agreement; or

(ii) a debt suspension agreement.

(4) Except as provided in Subsection (6), a debt cancellation agreement or a debt suspension agreement may be issued only by an insurer authorized to issue a debt cancellation agreement or debt suspension agreement under this section.

(5) (a) The rules promulgated by the commissioner under this section shall regulate the issuance of a debt cancellation agreement or debt suspension agreement according to the functional insurance equivalent of each type of debt cancellation agreement or debt suspension agreement.

(b) Except as provided in Subsection (5)(c), in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may by rule determine the functional insurance equivalent of each type of debt cancellation agreement or debt suspension agreement.

(c) Notwithstanding Subsection (5)(b), the functional insurance equivalent of a

debt cancellation agreement that provides for the cancellation of indebtedness at death is credit life insurance.

(6) Notwithstanding the other provisions of this section, the issuance of a debt cancellation agreement or a debt suspension agreement by an institution or a subsidiary of an institution is:

(a) not subject to this section; and

(b) subject to the jurisdiction of the primary regulator of:

(i) the institution; or

(ii) the subsidiary of an institution.

(7) This section does not apply to a guaranteed asset protection waiver.

Amended by Chapter 274, 2010 General Session

31A-21-110. Prohibition against certain use of Social Security number -- Exceptions -- Applicability of section.

(1) As used in this section "publicly display or publicly post" means to intentionally communicate or otherwise make available to the general public.

(2) An insurer not subject to Section 31A-22-634 may not do any of the following:

(a) publicly display or publicly post in any manner an individual's Social Security number; or

(b) print an individual's Social Security number on any card required for the individual to access products or services provided or covered by the insurer.

(3) This section does not prevent:

(a) the collection, use, or release of a Social Security number as required by state or federal law;

(b) the use of a Social Security number for internal verification or administrative purposes; or

(c) the release of a Social Security number:

(i) for claims administration purposes; or

(ii) as part of the verification, eligibility, or payment process.

(4) (a) An insurer shall comply with this section by July 1, 2005.

(b) An insurer may obtain an extension for compliance with this section in accordance with this Subsection (4)(b).

(i) The request for extension shall:

(A) be in writing to the department prior to July 1, 2005; and

(B) provide an explanation as to why the insurer cannot comply.

(ii) The commissioner shall grant a request for extension:

(A) for a period of time not to exceed March 1, 2006; and

(B) if the commissioner finds that the explanation provided under Subsection (4)(b)(i) is a reasonable explanation.

Enacted by Chapter 2, 2004 General Session

31A-21-111. Insurers to follow terms of policy.

Unless otherwise provided by this title, an insurer shall follow the terms of an

insurance policy issued or assumed by the insurer.

Enacted by Chapter 197, 2006 General Session

31A-21-112. Language other than English.

(1) An insurer may conduct a transaction in a language other than English through an employee or agent acting as interpreter or through an interpreter provided by the customer.

(2) An insurer may provide a customer an insurance policy, endorsement, rider, or explanatory or advertising material in a language other than English. If there is a dispute or complaint regarding the insurance policy, endorsement, rider, or explanatory or advertising material, the English language version of the insurance coverage shall control the resolution of the dispute or complaint.

(3) A non-English language policy delivered or issued for delivery in this state is considered to be in compliance with this title if the insurer certifies that the policy is translated from an English language policy that complies with this title.

(4) If an insurance policy, endorsement, or rider is provided in a language other than English, it shall be accompanied by:

(a) the corresponding English language version; and

(b) a disclaimer in both English and the other language that states that the foreign language version is provided only as an accommodation or courtesy to the customer and the English language version shall control the resolution of any dispute or complaint.

Enacted by Chapter 443, 2013 General Session

31A-21-201. Filing of forms.

(1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale until the form is filed with the commissioner.

(b) A form is considered filed with the commissioner when the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3) (a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form:

(A) is inequitable;

(B) is unfairly discriminatory;

(C) is misleading;

(D) is deceptive;

(E) is obscure;

(F) is unfair;

(G) encourages misrepresentation; or
(H) is not in the public interest;
(ii) the form provides benefits or contains another provision that endangers the solidity of the insurer;
(iii) except an application required by Section 31A-22-635, the form is an insurance policy or application for an insurance policy that fails to conspicuously, as defined by rule, provide:
(A) the exact name of the insurer;
(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy; and
(C) for a life insurance and annuity insurance policy only, the address of the administrative office of the insurer filing the insurance policy or application for the insurance policy;
(iv) the form violates a statute or a rule adopted by the commissioner; or
(v) the form is otherwise contrary to law.
(b) Subsection (3)(a)(iii) does not apply to an endorsement to an insurance policy.
(c) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the order, the use of the form be discontinued.
(ii) Once use of a form is prohibited, the form may not be used until appropriate changes are filed with and reviewed by the commissioner.
(iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to the existing policyholders.
(d) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:
(i) be in writing;
(ii) constitute an order; and
(iii) state the reasons for the prohibition.
(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that a form be subject to the commissioner's approval before its use.
(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for a form if the procedures are different from the procedures stated in this section.
(c) The type of form that under Subsection (4)(a) the commissioner may require approval of before use includes:
(i) a form for a particular class of insurance;
(ii) a form for a specific line of insurance;
(iii) a specific type of form; or
(iv) a form for a specific market segment.
(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):
(i) a form:
(A) filed under this section for use; or

(B) that is in use; and

(ii) a document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus five years from:

(i) the last day on which the form is used; or

(ii) the last day an insurance policy that is issued using the form is in effect.

Amended by Chapter 10, 2010 General Session

31A-21-202. Explicit approval required.

(1) The following clauses are disapproved unless the commissioner gives them explicit approval:

(a) clauses requiring more expeditious notice of loss or proof of loss than is required by Section 31A-21-312 or rules adopted under that section; and

(b) a schedule of reinstatement fees under Section 31A-22-608, if made a part of the policy. This type of schedule need not be included in the policy but may be given approval as a separate document specifically made applicable to particular classes of policies and incorporated in the policy by reference.

(2) If an insurer fails to obtain explicit approval from the commissioner for the clauses specified in Subsection (1), the clauses are void.

Amended by Chapter 204, 1986 General Session

31A-21-203. Authorized clauses for insurance forms.

(1) The commissioner may not adopt mandatory uniform clauses. However, the commissioner may adopt authorized clauses by rule upon a finding that:

(a) price or coverage competition is ineffective because diversity in language or content makes comparison difficult;

(b) provision of language, content, or form of specific clauses is necessary to provide certainty of meaning to those clauses;

(c) regulation of policy forms would be more effective or litigation would be substantially reduced if there were increased standardization of certain clauses; or

(d) reasonable minimum standards of insurance protection are needed for policies to serve a useful purpose.

(2) Any rule creating an authorized clause may prescribe that to be treated as an authorized clause there shall be verbatim or substantial adherence to prescribed language, that certain standards or criteria shall be met, or that certain drafting principles shall be followed. The rules may also permit liberalization of prescribed language. A rule may prescribe verbatim adherence only after the commissioner has made a finding that substantial adherence to the prescribed language is not sufficient and that liberalization of prescribed language will frustrate the purposes of the prescription. If an insurer uses authorized clauses as part of filed forms, the commissioner may only disapprove those clauses under Section 31A-21-201 upon a finding that improper combination of clauses makes them violate the criteria of Section 31A-21-201.

Enacted by Chapter 242, 1985 General Session

31A-21-301. Clauses required to be in a prominent position.

(1) The following portions of insurance policies shall appear conspicuously in the policy:

(a) as required by Subsection 31A-21-201(3)(a)(iii):

(i) the exact name of the insurer;

(ii) the state of domicile of the insurer; and

(iii) for life insurance and annuity policies only, the address of the administrative office of the insurer;

(b) information that two or more insurers under Subsection (1)(a) undertake only several liability, as required by Section 31A-21-306;

(c) if a policy is assessable, a statement of that;

(d) a statement that benefits are variable, as required by Section 31A-22-411; however, the methods of calculation need not be in a prominent position;

(e) the right to return a life or accident and health insurance policy under Sections 31A-22-423 and 31A-22-606; and

(f) the beginning and ending dates of insurance protection.

(2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately from any other clause.

Amended by Chapter 10, 2010 General Session

31A-21-302. Premiums.

(1) Subject to Section 31A-21-310 and Subsection 31A-21-106(1), the policy shall clearly state the amount of the total premium or shall explain in detail how it is calculated. Any fee, charge, or other consideration that is not part of the premium shall be disclosed and explained in writing to the insured. The disclosure and explanation shall be clearly stated either on the policy, or on the insurer's billing to the insured. The premium need not be contained in a certificate issued under a group policy. This Subsection (1) does not preclude premium adjustments or changes upon the renewal or endorsement of an existing policy. However, the renewal or endorsement notice shall contain or be accompanied by a statement of the renewal or endorsement premium or credit.

(2) Except as provided in Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, no person may charge or receive any consideration for the insurance policy which is not stated in Subsection (1).

(3) No person may knowingly collect any excessive amount as a premium or any amount for insurance which is not in the course of processing. Any amount unknowingly collected shall be returned immediately on learning of the mistake. Prepayment of premiums pursuant to the policy is not an excessive collection. Insurance is in the course of processing if an application has been made for it which is being considered by the insurer, even though it has not yet been accepted or rejected.

Amended by Chapter 298, 2003 General Session

31A-21-303. Cancellation, issuance, renewal.

(1) (a) Except as otherwise provided in this section, other statutes, or by rule under Subsection (1)(c), this section applies to all policies of insurance:

(i) except for:

(A) life insurance;

(B) accident and health insurance; and

(C) annuities; and

(ii) if the policies of insurance are issued on forms that are subject to filing under Subsection 31A-21-201(1).

(b) A policy may provide terms more favorable to insureds than this section requires.

(c) The commissioner may by rule totally or partially exempt from this section classes of insurance policies in which the insureds do not need protection against arbitrary or unannounced termination.

(d) The rights provided by this section are in addition to and do not prejudice any other rights the insureds may have at common law or under other statutes.

(2) (a) As used in this Subsection (2), "grounds" means:

(i) material misrepresentation;

(ii) substantial change in the risk assumed, unless the insurer should reasonably have foreseen the change or contemplated the risk when entering into the contract;

(iii) substantial breaches of contractual duties, conditions, or warranties;

(iv) attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional return of premium; or

(v) in the case of motor vehicle insurance, revocation or suspension of the driver's license of:

(A) the named insured; or

(B) any other person who customarily drives the motor vehicle.

(b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:

(A) the expiration of the agreed term; or

(B) one year from the effective date of the policy or renewal.

(ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the insurer for:

(A) nonpayment of a premium when due; or

(B) on grounds defined in Subsection (2)(a).

(c) (i) The cancellation provided by Subsection (2)(b), except cancellation for nonpayment of premium, is effective no sooner than 30 days after the delivery or first-class mailing of a written notice to the policyholder.

(ii) Cancellation for nonpayment of premium is effective no sooner than 10 days after delivery or first class mailing of a written notice to the policyholder.

(d) (i) Notice of cancellation for nonpayment of premium shall include a statement of the reason for cancellation.

(ii) Subsection (7) applies to the notice required for grounds of cancellation other than nonpayment of premium.

(e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not been previously renewed if the contract has been in effect less than 60 days when the written notice of cancellation is mailed or delivered.

(ii) A cancellation under this Subsection (2)(e) may not be effective until at least 10 days after the delivery to the insured of a written notice of cancellation.

(iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage prepaid, to the insured at the insured's last-known address, delivery is considered accomplished after the passing, since the mailing date, of the mailing time specified in the Utah Rules of Civil Procedure.

(iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the procedures described in Subsection (7).

(3) A policy may be issued for a term longer than one year or for an indefinite term if the policy includes a clause providing for cancellation by the insurer by giving notice as provided in Subsection (4)(b)(i) 30 days prior to any anniversary date.

(4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the policy renewed:

(i) on the terms then being applied by the insurer to similar risks; and

(ii) (A) for an additional period of time equivalent to the expiring term if the agreed term is one year or less; or

(B) for one year if the agreed term is longer than one year.

(b) Except as provided in Subsections (4)(c) and (5), the right to renewal under Subsection (4)(a) is extinguished if:

(i) at least 30 days prior to the policy expiration or anniversary date a notice of intention not to renew the policy beyond the agreed expiration or anniversary date is delivered or sent by first-class mail by the insurer to the policyholder at the policyholder's last-known address;

(ii) not more than 45 nor less than 14 days prior to the due date of the renewal premium, the insurer delivers or sends by first-class mail a notice to the policyholder at the policyholder's last-known address, clearly stating:

(A) the renewal premium;

(B) how the renewal premium may be paid; and

(C) that failure to pay the renewal premium by the due date extinguishes the policyholder's right to renewal;

(iii) the policyholder has:

(A) accepted replacement coverage; or

(B) requested or agreed to nonrenewal; or

(iv) the policy is expressly designated as nonrenewable.

(c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail to renew an insurance policy as a result of a telephone call or other inquiry that:

(i) references a policy coverage; and

(ii) does not result in the insured requesting payment of a claim.

(d) Failure to renew under this Subsection (4) is subject to Subsection (5).

(5) Notwithstanding Subsection (4), an insurer may not fail to renew the following personal lines insurance policies solely on the basis of:

(a) in the case of a motor vehicle insurance policy:

(i) a claim from the insured that:

(A) results from an accident in which:
(I) the insured is not at fault; and
(II) the driver of the motor vehicle that is covered by the motor vehicle insurance policy is 21 years of age or older; and
(B) is the only claim meeting the condition of Subsection (5)(a)(i)(A) within a 36-month period;
(ii) a single traffic violation by an insured that:
(A) is a violation of a speed limit under Title 41, Chapter 6a, Traffic Code;
(B) is not in excess of 10 miles per hour over the speed limit;
(C) is not a traffic violation under:
(I) Section 41-6a-601;
(II) Section 41-6a-604; or
(III) Section 41-6a-605;
(D) is not a violation by an insured driver who is younger than 21 years of age; and
(E) is the only violation meeting the conditions of Subsections (5)(a)(ii)(A) through (D) within a 36-month period; or
(iii) a claim for damage that:
(A) results solely from:
(I) wind;
(II) hail;
(III) lightning; or
(IV) an earthquake;
(B) is not preventable by the exercise of reasonable care; and
(C) is the only claim meeting the conditions of Subsections (5)(a)(iii)(A) and (B) within a 36-month period; and
(b) in the case of a homeowner's insurance policy, a claim by the insured that is for damage that:
(i) results solely from:
(A) wind;
(B) hail; or
(C) lightning;
(ii) is not preventable by the exercise of reasonable care; and
(iii) is the only claim meeting the conditions of Subsections (5)(b)(i) and (ii) within a 36-month period.
(6) (a) (i) Subject to Subsection (6)(b), if the insurer offers or purports to renew the policy, but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or rates at least 30 days prior to the expiration date of the prior policy.
(ii) If the insurer did not give the prior notification described in Subsection (6)(a)(i) to the policyholder, the new terms or rates do not take effect until 30 days after the notice is delivered or sent by first-class mail, in which case the policyholder may elect to cancel the renewal policy at any time during the 30-day period.
(iii) Return premiums or additional premium charges shall be calculated proportionately on the basis that the old rates apply.

(b) Subsection (6)(a) does not apply if the only change in terms that is adverse to the policyholder is:

(i) a rate increase generally applicable to the class of business to which the policy belongs;

(ii) a rate increase resulting from a classification change based on the altered nature or extent of the risk insured against; or

(iii) a policy form change made to make the form consistent with Utah law.

(7) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state with reasonable precision the facts on which the insurer's decision is based, the insurer shall send by first-class mail or deliver that information within 10 working days after receipt of a written request by the policyholder.

(b) A notice under Subsection (2)(c) is not effective unless it contains information about the policyholder's right to make the request.

(8) (a) An insurer that gives a notice of nonrenewal or cancellation of insurance on a motor vehicle insurance policy issued in accordance with the requirements of Chapter 22, Part 3, Motor Vehicle Insurance, for nonpayment of a premium shall provide notice of nonrenewal or cancellation to a lienholder if the insurer has been provided the name and mailing address of the lienholder.

(b) The notice described in Subsection (8)(a) shall be provided to the lienholder by first class mail or, if agreed by the parties, any electronic means of communication.

(c) A lienholder shall provide a current physical address of notification or an electronic address of notification to an insurer that is required to make a notification under Subsection (8)(a).

(9) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage provided by the insurance being cancelled or nonrenewed, a notice of cancellation or nonrenewal required under Subsection (2)(c) or (4)(b)(i) may not be effective unless it contains instructions to the policyholder for applying for insurance through the available risk-sharing plan.

(10) There is no liability on the part of, and no cause of action against, any insurer, its authorized representatives, agents, employees, or any other person furnishing to the insurer information relating to the reasons for cancellation or nonrenewal or for any statement made or information given by them in complying or enabling the insurer to comply with this section unless actual malice is proved by clear and convincing evidence.

(11) This section does not alter any common law right of contract rescission for material misrepresentation.

Amended by Chapter 190, 2010 General Session

31A-21-304. Special cancellation provisions.

Whether or not Section 31A-21-303 is also applicable:

(1) Section 31A-21-305 applies to cancellation on request of a premium finance company;

(2) Section 70C-6-304 applies to cancellation upon request of a creditor; and

(3) Sections 41-12a-404 and 41-12a-405 apply to the cancellation or other termination of insurance coverage or of a surety bond after the insurer or surety has

provided a certificate of insurance or suretyship to the Department of Public Safety.

Amended by Chapter 91, 1987 General Session

31A-21-305. Cancellation upon request of a premium finance company.

(1) As used in this section:

(a) "Insurance premium finance company" means a person engaged in the business of entering into premium finance agreements.

(b) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to an insurance premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance producer in payment of premiums on an insurance policy, together with a service charge, an interest charge, or both.

(2) When a premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance policy listed in the agreement, the following applies:

(a) Not less than 10 days' written notice of the intent of the insurance premium finance company to order cancellation of the insurance policy, unless the policyholder's default is cured prior to the date stated in the notice, shall be delivered or mailed first-class to the policyholder. The insurance producer indicated on the premium finance agreement shall also be given the same notice.

(b) Pursuant to the power of attorney or other authority, evidence of which is delivered to the insurer, the insurance premium finance company may order cancellation on behalf of the insured. This cancellation shall be effected by mailing to the insurer a written notice stating when the cancellation is effective. The insurance policy shall be cancelled as if the notice of cancellation had been given by the insured, but without requiring the return of the insurance policy. The insurance premium finance company shall also send a copy of the same notice to the insured at his last known address and to the insurance producer indicated on the premium finance agreement.

(c) Where statutory, rule, or contractual restrictions provide that the insurance policy may not be cancelled unless notice is given to a governmental agency, mortgagee, or other third party, the insurer shall give the prescribed notice on behalf of itself or the insured to that governmental agency, mortgagee, or other third party within a reasonable time after the day it receives the notice of cancellation from the premium finance company. When any statutory, rule, or contractual restrictions require the continuation of insurance beyond the effective date of cancellation specified by the premium finance company, the insurance is limited to the coverage required by those restrictions and to the persons those restrictions are designed to protect.

(d) Whenever a financed insurance policy is cancelled, the insurer shall return any unearned premiums due under the insurance policy to the insurance premium finance company for the account of the insured, and this action by the insurer satisfies the insurer's obligations under the insurance policy which relate to the return of unearned premiums. If the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund that excess to the insured if it exceeds $5.

(3) No filing of the premium finance agreement or recording of a premium

finance transaction is necessary to perfect the validity of the agreement as a secured transaction as against creditors, subsequent purchasers, pledgees, encumbrancers, successors, or assigns.

Amended by Chapter 298, 2003 General Session

31A-21-306. Policies or surety bonds jointly issued.

Two or more insurers may together issue a policy or surety bond. Their liability shall be joint and several with respect to the policy or bond. The policy or bond shall state the proportion or amount of premium to be paid to each insurer and, as between the issuing insurers, the type and the proportion or amount of liability each insurer assumes. Service of process on any of the insurers is service on all of them.

Amended by Chapter 204, 1986 General Session

31A-21-307. Other insurance.

(1) When two or more policies promise to indemnify an insured against the same loss without intending cumulative coverage, no "other insurance" provisions of the policies may reduce the aggregate protection of the insured below the lesser of the actual insured loss suffered by the insured and the maximum indemnification promised by any policy without regard to any "other insurance" provision.

(2) Subject to Subsection (1), the policies may by their terms define the extent to which each insurance is primary and each is excess, but if the "other insurance" terms of the policies are inconsistent, there is joint and several liability to the insured on any coverage which overlaps and which has inconsistent terms. Subsequent settlement among the insurers does not alter any rights of the insured. The commissioner may adopt rules consistent with this section concerning "other insurance."

(3) This section does not apply to accident and health insurance policies. Refer to Section 31A-22-619 for the coordination of accident and health benefits.

Amended by Chapter 116, 2001 General Session

31A-21-308. Limitations on loss to be borne by insurer.

(1) An insurance policy indemnifying an insured against loss may by clear language limit the part of the loss to be paid by the insurer to a specified or determinable maximum amount, to loss in excess of a specified or determinable amount, to a specified proportion of the loss which may vary with the amount of the loss, or to any combination of these methods. If the policy covers various risks, different limitations may be provided separately for each risk, if the policy clearly states that.

(2) A policy indemnifying an insured against loss of or damage to property may limit the part of the loss to be paid by the insurer to a percentage of the total loss that corresponds to the ratio of the insured sum to a specified percentage of the value of the insured property.

Enacted by Chapter 242, 1985 General Session

31A-21-309. Nonwaiver clause.

An insurer may insert a provision in any insurance policy that no change in the policy is valid unless approved by an executive officer of the insurer, or unless the approval is endorsed on the policy or attached to it, or both, and that no agent has authority to change the policy or waive any of its provisions. This does not preclude a person claiming a right under the policy from relying on waiver or estoppel in an appropriate case.

Enacted by Chapter 242, 1985 General Session

31A-21-310. Dividends on policies.

(1) Section 31A-22-418 applies to life insurance and annuities.

(2) Any insurer may distribute a portion of surplus attributable to policies other than life insurance or annuities, in amounts and with classifications the board of directors determines to be fair and reasonable. This distribution may not be contingent on the renewal of any policy or of premium payments unless the policy stated that limitation when it was written. A schedule explaining the basis for the distribution shall be filed with the commissioner prior to the distribution. The schedule shall be kept confidential by the commissioner unless he finds that the interests of insureds and the public require that it be made public.

(3) Any insurer may distribute surplus to any class of policyholder, even if their policies do not provide for it. A schedule explaining the basis for the distribution shall be filed with the commissioner under Subsection (2) at least 30 days prior to the distribution. The commissioner shall disallow any distribution which is materially unfair to other policyholders or which would place the insurer in a financially hazardous condition.

(4) It is permissible to provide an indivisible dividend to classes of policyholders having more than one type of policy, including a combination of life or annuities with other types of insurance.

Enacted by Chapter 242, 1985 General Session

31A-21-311. Group and blanket insurance.

(1) (a) (i) Except under Subsection (1)(d), an insurer issuing a group insurance policy other than a blanket insurance policy shall, as soon as practicable after the coverage is effective, provide a certificate for each member of the insured group, except that only one certificate need be provided for the members of a family unit.

(ii) The certificate required by this Subsection (1) shall:

(A) provide the exact name of the insurer;

(B) state the state of domicile of the insurer; and

(C) contain a summary of the essential features of the insurance coverage, including:

(I) any rights of conversion to an individual policy;

(II) in the case of group life insurance, any continuation of coverage during total disability; and

(III) in the case of group life insurance, the incontestability provision.

(iii) Upon receiving a written request, the insurer shall inform any insured how the insured may inspect, during normal business hours at a place reasonably convenient to the insured:

(A) a copy of the policy; or

(B) a summary of the policy containing all the details that are relevant to the certificate holder.

(b) The commissioner may by rule impose a requirement similar to Subsection (1)(a) on any class of blanket insurance policies for which the commissioner finds that the group of persons covered is constant enough for that type of action to be practicable and not unreasonably expensive.

(c) (i) A certificate shall be provided in a manner reasonably calculated to bring the certificate to the attention of the certificate holder.

(ii) The insurer may deliver or mail a certificate:

(A) directly to the certificate holders; or

(B) in bulk to the policyholder to transmit to certificate holders.

(iii) An affidavit by the insurer that the insurer mailed the certificates in the usual course of business creates a rebuttable presumption that the insurer has mailed the certificate to:

(A) a certificate holder; or

(B) a policyholder as provided in Subsection (1)(c)(ii)(B).

(d) The commissioner may by rule or order prescribe substitutes for delivery or mailing of certificates that are reasonably calculated to inform a certificate holder of the certificate holder's rights, including:

(i) booklets describing the coverage;

(ii) the posting of notices in the place of business; or

(iii) publication in a house organ.

(2) Unless a certificate or an authorized substitute has been made available to the certificate holder when required by this section, an act or omission forbidden to or required of the certificate holder by the certificate after the coverage has become effective as to the certificate holder, other than intentionally causing the loss insured against or failing to make required contributory premium payments, may not affect the insurer's obligations under the insurance contract.

Amended by Chapter 252, 2003 General Session

31A-21-312. Notice and proof of loss.

(1) Every insurance policy shall provide that:

(a) when notice of loss is required separately from proof of loss, notice given by or on behalf of the insured to any authorized agent of the insurer within this state, with particulars sufficient to identify the policy, is notice to the insurer; and

(b) failure to give any notice or file any proof of loss required by the policy within the time specified in the policy does not invalidate a claim made by the insured, if the insured shows that it was not reasonably possible to give the notice or file the proof of loss within the prescribed time and that notice was given or proof of loss filed as soon as reasonably possible.

(2) Failure to give notice or file proof of loss as required by Subsection (1)(b)

does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure. This subsection may not be construed to extend the statute of limitations applicable under Section 31A-21-313.

(3) The insurer shall, on request, promptly furnish an insured any forms or instructions needed to make a proof of loss.

(4) As an alternative to giving notice directly under Subsection (1)(a), it is a sufficient service of notice or of proof of loss if a first class postage prepaid envelope addressed to the insurer and containing the proper notice or proof of loss is deposited in any United States post office within the time prescribed.

(5) The commissioner shall adopt rules dealing with notice of loss and proof of loss time limitations under insurance policies. Under Section 31A-21-202, the commissioner's express approval shall be received before any contract clause requiring notice of loss or proof of loss in a manner inconsistent with the rule may be used in an insurance contract.

(6) The acknowledgment by the insurer of the receipt of notice, the furnishing of forms for filing proofs of loss, the acceptance of those proofs, or the investigation of any claim are not alone sufficient to waive any of the rights of the insurer in defense of any claim arising under the insurance policy.

Amended by Chapter 297, 2011 General Session

31A-21-313. Limitation of actions.

(1) An action on a written policy or contract of first party insurance shall be commenced within three years after the inception of the loss.

(2) Except as provided in Subsection (1) or elsewhere in this title, the law applicable to limitation of actions in Title 78B, Chapter 2, Statutes of Limitations, applies to actions on insurance policies.

(3) An insurance policy may not:

(a) limit the time for beginning an action on the policy to a time less than that authorized by statute;

(b) prescribe in what court an action may be brought on the policy; or

(c) provide that no action may be brought, subject to permissible arbitration provisions in contracts.

(4) Unless by verified complaint it is alleged that prejudice to the complainant will arise from a delay in bringing suit against an insurer, which prejudice is other than the delay itself, no action may be brought against an insurer on an insurance policy to compel payment under the policy until the earlier of:

(a) 60 days after proof of loss has been furnished as required under the policy;

(b) waiver by the insurer of proof of loss; or

(c) the insurer's denial of full payment.

(5) The period of limitation is tolled during the period in which the parties conduct an appraisal or arbitration procedure prescribed by the insurance policy, by law, or as agreed to by the parties.

Amended by Chapter 297, 2011 General Session

31A-21-314. Prohibited provisions.

No insurance policy subject to this chapter may contain any provision:

(1) requiring it to be construed according to the laws of another jurisdiction except as necessary to meet the requirements of compulsory insurance laws of other jurisdictions;

(2) depriving Utah courts of jurisdiction over an action against the insurer, except as provided in permissible arbitration provisions; or

(3) limiting the right of action against the insurer to less than three years from the date the cause of action accrues.

Amended by Chapter 95, 1987 General Session

31A-21-315. Refund of canceled health insurance premiums and Medicare supplement insurance premiums.

(1) As used in this section, "unearned amount of the collected premium" means the amount of the collected premium applicable to the unexpired portion of the time period to which the policy or certificate relates.

(2) If a health insurance policy or a Medicare supplement policy is cancelled for a reason other than a material misrepresentation, the insurer shall refund the unearned amount of the collected premium.

(3) If an insurer cancels a health insurance policy or a Medicare supplement policy because of a material misrepresentation on the application, the insurer shall refund all premiums collected minus claims that have been paid.

Amended by Chapter 156, 2009 General Session

31A-21-401. Scope and construction of part.

This part applies to all mass marketed life or accident and health insurance, notwithstanding Subsection 31A-1-103(3). This part may not be construed to limit the application of other provisions of this title to insurers effecting mass marketed life or accident and health insurance policies on persons in this state.

Amended by Chapter 116, 2001 General Session

31A-21-402. Definitions.

As used in this part:

(1) "Direct response solicitation" means any offer by an insurer to persons in this state, either directly or through a third party, to effect life or accident and health insurance coverage which enables the individual to apply or enroll for the insurance on the basis of the offer. Direct response solicitation does not include solicitations for insurance through an employee benefit plan exempt from state regulation under preemptive federal law, nor does it include solicitations through the individual's creditor with respect to credit life or credit accident and health insurance.

(2) "Mass marketed life or accident and health insurance" means the insurance under any individual, franchise, group, or blanket policy of life or accident and health insurance which is offered by means of direct response solicitation through a

sponsoring organization or through the mails or other mass communications media and under which the person insured pays all or substantially all of the cost of his insurance.

Amended by Chapter 116, 2001 General Session

31A-21-403. Orders terminating effectiveness of policies.

Upon the commissioner's order, no mass marketed life or accident and health insurance issued by an insurer may continue to be effected on persons in this state. The commissioner may issue an order under this section only if the commissioner finds, after a hearing, that the total charges for the insurance to the persons insured are unreasonable in relation to the benefits provided. The commissioner's findings under this section shall be in writing. Orders under this section may direct the insurer to cease effecting the insurance until the total charges for the insurance are found by the commissioner to be reasonable in relation to the benefits provided.

Amended by Chapter 297, 2011 General Session

31A-21-404. Out-of-state insurers.

Any insurer extending mass marketed life or accident and health insurance under a group or blanket policy issued outside of this state to residents of this state shall, with respect to the mass marketed life or accident and health insurance policy:

(1) comply with:

(a) Sections 31A-23a-402, 31A-23a-402.5, and 31A-23a-403; and

(b) Chapter 26, Part 3, Claim Practices; and

(2) upon the commissioner's request, deliver to the commissioner a copy of any mass marketed life or accident and health insurance policy, certificates issued under these policies, and advertising material used in this state in connection with the policy.

Amended by Chapter 62, 2011 General Session

31A-21-501. Definitions.

For purposes of this part:

(1) "Applicant" means:

(a) in the case of an individual life or accident and health policy, the person who seeks to contract for insurance benefits; or

(b) in the case of a group life or accident and health policy, the proposed certificate holder.

(2) "Cohabitant" means an emancipated individual pursuant to Section 15-2-1 or an individual who is 16 years of age or older who:

(a) is or was a spouse of the other party;

(b) is or was living as if a spouse of the other party;

(c) is related by blood or marriage to the other party;

(d) has one or more children in common with the other party; or

(e) resides or has resided in the same residence as the other party.

(3) "Child abuse" means the commission or attempt to commit against a child a criminal offense described in:

(a) Title 76, Chapter 5, Part 1, Assault and Related Offenses;
(b) Title 76, Chapter 5, Part 4, Sexual Offenses;
(c) Section 76-9-702, Lewdness;
(d) Section 76-9-702.1, Sexual battery; or
(e) Section 76-9-702.5, Lewdness involving a child.

(4) "Domestic violence" means any criminal offense involving violence or physical harm or threat of violence or physical harm, or any attempt, conspiracy, or solicitation to commit a criminal offense involving violence or physical harm, when committed by one cohabitant against another and includes commission or attempt to commit, any of the following offenses by one cohabitant against another:
(a) aggravated assault, as described in Section 76-5-103;
(b) assault, as described in Section 76-5-102;
(c) criminal homicide, as described in Section 76-5-201;
(d) harassment, as described in Section 76-5-106;
(e) electronic communication harassment, as described in Section 76-9-201;
(f) kidnaping, child kidnaping, or aggravated kidnaping, as described in Sections 76-5-301, 76-5-301.1, and 76-5-302;
(g) mayhem, as described in Section 76-5-105;
(h) sexual offenses, as described in Title 76, Chapter 5, Part 4, and Section 76-5b-201;
(i) stalking, as described in Section 76-5-106.5;
(j) unlawful detention or unlawful detention of a minor, as described in Section 76-5-304;
(k) violation of a protective order or ex parte protective order, as described in Section 76-5-108;
(l) any offense against property described in Title 76, Chapter 6, Part 1, Property Destruction, Part 2, Burglary and Criminal Trespass, or Part 3, Robbery;
(m) possession of a deadly weapon with intent to assault, as described in Section 76-10-507; or
(n) discharge of a firearm from a vehicle, near a highway, or in the direction of any person, building, or vehicle, as described in Section 76-10-508.

(5) "Subject of domestic abuse" means an individual who is, has been, may currently be, or may have been subject to domestic violence or child abuse.

Amended by Chapter 39, 2012 General Session
Amended by Chapter 303, 2012 General Session

31A-21-502. Scope of part.

This part applies to only life and accident and health insurance.

Amended by Chapter 116, 2001 General Session

31A-21-503. Discrimination based on domestic violence or child abuse prohibited.

(1) Except as provided in Subsection (2), an insurer of life or accident and health insurance may not consider whether an insured or applicant is the subject of domestic

abuse as a factor to:

(a) refuse to insure the applicant;

(b) refuse to continue to insure the insured;

(c) refuse to renew or reissue a policy to insure the insured or applicant;

(d) limit the amount, extent, or kind of coverage available to the insured or applicant;

(e) charge a different rate for coverage to the insured or applicant;

(f) exclude or limit benefits or coverage under an insurance policy or contract for losses incurred;

(g) deny a claim; or

(h) terminate coverage or fail to provide conversion privileges in violation of Section 31A-22-612 under a group accident and health policy for the insured because the coverage was issued in the name of the perpetrator of the domestic violence or abuse.

(2) (a) Notwithstanding Subsection (1), an insurer may underwrite on the basis of the physical or mental condition of an insured or applicant if the underwriting is on the basis of a determination that there is a correlation between the medical or mental condition and a material increase in insurance risk.

(b) For purposes of Subsection (2)(a), the fact that an insured or applicant is a subject of domestic abuse is not a mental or physical condition.

(c) The determination required by Subsection (2)(a) shall be made in conformance with sound actuarial principles.

(d) Within 30 days after receiving an oral or written request from an insured or applicant, an insurer shall disclose in writing:

(i) the basis of an action permitted under Subsection (2)(a); and

(ii) if the policy has been issued or modified, the extent the action taken will impact the amount, extent, or kind of coverage or benefits available to the insured.

Amended by Chapter 319, 2013 General Session

31A-21-504. Investigation -- Use of information used -- Disclosure.

(1) An insurer may not ask an insured or applicant or use any other means to determine whether the insured or applicant is the subject of domestic abuse.

(2) If an insured or applicant voluntarily discloses to the insurer or to the insured's or applicant's treating physician that the insured or applicant or a member of the insured's or applicant's household is the subject of domestic abuse, an insurer may not use the information of domestic violence or child abuse in violation of this part.

(3) (a) An insurer may not disclose or transfer information to a third party relating to whether a specifically identifiable insured or applicant is the subject of domestic abuse unless the information:

(i) is required to be disclosed by the commissioner;

(ii) is required to be disclosed by a court of competent jurisdiction;

(iii) is necessary for the direct provision of health care services;

(iv) is permitted to be disclosed to an authorized agency under Chapter 31, Insurance Fraud Act;

(v) is required to be disclosed by abuse reporting laws; or

(vi) is authorized to be disclosed by the written consent of the individual who is the subject of domestic abuse, if that person is at least 18 years old.

(b) Subsection (3)(a) may not prevent an insured or applicant from obtaining the insured's or applicant's own medical or insurance records.

(c) Disclosure of information permitted under Subsection (3)(a) is subject to any state or federal law related to the confidentiality of medical information.

(d) For purposes of Subsection (3)(a), "third party" does not include an insurer's employees, agents, or contractors who are engaged in the insurer's necessary business operation.

(4) This section may not be construed to prohibit an insurer from:

(a) asking an applicant or insured about a medical condition, even if the condition is related to domestic violence or child abuse;

(b) using information obtained under Subsection (4)(a) for the purpose of actions or practices permitted under this part.

Enacted by Chapter 132, 1997 General Session

31A-21-505. Limit on liability.

An insurer that issues a life or accident and health insurance policy to an individual who is the subject of domestic abuse is not liable civilly or criminally for the death of or any injuries to the insured as a result of domestic violence or child abuse beyond the obligations of the insurer under:

(1) the insurance policy; or

(2) this title.

Amended by Chapter 116, 2001 General Session

31A-21-506. Enforcement -- Private rights.

(1) An insurer that violates this part is subject to any penalty permitted under this title.

(2) This part does not:

(a) create a private right of action for a violation of this part; or

(b) limit or impair the right of an individual to sue and recover damages from the insurer in a civil action for a cause of action that is not based on a violation of this part.

Enacted by Chapter 132, 1997 General Session

31A-22-101. Scope of part.

This Part 1 applies to those suretyship obligations that are subject to Chapter 21 and this chapter under Section 31A-21-101.

Amended by Chapter 90, 2004 General Session

31A-22-102. Bonds need not be under seal.

Under this code, no suretyship obligation is required to be under seal.

Enacted by Chapter 242, 1985 General Session

31A-22-103. Validity of surety bonds.

(1) An undertaking to stand as surety which is issued by an insurer authorized to do a surety business in this state is complete compliance with any qualification requirement in Utah law respecting surety bonds. This undertaking is acceptable to any state official or court-appointed fiduciary authorized to receive or empowered to require the undertaking. A copy of a surety's certificate of authority, certified by the commissioner, is prima facie evidence that a surety was authorized to do business in this state on the date of the certificate.

(2) No instrument executed by an insurer authorized to do a surety business is ineffective because of the insurer's failure to attach a copy of its certificate of authority to do business in this state. However, a public official or court-appointed fiduciary may, by prior written request, require that a copy of the insurer's certificate of authority, certified by the commissioner, be delivered. The insurer's failure to deliver a certified copy of the surety's certificate of authority within 10 days of receipt of the request is adequate grounds for refusing to accept the suretyship instrument. Failure to request a copy of the certificate of authority prior to accepting the surety instrument is a waiver of the right to request the certificate.

(3) After executing an obligation of suretyship, no insurer may deny its corporate power to execute that type of instrument or to incur that type of liability in any proceeding against the insurer upon that instrument.

Amended by Chapter 204, 1986 General Session

31A-22-104. Indemnity agreements and security for benefit of surety.

(1) Any insurer authorized to do a surety business may contract with any person, including a principal debtor under a suretyship obligation, for indemnity or security to protect the surety against losses. No indemnity agreement or provision of security by the principal debtor releases from or changes the liability of the principal debtor or of the sureties from the terms established in the bond. No surety may be indemnified through funds held by the principal debtor in a fiduciary capacity.

(2) Security may be in any of the following forms:

(a) deposits of money or other property of the principal debtor which can be held by a responsible financial institution authorized by law to do that type of business, in a manner that prevents withdrawal or alienation of the money or other property without the written consent of the sureties or an order of a court of competent jurisdiction made after notice is given to the sureties and a hearing is held as directed by the court; or

(b) security interests in real or personal property perfected under the laws of Utah.

(3) This section does not affect a surety's common-law right to reimbursement, subrogation, or exoneration.

Amended by Chapter 218, 1987 General Session

31A-22-105. Common control of fiduciary funds permissible.

Any fiduciary from whom a bond, undertaking, or other obligation is required may agree and arrange with his sureties for the deposit for safekeeping of any and all assets for which he is responsible with a depository institution authorized by law to hold the assets, in a manner which prevents the withdrawal or alienation of any part of the property without the written consent of the sureties, or an order of the court made after notice is given to the sureties and a hearing is held as directed by the court. This deposit agreement does not release or change the fiduciary responsibility of the principal, or the liability of the principal or sureties as established under the bond.

Enacted by Chapter 242, 1985 General Session

31A-22-106. Petition of fiduciary's surety to be relieved from liability.

Any surety securing others against losses caused by breach of duty by a fiduciary, herein called "principal," may petition the court where the surety's obligation is filed or which has jurisdiction over the principal, for an order relieving the surety from further liability for the acts or omissions of the principal. This order may be issued only after the court is satisfied that the principal has accounted to the petitioner and has obtained a new surety. The surety relieved from liability shall refund any unearned part of the premium paid which the surety held as consideration for its promise to be surety. To relieve a surety from liability, the court may order the principal to account, to obtain a new surety, or to refrain from acting except to preserve property held in a fiduciary capacity.

Enacted by Chapter 242, 1985 General Session

31A-22-107. Bond premium allowable expense of fiduciary.

Any fiduciary required by law, or the court in providing a surety to secure the fiduciary's performance, may include as part of the expense of executing the fiduciary responsibility a reasonable premium paid to a surety for becoming the fiduciary's surety. However, the court may not allow an expense allowance greater than the larger of 1% of the surety's maximum obligation or $25.

Enacted by Chapter 242, 1985 General Session

31A-22-201. Required provisions of liability insurance policies.

Every liability insurance policy shall provide that the bankruptcy or insolvency of the insured may not diminish any liability of the insurer to third parties, and that if execution against the insured is returned unsatisfied, an action may be maintained against the insurer to the extent that the liability is covered by the policy.

Enacted by Chapter 242, 1985 General Session

31A-22-202. Protection of third-party claimants.

No insurance contract insuring against loss or damage through legal liability for the bodily injury or death by accident of any person, or for damage to the property of any person may be retroactively abrogated to the detriment of any third-party claimant

by any agreement between the insurer and insured after the occurrence of any injury, death, or damage for which the insured may be liable. This attempted abrogation is void.

Enacted by Chapter 242, 1985 General Session

31A-22-203. Notice and proof of loss.

Section 31A-21-312 applies to the notice required under liability policies. Subsection 31A-21-312(1) may not be construed to extend the normal provisions of any claims-made coverage that required notice of an occurrence or claim prior to the expiration of the policy for coverage to be in force.

Amended by Chapter 10, 1988 Special Session 2

31A-22-204. Restriction on limitation of coverage.

No insurer may limit coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force, unless the policy contains on the cover page, a conspicuous statement that the coverage of the policy is limited in that way.

Enacted by Chapter 242, 1985 General Session

31A-22-301. Definitions.

As used in this part:

(1) "Motor vehicle" has the same meaning as under Subsection 41-12a-103(4).

(2) "Motor vehicle business" means a motor vehicle sales agency, repair shop, service station, storage garage, or public parking place.

(3) "Motor vehicle liability policy" means a policy which satisfies the requirements of Sections 31A-22-303 and 31A-22-304.

(4) "Occupying" means being in or on a motor vehicle as a passenger or operator, or being engaged in the immediate acts of entering, boarding, or alighting from a motor vehicle.

(5) "Operator" has the same meaning as under Subsection 41-12a-103(7).

(6) "Owner" has the same meaning as under Subsection 41-12a-103(8).

(7) "Pedestrian" means any natural person not occupying a motor vehicle.

Amended by Chapter 91, 1987 General Session

31A-22-302. Required components of motor vehicle insurance policies -- Exceptions.

(1) Every policy of insurance or combination of policies purchased to satisfy the owner's or operator's security requirement of Section 41-12a-301 shall include:

(a) motor vehicle liability coverage under Sections 31A-22-303 and 31A-22-304;

(b) uninsured motorist coverage under Section 31A-22-305, unless affirmatively waived under Subsection 31A-22-305(5);

(c) underinsured motorist coverage under Section 31A-22-305.3, unless

affirmatively waived under Subsection 31A-22-305.3(3); and

(d) except as provided in Subsection (2) and subject to Subsection (4), personal injury protection under Sections 31A-22-306 through 31A-22-309.

(2) A policy of insurance or combination of policies, purchased to satisfy the owner's or operator's security requirement of Section 41-12a-301 for a motorcycle, off-highway vehicle, street-legal all-terrain vehicle, trailer, or semitrailer is not required to have personal injury protection under Sections 31A-22-306 through 31A-22-309.

(3) A card issued by an insurance company as evidence of owner's or operator's security under Section 41-12a-303.2 on or after July 1, 2014, may not display the owner's or operator's address on the card.

(4) (a) First party medical coverages may be offered or included in policies issued to motorcycle, off-highway vehicle, street-legal all-terrain vehicle, trailer, and semitrailer owners or operators.

(b) Owners and operators of motorcycles, off-highway vehicles, street-legal all-terrain vehicles, trailers, and semitrailers are not covered by personal injury protection coverages in connection with injuries incurred while operating any of these vehicles.

(5) First party medical coverage expenses shall be governed by the relative value study provisions under Subsections 31A-22-307(2) and (3).

Amended by Chapter 91, 2013 General Session

31A-22-302.5. Named driver exclusions.

(1) A policy of personal lines insurance or combination of personal lines policies purchased to satisfy the owner's or operator's security requirement under Section 41-12a-301 may specifically exclude from coverage:

(a) a person who is a resident of the named insured's household, including a person who usually makes the person's home in the same household but temporarily lives elsewhere; or

(b) a person who usually or customarily operates the motor vehicle.

(2) The named driver exclusion under Subsection (1) is effective only if:

(a) at the time of the proposed exclusion, each person excluded from coverage satisfies the owner's or operator's security requirement under Section 41-12a-301, independently of the named insured's proof of owner's or operator's security;

(b) any named insured and the person excluded from coverage each provide written consent to the exclusion; and

(c) the insurer includes the name of each person excluded from coverage in the evidence of insurance provided to an additional insured or loss payee.

(3) The provisions of Subsection (2)(a) do not apply to the named driver exclusion of the person excluded from coverage if the person's driver license has been denied, suspended, or revoked.

(4) The named driver exclusion shall remain effective until removed by the insurer.

(5) If the driver license of a person excluded from coverage under Subsection (1) has been denied, suspended, revoked, or disqualified and the person excluded from coverage subsequently operates a motor vehicle, the exclusion shall:

(a) exclude all liability coverage and all physical damage coverage without regard to the comparative fault of the excluded driver;

(b) proportionately reduce any benefits otherwise payable to the person excluded from coverage and to any named insured for benefits payable under uninsured motorist coverage, underinsured motorist coverage, personal injury protection coverage, and first party medical coverage to the extent the person excluded from coverage was comparatively at fault; and

(c) if the person excluded from coverage is 50% or more at fault in causing the accident, bar both the excluded driver and any named insured from recovering any benefits under any coverage listed under Subsection (5)(b).

(6) The named driver exclusion under Subsection (1) does not apply when the person excluded from coverage is:

(a) a non-driving passenger in a motor vehicle; or

(b) a pedestrian.

Amended by Chapter 425, 2011 General Session

31A-22-303. Motor vehicle liability coverage.

(1) (a) In addition to complying with the requirements of Chapter 21, Insurance Contracts in General, and Chapter 22, Part 2, Liability Insurance in General, a policy of motor vehicle liability coverage under Subsection 31A-22-302(1)(a) shall:

(i) name the motor vehicle owner or operator in whose name the policy was purchased, state that named insured's address, the coverage afforded, the premium charged, the policy period, and the limits of liability;

(ii) (A) if it is an owner's policy, designate by appropriate reference all the motor vehicles on which coverage is granted, insure the person named in the policy, insure any other person using any named motor vehicle with the express or implied permission of the named insured, and, except as provided in Section 31A-22-302.5, insure any person included in Subsection (1)(a)(iii) against loss from the liability imposed by law for damages arising out of the ownership, maintenance, or use of these motor vehicles within the United States and Canada, subject to limits exclusive of interest and costs, for each motor vehicle, in amounts not less than the minimum limits specified under Section 31A-22-304; or

(B) if it is an operator's policy, insure the person named as insured against loss from the liability imposed upon him by law for damages arising out of the insured's use of any motor vehicle not owned by him, within the same territorial limits and with the same limits of liability as in an owner's policy under Subsection (1)(a)(ii)(A);

(iii) except as provided in Section 31A-22-302.5, insure persons related to the named insured by blood, marriage, adoption, or guardianship who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere, to the same extent as the named insured;

(iv) where a claim is brought by the named insured or a person described in Subsection (1)(a)(iii), the available coverage of the policy may not be reduced or stepped-down because:

(A) a permissive user driving a covered motor vehicle is at fault in causing an accident; or

(B) the named insured or any of the persons described in this Subsection (1)(a)(iii) driving a covered motor vehicle is at fault in causing an accident; and

(v) cover damages or injury resulting from a covered driver of a motor vehicle who is stricken by an unforeseeable paralysis, seizure, or other unconscious condition and who is not reasonably aware that paralysis, seizure, or other unconscious condition is about to occur to the extent that a person of ordinary prudence would not attempt to continue driving.

(b) The driver's liability under Subsection (1)(a)(v) is limited to the insurance coverage.

(c) (i) "Guardianship" under Subsection (1)(a)(iii) includes the relationship between a foster parent and a minor who is in the legal custody of the Division of Child and Family Services if:

(A) the minor resides in a foster home, as defined in Section 62A-2-101, with a foster parent who is the named insured; and

(B) the foster parent has signed to be jointly and severally liable for compensatory damages caused by the minor's operation of a motor vehicle in accordance with Section 53-3-211.

(ii) "Guardianship" as defined under this Subsection (1)(c) ceases to exist when a minor described in Subsection (1)(c)(i)(A) is no longer a resident of the named insured's household.

(2) (a) A policy containing motor vehicle liability coverage under Subsection 31A-22-302(1)(a) may:

(i) provide for the prorating of the insurance under that policy with other valid and collectible insurance;

(ii) grant any lawful coverage in addition to the required motor vehicle liability coverage;

(iii) if the policy is issued to a person other than a motor vehicle business, limit the coverage afforded to a motor vehicle business or its officers, agents, or employees to the minimum limits under Section 31A-22-304, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent; and

(iv) if issued to a motor vehicle business, restrict coverage afforded to anyone other than the motor vehicle business or its officers, agents, or employees to the minimum limits under Section 31A-22-304, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent.

(b) (i) The liability insurance coverage of a permissive user of a motor vehicle owned by a motor vehicle business shall be primary coverage.

(ii) The liability insurance coverage of a motor vehicle business shall be secondary to the liability insurance coverage of a permissive user as specified under Subsection (2)(b)(i).

(3) Motor vehicle liability coverage need not insure any liability:

(a) under any workers' compensation law under Title 34A, Utah Labor Code;

(b) resulting from bodily injury to or death of an employee of the named insured, other than a domestic employee, while engaged in the employment of the insured, or while engaged in the operation, maintenance, or repair of a designated vehicle; or

(c) resulting from damage to property owned by, rented to, bailed to, or transported by the insured.

(4) An insurance carrier providing motor vehicle liability coverage has the right to settle any claim covered by the policy, and if the settlement is made in good faith, the amount of the settlement is deductible from the limits of liability specified under Section 31A-22-304.

(5) A policy containing motor vehicle liability coverage imposes on the insurer the duty to defend, in good faith, any person insured under the policy against any claim or suit seeking damages which would be payable under the policy.

(6) (a) If a policy containing motor vehicle liability coverage provides an insurer with the defense of lack of cooperation on the part of the insured, that defense is not effective against a third person making a claim against the insurer, unless there was collusion between the third person and the insured.

(b) If the defense of lack of cooperation is not effective against the claimant, after payment, the insurer is subrogated to the injured person's claim against the insured to the extent of the payment and is entitled to reimbursement by the insured after the injured third person has been made whole with respect to the claim against the insured.

(7) A policy of motor vehicle liability coverage may limit coverage to the policy minimum limits under Section 31A-22-304 if the insured motor vehicle is operated by a person who has consumed any alcohol or any illegal drug or illegal substance if the policy or a specifically reduced premium was extended to the insured upon express written declaration executed by the insured that the insured motor vehicle would not be so operated.

(8) (a) When a claim is brought exclusively by a named insured or a person described in Subsection (1)(a)(iii) and asserted exclusively against a named insured or an individual described in Subsection (1)(a)(iii), the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Once the claimant has elected to commence litigation under Subsection (8)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of both parties and the defendant's liability insurer.

(c) (i) Unless otherwise agreed on in writing by the parties, a claim that is submitted to binding arbitration under Subsection (8)(a)(i) shall be resolved by a panel of three arbitrators.

(ii) Unless otherwise agreed on in writing by the parties, each party shall select an arbitrator. The arbitrators selected by the parties shall select a third arbitrator.

(d) Unless otherwise agreed on in writing by the parties, each party will pay the fees and costs of the arbitrator that party selects. Both parties shall share equally the fees and costs of the third arbitrator.

(e) Except as otherwise provided in this section, an arbitration procedure conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act, unless otherwise agreed on in writing by the parties.

(f) (i) Discovery shall be conducted in accordance with Rules 26b through 36,

Utah Rules of Civil Procedure.

(ii) All issues of discovery shall be resolved by the arbitration panel.

(g) A written decision of two of the three arbitrators shall constitute a final decision of the arbitration panel.

(h) Prior to the rendering of the arbitration award:

(i) the existence of a liability insurance policy may be disclosed to the arbitration panel; and

(ii) the amount of all applicable liability insurance policy limits may not be disclosed to the arbitration panel.

(i) The amount of the arbitration award may not exceed the liability limits of all the defendant's applicable liability insurance policies, including applicable liability umbrella policies. If the initial arbitration award exceeds the liability limits of all applicable liability insurance policies, the arbitration award shall be reduced to an amount equal to the liability limits of all applicable liability insurance policies.

(j) The arbitration award is the final resolution of all claims between the parties unless the award was procured by corruption, fraud, or other undue means.

(k) If the arbitration panel finds that the action was not brought, pursued, or defended in good faith, the arbitration panel may award reasonable fees and costs against the party that failed to bring, pursue, or defend the claim in good faith.

(l) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(9) An at-fault driver or an insurer issuing a policy of insurance under this part that is covering an at-fault driver may not reduce compensation to an injured party based on the injured party not being covered by a policy of insurance that provides personal injury protection coverage under Sections 31A-22-306 through 31A-22-309.

Amended by Chapter 172, 2010 General Session

31A-22-304. Motor vehicle liability policy minimum limits.

Policies containing motor vehicle liability coverage may not limit the insurer's liability under that coverage below the following:

(1) (a) $25,000 because of liability for bodily injury to or death of one person, arising out of the use of a motor vehicle in any one accident;

(b) subject to the limit for one person in Subsection (1)(a), in the amount of $65,000 because of liability for bodily injury to or death of two or more persons arising out of the use of a motor vehicle in any one accident; and

(c) in the amount of $15,000 because of liability for injury to, or destruction of, property of others arising out of the use of a motor vehicle in any one accident; or

(2) $80,000 in any one accident whether arising from bodily injury to or the death of others, or from destruction of, or damage to, the property of others.

Amended by Chapter 371, 2008 General Session

31A-22-305. Uninsured motorist coverage.

(1) As used in this section, "covered persons" includes:

(a) the named insured;

(b) persons related to the named insured by blood, marriage, adoption, or guardianship, who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere;

(c) any person occupying or using a motor vehicle:

(i) referred to in the policy; or

(ii) owned by a self-insured; and

(d) any person who is entitled to recover damages against the owner or operator of the uninsured or underinsured motor vehicle because of bodily injury to or death of persons under Subsection (1)(a), (b), or (c).

(2) As used in this section, "uninsured motor vehicle" includes:

(a) (i) a motor vehicle, the operation, maintenance, or use of which is not covered under a liability policy at the time of an injury-causing occurrence; or

(ii) (A) a motor vehicle covered with lower liability limits than required by Section 31A-22-304; and

(B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of the deficiency;

(b) an unidentified motor vehicle that left the scene of an accident proximately caused by the motor vehicle operator;

(c) a motor vehicle covered by a liability policy, but coverage for an accident is disputed by the liability insurer for more than 60 days or continues to be disputed for more than 60 days; or

(d) (i) an insured motor vehicle if, before or after the accident, the liability insurer of the motor vehicle is declared insolvent by a court of competent jurisdiction; and

(ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent that the claim against the insolvent insurer is not paid by a guaranty association or fund.

(3) Uninsured motorist coverage under Subsection 31A-22-302(1)(b) provides coverage for covered persons who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

(4) (a) For new policies written on or after January 1, 2001, the limits of uninsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy, unless a named insured rejects or purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer;

(iii) waives the higher coverage;

(iv) need only state in this or similar language that uninsured motorist coverage provides benefits or protection to you and other covered persons for bodily injury resulting from an accident caused by the fault of another party where the other party has no liability insurance; and

(v) discloses the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available

by the insurer under the named insured's motor vehicle policy.

(b) Any selection or rejection under this Subsection (4) continues for that issuer of the liability coverage until the insured requests, in writing, a change of uninsured motorist coverage from that liability insurer.

(c) (i) Subsections (4)(a) and (b) apply retroactively to any claim arising on or after January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsections (4)(a) and (b) clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

(d) For purposes of this Subsection (4), "new policy" means:

(i) any policy that is issued which does not include a renewal or reinstatement of an existing policy; or

(ii) a change to an existing policy that results in:

(A) a named insured being added to or deleted from the policy; or

(B) a change in the limits of the named insured's motor vehicle liability coverage.

(e) (i) As used in this Subsection (4)(e), "additional motor vehicle" means a change that increases the total number of vehicles insured by the policy, and does not include replacement, substitute, or temporary vehicles.

(ii) The adding of an additional motor vehicle to an existing personal lines or commercial lines policy does not constitute a new policy for purposes of Subsection (4)(d).

(iii) If an additional motor vehicle is added to a personal lines policy where uninsured motorist coverage has been rejected, or where uninsured motorist limits are lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice to a named insured within 30 days that:

(A) in the same manner as described in Subsection (4)(a)(iv), explains the purpose of uninsured motorist coverage; and

(B) encourages the named insured to contact the insurance company or insurance producer for quotes as to the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(f) A change in policy number resulting from any policy change not identified under Subsection (4)(d)(ii) does not constitute a new policy.

(g) (i) Subsection (4)(d) applies retroactively to any claim arising on or after January 1, 2001, for which, as of May 1, 2012, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsection (4):

(A) does not enlarge, eliminate, or destroy vested rights; and

(B) clarifies legislative intent.

(h) A self-insured, including a governmental entity, may elect to provide uninsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (4)(a) and (5)(a) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an uninsured motorist claim.

(i) Uninsured motorist coverage may not be sold with limits that are less than the minimum bodily injury limits for motor vehicle liability policies under Section 31A-22-304.

(j) The acknowledgment under Subsection (4)(a) continues for that issuer of the uninsured motorist coverage until the named insured requests, in writing, different uninsured motorist coverage from the insurer.

(k) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of uninsured motorist coverage in the same manner as described in Subsection (4)(a)(iv); and

(B) a disclosure of the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(ii) The disclosure required under Subsection (4)(k)(i) shall be sent to all named insureds that carry uninsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(l) For purposes of this Subsection (4), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(5) (a) (i) Except as provided in Subsection (5)(b), the named insured may reject uninsured motorist coverage by an express writing to the insurer that provides liability coverage under Subsection 31A-22-302(1)(a).

(ii) This rejection shall be on a form provided by the insurer that includes a reasonable explanation of the purpose of uninsured motorist coverage.

(iii) This rejection continues for that issuer of the liability coverage until the insured in writing requests uninsured motorist coverage from that liability insurer.

(b) (i) All persons, including governmental entities, that are engaged in the business of, or that accept payment for, transporting natural persons by motor vehicle, and all school districts that provide transportation services for their students, shall provide coverage for all motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance, uninsured motorist coverage of at least $25,000 per person and $500,000 per accident.

(ii) This coverage is secondary to any other insurance covering an injured covered person.

(c) Uninsured motorist coverage:

(i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers' Compensation Act;

(ii) may not be subrogated by the workers' compensation insurance carrier;

(iii) may not be reduced by any benefits provided by workers' compensation insurance;

(iv) may be reduced by health insurance subrogation only after the covered person has been made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (5)(c)(v), may be recovered:

(A) for a person under 18 years of age who is injured within the scope of Subsection (5)(c)(v) but limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(d) As used in this Subsection (5), "motor vehicle" has the same meaning as under Section 41-1a-102.

(6) When a covered person alleges that an uninsured motor vehicle under Subsection (2)(b) proximately caused an accident without touching the covered person or the motor vehicle occupied by the covered person, the covered person shall show the existence of the uninsured motor vehicle by clear and convincing evidence consisting of more than the covered person's testimony.

(7) (a) The limit of liability for uninsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(b) (i) Subsection (7)(a) applies to all persons except a covered person as defined under Subsection (8)(b)(ii).

(ii) A covered person as defined under Subsection (8)(b)(ii) is entitled to the highest limits of uninsured motorist coverage afforded for any one motor vehicle that the covered person is the named insured or an insured family member.

(iii) This coverage shall be in addition to the coverage on the motor vehicle the covered person is occupying.

(iv) Neither the primary nor the secondary coverage may be set off against the other.

(c) Coverage on a motor vehicle occupied at the time of an accident shall be primary coverage, and the coverage elected by a person described under Subsections (1)(a) and (b) shall be secondary coverage.

(8) (a) Uninsured motorist coverage under this section applies to bodily injury, sickness, disease, or death of covered persons while occupying or using a motor vehicle only if the motor vehicle is described in the policy under which a claim is made, or if the motor vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy. Except as provided in Subsection (7) or this Subsection (8), a covered person injured in a motor vehicle described in a policy that includes uninsured motorist benefits may not elect to collect uninsured motorist coverage benefits from any other motor vehicle insurance policy under which the person is a covered person.

(b) Each of the following persons may also recover uninsured motorist benefits under any one other policy in which they are described as a "covered person" as defined in Subsection (1):

(i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

(ii) except as provided in Subsection (8)(c), a covered person injured while occupying or using a motor vehicle that is not owned, leased, or furnished:

(A) to the covered person;
(B) to the covered person's spouse; or
(C) to the covered person's resident parent or resident sibling.
(c) (i) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:
(A) a dependent minor of parents who reside in separate households; and
(B) injured while occupying or using a motor vehicle that is not owned, leased, or furnished:
(I) to the covered person;
(II) to the covered person's resident parent; or
(III) to the covered person's resident sibling.
(ii) Each parent's policy under this Subsection (8)(c) is liable only for the percentage of the damages that the limit of liability of each parent's policy of uninsured motorist coverage bears to the total of both parents' uninsured coverage applicable to the accident.
(d) A covered person's recovery under any available policies may not exceed the full amount of damages.
(e) A covered person in Subsection (8)(b) is not barred against making subsequent elections if recovery is unavailable under previous elections.
(f) (i) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.
(ii) Except to the extent permitted by Subsection (7) and this Subsection (8), interpolicy stacking is prohibited for uninsured motorist coverage.
(9) (a) When a claim is brought by a named insured or a person described in Subsection (1) and is asserted against the covered person's uninsured motorist carrier, the claimant may elect to resolve the claim:
(i) by submitting the claim to binding arbitration; or
(ii) through litigation.
(b) Unless otherwise provided in the policy under which uninsured benefits are claimed, the election provided in Subsection (9)(a) is available to the claimant only.
(c) Once the claimant has elected to commence litigation under Subsection (9)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the uninsured motorist carrier.
(d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (9)(a)(i) shall be resolved by a single arbitrator.
(ii) All parties shall agree on the single arbitrator selected under Subsection (9)(d)(i).
(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (9)(d)(ii), the parties shall select a panel of three arbitrators.
(e) If the parties select a panel of three arbitrators under Subsection (9)(d)(iii):
(i) each side shall select one arbitrator; and
(ii) the arbitrators appointed under Subsection (9)(e)(i) shall select one additional arbitrator to be included in the panel.
(f) Unless otherwise agreed to in writing:
(i) each party shall pay an equal share of the fees and costs of the arbitrator

selected under Subsection (9)(d)(i); or

(ii) if an arbitration panel is selected under Subsection (9)(d)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (9)(e)(ii).

(g) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(h) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f), 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of Subsections (10)(a) through (c) are satisfied.

(ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure shall be determined based on the claimant's specific monetary amount in the written demand for payment of uninsured motorist coverage benefits as required in Subsection (10)(a)(i)(A).

(iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to arbitration claims under this part.

(i) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

(j) A written decision by a single arbitrator or by a majority of the arbitration panel shall constitute a final decision.

(k) (i) Except as provided in Subsection (10), the amount of an arbitration award may not exceed the uninsured motorist policy limits of all applicable uninsured motorist policies, including applicable uninsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all applicable uninsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined uninsured motorist policy limits of all applicable uninsured motorist policies.

(l) The arbitrator or arbitration panel may not decide the issues of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) any allegations or claims asserting consequential damages or bad faith liability.

(m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(n) If the arbitrator or arbitration panel finds that the action was not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the claim in good faith.

(o) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (9)(l) between the parties unless:

(i) the award was procured by corruption, fraud, or other undue means;

(ii) either party, within 20 days after service of the arbitration award:

(A) files a complaint requesting a trial de novo in the district court; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (9)(o)(ii)(A).

(p) (i) Upon filing a complaint for a trial de novo under Subsection (9)(o), the claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (9)(o)(ii)(A).

(q) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (9)(o), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the uninsured motorist carrier, as the moving party in a trial de novo requested under Subsection (9)(o), does not obtain a verdict that is at least 20% less than the arbitration award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (9)(q)(iv), the costs under this Subsection (9)(q) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (9)(q) may not exceed $2,500 unless Subsection (10)(h)(iii) applies.

(r) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (9)(q), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(s) If a district court determines, upon a motion of the nonmoving party, that the moving party's use of the trial de novo process was filed in bad faith in accordance with Section 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.

(t) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(u) If there are multiple uninsured motorist policies, as set forth in Subsection (8), the claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist carriers.

(10) (a) Within 30 days after a covered person elects to submit a claim for uninsured motorist benefits to binding arbitration or files litigation, the covered person shall provide to the uninsured motorist carrier:

(i) a written demand for payment of uninsured motorist coverage benefits, setting forth:

(A) the specific monetary amount of the demand; and

(B) the factual and legal basis and any supporting documentation for the demand;

(ii) a written statement under oath disclosing:

(A) (I) the names and last known addresses of all health care providers who have rendered health care services to the covered person that are material to the claims for which uninsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) whether the covered person has seen other health care providers who have rendered health care services to the covered person, which the covered person claims are immaterial to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (10)(a)(ii)(A)(I);

(B) (I) the names and last known addresses of all health insurers or other entities to whom the covered person has submitted claims for health care services or benefits material to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) whether the identity of any health insurers or other entities to whom the covered person has submitted claims for health care services or benefits, which the covered person claims are immaterial to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

(C) if lost wages, diminished earning capacity, or similar damages are claimed, all employers of the covered person for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised;

(D) other documents to reasonably support the claims being asserted; and

(E) all state and federal statutory lienholders including a statement as to whether the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens; and

(iii) signed authorizations to allow the uninsured motorist carrier to only obtain records and billings from the individuals or entities disclosed.

(b) (i) If the uninsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (10)(a)(ii) is reasonably necessary, the uninsured motorist carrier may:

(A) make a request for the disclosure of the identity of the health care providers or health care insurers; and

(B) make a request for authorizations to allow the uninsured motorist carrier to only obtain records and billings from the individuals or entities not disclosed.

(ii) If the covered person does not provide the requested information within 10 days:

(A) the covered person shall disclose, in writing, the legal or factual basis for the failure to disclose the health care providers or health care insurers; and

(B) either the covered person or the uninsured motorist carrier may request the

arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be provided if the covered person has elected arbitration.

(iii) The time periods imposed by Subsection (10)(c)(i) are tolled pending resolution of the dispute concerning the disclosure and production of records of the health care providers or health care insurers.

(c) (i) An uninsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of uninsured motorist benefits under Subsection (10)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and receipt of the items specified in Subsections (10)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (10)(a)(i);

(B) except as provided in Subsection (10)(c)(i)(C), tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed to the covered person; and

(C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens, tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed to the covered person less:

(I) if the amount of the state or federal statutory lien is established, the amount of the lien; or

(II) if the amount of the state or federal statutory lien is not established, two times the amount of the medical expenses subject to the state or federal statutory lien until such time as the amount of the state or federal statutory lien is established.

(ii) If the amount tendered by the uninsured motorist carrier under Subsection (10)(c)(i) is the total amount of the uninsured motorist policy limits, the tendered amount shall be accepted by the covered person.

(d) A covered person who receives a written response from an uninsured motorist carrier as provided for in Subsection (10)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (10)(c)(i) as payment in full of all uninsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (10)(c)(i) as partial payment of all uninsured motorist claims; and

(B) litigate or arbitrate the remaining claim.

(e) If a covered person elects to accept the amount tendered under Subsection (10)(c)(i) as partial payment of all uninsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the uninsured motorist carrier under Subsection (10)(c)(i).

(f) In an arbitration proceeding on the remaining uninsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (10)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of uninsured motorist benefits provided by the policy.

(g) If the final award obtained through arbitration or litigation is greater than the

average of the covered person's initial written demand for payment provided for in Subsection (10)(a)(i) and the uninsured motorist carrier's initial written response provided for in Subsection (10)(c)(i), the uninsured motorist carrier shall pay:

(i) the final award obtained through arbitration or litigation, except that if the award exceeds the policy limits of the subject uninsured motorist policy by more than $15,000, the amount shall be reduced to an amount equal to the policy limits plus $15,000; and

(ii) any of the following applicable costs:

(A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

(B) the arbitrator or arbitration panel's fee; and

(C) the reasonable costs of expert witnesses and depositions used in the presentation of evidence during arbitration or litigation.

(h) (i) The covered person shall provide an affidavit of costs within five days of an arbitration award.

(ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to which the uninsured motorist carrier objects.

(B) The objection shall be resolved by the arbitrator or arbitration panel.

(iii) The award of costs by the arbitrator or arbitration panel under Subsection (10)(g)(ii) may not exceed $5,000.

(i) (i) A covered person shall disclose all material information, other than rebuttal evidence, within 30 days after a covered person elects to submit a claim for uninsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (10)(a).

(ii) If the information under Subsection (10)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (10)(g).

(j) This Subsection (10) does not limit any other cause of action that arose or may arise against the uninsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (10) only apply to motor vehicle accidents that occur on or after March 30, 2010.

Amended by Chapter 460, 2013 General Session

31A-22-305.3. Underinsured motorist coverage.

(1) As used in this section:

(a) "Covered person" has the same meaning as defined in Section 31A-22-305.

(b) (i) "Underinsured motor vehicle" includes a motor vehicle, the operation, maintenance, or use of which is covered under a liability policy at the time of an injury-causing occurrence, but which has insufficient liability coverage to compensate fully the injured party for all special and general damages.

(ii) The term "underinsured motor vehicle" does not include:

(A) a motor vehicle that is covered under the liability coverage of the same policy that also contains the underinsured motorist coverage;

(B) an uninsured motor vehicle as defined in Subsection 31A-22-305(2); or

(C) a motor vehicle owned or leased by:

(I) a named insured;

(II) a named insured's spouse; or

(III) a dependent of a named insured.

(2) (a) Underinsured motorist coverage under Subsection 31A-22-302(1)(c) provides coverage for a covered person who is legally entitled to recover damages from an owner or operator of an underinsured motor vehicle because of bodily injury, sickness, disease, or death.

(b) A covered person occupying or using a motor vehicle owned, leased, or furnished to the covered person, the covered person's spouse, or covered person's resident relative may recover underinsured benefits only if the motor vehicle is:

(i) described in the policy under which a claim is made; or

(ii) a newly acquired or replacement motor vehicle covered under the terms of the policy.

(3) (a) For new policies written on or after January 1, 2001, the limits of underinsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy, unless a named insured rejects or purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer;

(iii) waives the higher coverage;

(iv) need only state in this or similar language that underinsured motorist coverage provides benefits or protection to you and other covered persons for bodily injury resulting from an accident caused by the fault of another party where the other party has insufficient liability insurance; and

(v) discloses the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(b) Any selection or rejection under Subsection (3)(a) continues for that issuer of the liability coverage until the insured requests, in writing, a change of underinsured motorist coverage from that liability insurer.

(c) (i) Subsections (3)(a) and (b) apply retroactively to any claim arising on or after January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsections (3)(a) and (b) clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

(d) For purposes of this Subsection (3), "new policy" means:

(i) any policy that is issued which does not include a renewal or reinstatement of an existing policy; or

(ii) a change to an existing policy that results in:

(A) a named insured being added to or deleted from the policy; or

(B) a change in the limits of the named insured's motor vehicle liability coverage.

(e) (i) As used in this Subsection (3)(e), "additional motor vehicle" means a change that increases the total number of vehicles insured by the policy, and does not

include replacement, substitute, or temporary vehicles.

(ii) The adding of an additional motor vehicle to an existing personal lines or commercial lines policy does not constitute a new policy for purposes of Subsection (3)(d).

(iii) If an additional motor vehicle is added to a personal lines policy where underinsured motorist coverage has been rejected, or where underinsured motorist limits are lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice to a named insured within 30 days that:

(A) in the same manner described in Subsection (3)(a)(iv), explains the purpose of underinsured motorist coverage; and

(B) encourages the named insured to contact the insurance company or insurance producer for quotes as to the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(f) A change in policy number resulting from any policy change not identified under Subsection (3)(d)(ii) does not constitute a new policy.

(g) (i) Subsection (3)(d) applies retroactively to any claim arising on or after January 1, 2001 for which, as of May 1, 2012, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsection (3)(d):

(A) does not enlarge, eliminate, or destroy vested rights; and

(B) clarifies legislative intent.

(h) A self-insured, including a governmental entity, may elect to provide underinsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (3)(a) and(l) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an underinsured motorist claim.

(i) Underinsured motorist coverage may not be sold with limits that are less than:

(i) $10,000 for one person in any one accident; and

(ii) at least $20,000 for two or more persons in any one accident.

(j) An acknowledgment under Subsection (3)(a) continues for that issuer of the underinsured motorist coverage until the named insured, in writing, requests different underinsured motorist coverage from the insurer.

(k) (i) The named insured's underinsured motorist coverage, as described in Subsection (2), is secondary to the liability coverage of an owner or operator of an underinsured motor vehicle, as described in Subsection (1).

(ii) Underinsured motorist coverage may not be set off against the liability coverage of the owner or operator of an underinsured motor vehicle, but shall be added to, combined with, or stacked upon the liability coverage of the owner or operator of the underinsured motor vehicle to determine the limit of coverage available to the injured person.

(l) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of underinsured motorist coverage in the same manner as described in Subsection (3)(a)(iv); and

(B) a disclosure of the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(ii) The disclosure required under this Subsection (3)(l) shall be sent to all named insureds that carry underinsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(m) For purposes of this Subsection (3), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(4) (a) (i) Except as provided in this Subsection (4), a covered person injured in a motor vehicle described in a policy that includes underinsured motorist benefits may not elect to collect underinsured motorist coverage benefits from another motor vehicle insurance policy.

(ii) The limit of liability for underinsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(iii) Subsection (4)(a)(ii) applies to all persons except a covered person described under Subsections (4)(b)(i) and (ii).

(b) (i) Except as provided in Subsection (4)(b)(ii), a covered person injured while occupying, using, or maintaining a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's spouse, or the covered person's resident parent or resident sibling, may also recover benefits under any one other policy under which the covered person is also a covered person.

(ii) (A) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

(I) a dependent minor of parents who reside in separate households; and

(II) injured while occupying or using a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's resident parent, or the covered person's resident sibling.

(B) Each parent's policy under this Subsection (4)(b)(ii) is liable only for the percentage of the damages that the limit of liability of each parent's policy of underinsured motorist coverage bears to the total of both parents' underinsured coverage applicable to the accident.

(iii) A covered person's recovery under any available policies may not exceed the full amount of damages.

(iv) Underinsured coverage on a motor vehicle occupied at the time of an accident is primary coverage, and the coverage elected by a person described under Subsections 31A-22-305(1)(a) and (b) is secondary coverage.

(v) The primary and the secondary coverage may not be set off against the other.

(vi) A covered person as described under Subsection (4)(b)(i) is entitled to the

highest limits of underinsured motorist coverage under only one additional policy per household applicable to that covered person as a named insured, spouse, or relative.

(vii) A covered injured person is not barred against making subsequent elections if recovery is unavailable under previous elections.

(viii) (A) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(B) Except to the extent permitted by this Subsection (4), interpolicy stacking is prohibited for underinsured motorist coverage.

(c) Underinsured motorist coverage:

(i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers' Compensation Act;

(ii) may not be subrogated by a workers' compensation insurance carrier;

(iii) may not be reduced by benefits provided by workers' compensation insurance;

(iv) may be reduced by health insurance subrogation only after the covered person is made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (4)(c)(v), may be recovered:

(A) for a person under 18 years of age who is injured within the scope of Subsection (4)(c)(v), but is limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(5) The inception of the loss under Subsection 31A-21-313(1) for underinsured motorist claims occurs upon the date of the last liability policy payment.

(6) (a) Within five business days after notification that all liability insurers have tendered their liability policy limits, the underinsured carrier shall either:

(i) waive any subrogation claim the underinsured carrier may have against the person liable for the injuries caused in the accident; or

(ii) pay the insured an amount equal to the policy limits tendered by the liability carrier.

(b) If neither option is exercised under Subsection (6)(a), the subrogation claim is considered to be waived by the underinsured carrier.

(7) Except as otherwise provided in this section, a covered person may seek, subject to the terms and conditions of the policy, additional coverage under any policy:

(a) that provides coverage for damages resulting from motor vehicle accidents; and

(b) that is not required to conform to Section 31A-22-302.

(8) (a) When a claim is brought by a named insured or a person described in Subsection 31A-22-305(1) and is asserted against the covered person's underinsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which underinsured benefits are claimed, the election provided in Subsection (8)(a) is available to the claimant only.

(c) Once a claimant elects to commence litigation under Subsection (8)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the underinsured motorist coverage carrier.

(d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (8)(d)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (8)(d)(ii), the parties shall select a panel of three arbitrators.

(e) If the parties select a panel of three arbitrators under Subsection (8)(d)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (8)(e)(i) shall select one additional arbitrator to be included in the panel.

(f) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(d)(i); or

(ii) if an arbitration panel is selected under Subsection (8)(d)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(e)(ii).

(g) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section is governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(h) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f), 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of Subsections (9)(a) through (c) are satisfied.

(ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure shall be determined based on the claimant's specific monetary amount in the written demand for payment of uninsured motorist coverage benefits as required in Subsection (9)(a)(i)(A).

(iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to arbitration claims under this part.

(i) An issue of discovery shall be resolved by the arbitrator or the arbitration panel.

(j) A written decision by a single arbitrator or by a majority of the arbitration panel constitutes a final decision.

(k) (i) Except as provided in Subsection (9), the amount of an arbitration award may not exceed the underinsured motorist policy limits of all applicable underinsured motorist policies, including applicable underinsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the underinsured motorist policy limits of all applicable underinsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined underinsured motorist policy limits of all applicable

underinsured motorist policies.

(l) The arbitrator or arbitration panel may not decide an issue of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) an allegation or claim asserting consequential damages or bad faith liability.

(m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(n) If the arbitrator or arbitration panel finds that the arbitration is not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the arbitration in good faith.

(o) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (8)(l) between the parties unless:

(i) the award is procured by corruption, fraud, or other undue means;

(ii) either party, within 20 days after service of the arbitration award:

(A) files a complaint requesting a trial de novo in the district court; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (8)(o)(ii)(A).

(p) (i) Upon filing a complaint for a trial de novo under Subsection (8)(o), a claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (8)(o)(ii)(A).

(q) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (8)(o), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the underinsured motorist carrier, as the moving party in a trial de novo requested under Subsection (8)(o), does not obtain a verdict that is at least 20% less than the arbitration award, the underinsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (8)(q)(iv), the costs under this Subsection (8)(q) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (8)(q) may not exceed $2,500 unless Subsection (9)(h)(iii) applies.

(r) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (8)(q), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(s) If a district court determines, upon a motion of the nonmoving party, that a

moving party's use of the trial de novo process is filed in bad faith in accordance with Section 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.

(t) Nothing in this section is intended to limit a claim under another portion of an applicable insurance policy.

(u) If there are multiple underinsured motorist policies, as set forth in Subsection (4), the claimant may elect to arbitrate in one hearing the claims against all the underinsured motorist carriers.

(9) (a) Within 30 days after a covered person elects to submit a claim for underinsured motorist benefits to binding arbitration or files litigation, the covered person shall provide to the underinsured motorist carrier:

(i) a written demand for payment of underinsured motorist coverage benefits, setting forth:

(A) the specific monetary amount of the demand; and

(B) the factual and legal basis and any supporting documentation for the demand;

(ii) a written statement under oath disclosing:

(A) (I) the names and last known addresses of all health care providers who have rendered health care services to the covered person that are material to the claims for which the underinsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) whether the covered person has seen other health care providers who have rendered health care services to the covered person, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (9)(a)(ii)(A)(I);

(B) (I) the names and last known addresses of all health insurers or other entities to whom the covered person has submitted claims for health care services or benefits material to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) whether the identity of any health insurers or other entities to whom the covered person has submitted claims for health care services or benefits, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

(C) if lost wages, diminished earning capacity, or similar damages are claimed, all employers of the covered person for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised;

(D) other documents to reasonably support the claims being asserted; and

(E) all state and federal statutory lienholders including a statement as to whether

the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens; and

(iii) signed authorizations to allow the underinsured motorist carrier to only obtain records and billings from the individuals or entities disclosed.

(b) (i) If the underinsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (9)(a)(ii) is reasonably necessary, the underinsured motorist carrier may:

(A) make a request for the disclosure of the identity of the health care providers or health care insurers; and

(B) make a request for authorizations to allow the underinsured motorist carrier to only obtain records and billings from the individuals or entities not disclosed.

(ii) If the covered person does not provide the requested information within 10 days:

(A) the covered person shall disclose, in writing, the legal or factual basis for the failure to disclose the health care providers or health care insurers; and

(B) either the covered person or the underinsured motorist carrier may request the arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be provided if the covered person has elected arbitration.

(iii) The time periods imposed by Subsection (9)(c)(i) are tolled pending resolution of the dispute concerning the disclosure and production of records of the health care providers or health care insurers.

(c) (i) An underinsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of underinsured motorist benefits under Subsection (9)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and receipt of the items specified in Subsections (9)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (9)(a)(i);

(B) except as provided in Subsection (9)(c)(i)(C), tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person; and

(C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens, tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person less:

(I) if the amount of the state or federal statutory lien is established, the amount of the lien; or

(II) if the amount of the state or federal statutory lien is not established, two times the amount of the medical expenses subject to the state or federal statutory lien until such time as the amount of the state or federal statutory lien is established.

(ii) If the amount tendered by the underinsured motorist carrier under Subsection (9)(c)(i) is the total amount of the underinsured motorist policy limits, the tendered amount shall be accepted by the covered person.

(d) A covered person who receives a written response from an underinsured

motorist carrier as provided for in Subsection (9)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (9)(c)(i) as payment in full of all underinsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (9)(c)(i) as partial payment of all underinsured motorist claims; and

(B) litigate or arbitrate the remaining claim.

(e) If a covered person elects to accept the amount tendered under Subsection (9)(c)(i) as partial payment of all underinsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the underinsured motorist carrier under Subsection (9)(c)(i).

(f) In an arbitration proceeding on the remaining underinsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (9)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of underinsured motorist benefits provided by the policy.

(g) If the final award obtained through arbitration or litigation is greater than the average of the covered person's initial written demand for payment provided for in Subsection (9)(a)(i) and the underinsured motorist carrier's initial written response provided for in Subsection (9)(c)(i), the underinsured motorist carrier shall pay:

(i) the final award obtained through arbitration or litigation, except that if the award exceeds the policy limits of the subject underinsured motorist policy by more than $15,000, the amount shall be reduced to an amount equal to the policy limits plus $15,000; and

(ii) any of the following applicable costs:

(A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

(B) the arbitrator or arbitration panel's fee; and

(C) the reasonable costs of expert witnesses and depositions used in the presentation of evidence during arbitration or litigation.

(h) (i) The covered person shall provide an affidavit of costs within five days of an arbitration award.

(ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to which the underinsured motorist carrier objects.

(B) The objection shall be resolved by the arbitrator or arbitration panel.

(iii) The award of costs by the arbitrator or arbitration panel under Subsection (9)(g)(ii) may not exceed $5,000.

(i) (i) A covered person shall disclose all material information, other than rebuttal evidence, within 30 days after a covered person elects to submit a claim for underinsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (9)(a).

(ii) If the information under Subsection (9)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (9)(g).

(j) This Subsection (9) does not limit any other cause of action that arose or may arise against the underinsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (9) only apply to motor vehicle accidents

that occur on or after March 30, 2010.

Amended by Chapter 460, 2013 General Session

31A-22-305.5. Uninsured motorist property damage coverage -- Coverage limitations.

(1) (a) At the request of the named insured, every motor vehicle liability policy of insurance under Sections 31A-22-303 and 31A-22-304 or combination of policies purchased to satisfy the owner's or operator's security requirement of Section 41-12a-301 which policy does not provide insurance for collision damage shall provide uninsured motorist property damage coverage for property damage to the motor vehicle described in the policy.

(b) The uninsured motorist property damage coverage provided under Subsection (1)(a) shall be for the benefit of covered persons, as defined under Section 31A-22-305, who are legally entitled to recover damages:

(i) from the owner or operator of an uninsured motor vehicle, as defined under Subsections 31A-22-305(2)(a), (c), and (d); and

(ii) arising out of the operation, maintenance, or use of an uninsured motor vehicle.

(2) (a) Except as provided under Subsection (5), the coverage provided under this section shall include payment for loss or damage to the motor vehicle described in the policy, not to exceed the motor vehicle's actual cash value or $3,500, whichever is less.

(b) Property damage does not include compensation for loss of use of the motor vehicle.

(3) The coverage provided under this section shall be payable only if:

(a) the occurrence causing the property damage involves actual physical contact between the covered motor vehicle and an uninsured motor vehicle;

(b) the owner, operator, or license plate number of the uninsured motor vehicle is identified; and

(c) the insured or someone on his behalf reports the occurrence within 10 days to the insurer or his agent.

(4) Except as provided under Subsection (5), the coverage provided under this section shall be subject to a $250 deductible and shall be excess to any other insurance covering property damage to the motor vehicle described in the policy.

(5) The insurer providing coverage under this section may, at appropriate premium rates, make available additional:

(a) coverage above the limits provided under Subsection (2); and

(b) deductibles for the coverage under Subsection (5)(a) above the limits provided under Subsection (4).

(6) A rating surcharge may not be applied to any policy of motor vehicle insurance issued in this state as a result of payment of a claim made under this section.

Amended by Chapter 37, 2005 General Session

31A-22-306. Personal injury protection.

Personal injury protection under Subsection 31A-22-302(2) provides the coverages and benefits described under Section 31A-22-307 to persons described under Section 31A-22-308, but is subject to the limitations, exclusions, and conditions set forth in Section 31A-22-309.

Amended by Chapter 204, 1986 General Session

31A-22-307. Personal injury protection coverages and benefits.

(1) Personal injury protection coverages and benefits include:

(a) up to the minimum amount required coverage of not less than $3,000 per person, the reasonable value of all expenses for necessary:

(i) medical services;

(ii) surgical services;

(iii) X-ray services;

(iv) dental services;

(v) rehabilitation services, including prosthetic devices;

(vi) ambulance services;

(vii) hospital services; and

(viii) nursing services;

(b) (i) the lesser of $250 per week or 85% of any loss of gross income and loss of earning capacity per person from inability to work, for a maximum of 52 consecutive weeks after the loss, except that this benefit need not be paid for the first three days of disability, unless the disability continues for longer than two consecutive weeks after the date of injury; and

(ii) a special damage allowance not exceeding $20 per day for a maximum of 365 days, for services actually rendered or expenses reasonably incurred for services that, but for the injury, the injured person would have performed for the injured person's household, except that this benefit need not be paid for the first three days after the date of injury unless the person's inability to perform these services continues for more than two consecutive weeks;

(c) funeral, burial, or cremation benefits not to exceed a total of $1,500 per person; and

(d) compensation on account of death of a person, payable to the person's heirs, in the total of $3,000.

(2) (a) (i) To determine the reasonable value of the medical expenses provided for in Subsection (1) and under Subsection 31A-22-309(1)(a)(v), the commissioner shall conduct a relative value study of services and accommodations for the diagnosis, care, recovery, or rehabilitation of an injured person in the most populous county in the state to assign a unit value and determine the 75th percentile charge for each type of service and accommodation.

(ii) The relative value study shall be updated every other year.

(iii) In conducting the relative value study, the department may consult or contract with appropriate public and private medical and health agencies or other technical experts.

(iv) The costs and expenses incurred in conducting, maintaining, and administering the relative value study shall be funded by the tax created under Section

59-9-105.

(v) Upon completion of the relative value study, the department shall prepare and publish a relative value study which sets forth the unit value and the 75th percentile charge assigned to each type of service and accommodation.

(b) (i) The reasonable value of any service or accommodation is determined by applying the unit value and the 75th percentile charge assigned to the service or accommodation under the relative value study.

(ii) If a service or accommodation is not assigned a unit value or the 75th percentile charge under the relative value study, the value of the service or accommodation shall equal the reasonable cost of the same or similar service or accommodation in the most populous county of this state.

(c) This Subsection (2) does not preclude the department from adopting a schedule already established or a schedule prepared by persons outside the department, if it meets the requirements of this Subsection (2).

(d) Every insurer shall report to the commissioner any pattern of overcharging, excessive treatment, or other improper actions by a health provider within 30 days after the day on which the insurer has knowledge of the pattern.

(e) (i) In disputed cases, a court on its own motion or on the motion of either party, may designate an impartial medical panel of not more than three licensed physicians to examine the claimant and testify on the issue of the reasonable value of the claimant's medical services or expenses.

(ii) An impartial medical panel designated under Subsection (2)(e)(i) shall consist of a majority of health care professionals within the same license classification and specialty as the provider of the claimant's medical services or expenses.

(3) Medical expenses as provided for in Subsection (1)(a) and in Subsection 31A-22-309(1)(a)(v) include expenses for any nonmedical remedial care and treatment rendered in accordance with a recognized religious method of healing.

(4) The insured may waive for the named insured and the named insured's spouse only the loss of gross income benefits of Subsection (1)(b)(i) if the insured states in writing that:

(a) within 31 days of applying for coverage, neither the insured nor the insured's spouse received any earned income from regular employment; and

(b) for at least 180 days from the date of the writing and during the period of insurance, neither the insured nor the insured's spouse will receive earned income from regular employment.

(5) This section does not:

(a) prohibit the issuance of a policy of insurance providing coverages greater than the minimum coverage required under this chapter; or

(b) require the segregation of those minimum coverages from other coverages in the same policy.

(6) Deductibles are not permitted with respect to the insurance coverages required under this section.

Amended by Chapter 197, 2006 General Session

31A-22-308. Persons covered by personal injury protection.

The following may receive benefits under personal injury protection coverage:

(1) the named insured, when injured in an accident involving any motor vehicle, regardless of whether the accident occurs in this state, the United States, its territories or possessions, or Canada, except where the injury is the result of the use or operation of the named insured's own motor vehicle not actually insured under the policy;

(2) persons related to the insured by blood, marriage, adoption, or guardianship who are residents of the insured's household, including those who usually make their home in the same household but temporarily live elsewhere under the circumstances described in Section (1), except where the person is injured as a result of the use or operation of his own motor vehicle not insured under the policy; and

(3) any other natural person whose injuries arise out of an automobile accident occurring while the person occupies a motor vehicle described in the policy with the express or implied consent of the named insured or while a pedestrian if he is injured in an accident occurring in Utah involving the described motor vehicle.

Amended by Chapter 327, 1990 General Session

31A-22-309. Limitations, exclusions, and conditions to personal injury protection.

(1) (a) A person who has or is required to have direct benefit coverage under a policy which includes personal injury protection may not maintain a cause of action for general damages arising out of personal injuries alleged to have been caused by an automobile accident, except where the person has sustained one or more of the following:

(i) death;

(ii) dismemberment;

(iii) permanent disability or permanent impairment based upon objective findings;

(iv) permanent disfigurement; or

(v) medical expenses to a person in excess of $3,000.

(b) Subsection (1)(a) does not apply to a person making an uninsured motorist claim.

(2) (a) Any insurer issuing personal injury protection coverage under this part may only exclude from this coverage benefits:

(i) for any injury sustained by the insured while occupying another motor vehicle owned by or furnished for the regular use of the insured or a resident family member of the insured and not insured under the policy;

(ii) for any injury sustained by any person while operating the insured motor vehicle without the express or implied consent of the insured or while not in lawful possession of the insured motor vehicle;

(iii) to any injured person, if the person's conduct contributed to his injury:

(A) by intentionally causing injury to himself; or

(B) while committing a felony;

(iv) for any injury sustained by any person arising out of the use of any motor vehicle while located for use as a residence or premises;

(v) for any injury due to war, whether or not declared, civil war, insurrection,

rebellion or revolution, or to any act or condition incident to any of the foregoing; or

(vi) for any injury resulting from the radioactive, toxic, explosive, or other hazardous properties of nuclear materials.

(b) The provisions of this subsection do not limit the exclusions which may be contained in other types of coverage.

(3) The benefits payable to any injured person under Section 31A-22-307 are reduced by:

(a) any benefits which that person receives or is entitled to receive as a result of an accident covered in this code under any workers' compensation or similar statutory plan; and

(b) any amounts which that person receives or is entitled to receive from the United States or any of its agencies because that person is on active duty in the military service.

(4) When a person injured is also an insured party under any other policy, including those policies complying with this part, primary coverage is given by the policy insuring the motor vehicle in use during the accident.

(5) (a) Payment of the benefits provided for in Section 31A-22-307 shall be made on a monthly basis as expenses are incurred.

(b) Benefits for any period are overdue if they are not paid within 30 days after the insurer receives reasonable proof of the fact and amount of expenses incurred during the period. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days after that proof is received by the insurer. Any part or all of the remainder of the claim that is later supported by reasonable proof is also overdue if not paid within 30 days after the proof is received by the insurer.

(c) If the insurer fails to pay the expenses when due, these expenses shall bear interest at the rate of 1-1/2% per month after the due date.

(d) The person entitled to the benefits may bring an action in contract to recover the expenses plus the applicable interest. If the insurer is required by the action to pay any overdue benefits and interest, the insurer is also required to pay a reasonable attorney's fee to the claimant.

(6) (a) Except as provided in Subsection (6)(b), every policy providing personal injury protection coverage is subject to the following:

(i) that where the insured under the policy is or would be held legally liable for the personal injuries sustained by any person to whom benefits required under personal injury protection have been paid by another insurer, including the Workers' Compensation Fund created under Chapter 33, the insurer of the person who would be held legally liable shall reimburse the other insurer for the payment, but not in excess of the amount of damages recoverable; and

(ii) that the issue of liability for that reimbursement and its amount shall be decided by mandatory, binding arbitration between the insurers.

(b) There shall be no right of reimbursement between insurers under Subsection (6)(a) if the insurer of the person who would be held legally liable for the personal injuries sustained has tendered its policy limit.

(c) (i) If the insurer of the person who would be held legally liable for the personal injuries sustained reimburses a no-fault insurer prior to settling a third party

liability claim with an injured person and subsequently determines that some or all of the reimbursed amount is needed to settle a third party claim, the insurer of the person who would be held legally liable for the personal injuries sustained shall provide written notice to the no-fault insurer that some or all of the reimbursed amount is needed to settle a third party liability claim.

(ii) The written notice described under Subsection (6)(c)(i) shall:

(A) identify the amount of the reimbursement that is needed to settle a third party liability claim;

(B) provide notice to the no-fault insurer that the no-fault insurer has 15 days to return the amount described in Subsection (6)(c)(ii)(A); and

(C) identify the third party liability insurer that the returned amount shall be paid to.

(iii) A no-fault insurer that receives a notice under this Subsection (6)(c) shall return the portion of the reimbursement identified under Subsection (6)(c)(ii) to the third party liability insurer identified under Subsection (6)(c)(ii)(C) within 15 business days from receipt of a notice under this Subsection (6)(c).

Amended by Chapter 162, 2008 General Session

31A-22-310. Assigned risk plan.

(1) After consultation with insurers authorized to issue policies containing the provisions specified under Section 31A-22-302, the insurance commissioner shall approve a reasonable plan for the equitable apportionment among the insurers of applicants for those policies who are in good faith entitled to, but are unable to procure, these policies through ordinary methods.

(2) Upon the commissioner's approval of a plan under this section, all insurers issuing policies described under Section 31A-22-302 shall subscribe to and participate in the commissioner's approved plan.

(3) Any applicant for a policy under the commissioner's plan, any person insured under the plan, and any insurer affected by the commissioner's plan may appeal to the insurance commissioner from any ruling or decision of the manager or committee designated to operate the plan.

(4) Section 31A-2-306 applies to the commissioner's decision on this appeal.

Amended by Chapter 161, 1987 General Session

31A-22-311. Definitions.

As used in Sections 31A-22-312 and 31A-22-314:

(1) "Authorized driver" means the person to whom the vehicle is rented and includes:

(a) his spouse if a licensed driver satisfying the rental company's minimum age requirement;

(b) his employer or coworker if engaged in business activity with the renter and if they are licensed drivers satisfying the rental company's minimum age requirement;

(c) any person who operates the vehicle during an emergency situation;

(d) any person who operates the vehicle while parking the vehicle at a

commercial establishment; or

(e) any person expressly listed by the rental company on the rental agreement as an authorized driver.

(2) "Damage" means any damage or loss to the rented vehicle resulting from a collision, including loss of use and any costs and expenses incident to the damage or loss.

(3) "Rental agreement" means any written agreement stating the terms and conditions governing the use of a private passenger motor vehicle provided by a rental company.

(4) "Rental company" means any person or organization in the business of providing private passenger motor vehicles to the public.

(5) "Renter" means any person or organization obtaining the use of a private passenger motor vehicle from a rental company under the terms of a rental agreement.

Amended by Chapter 316, 1994 General Session

31A-22-312. Liability for collision damage -- No security required -- No waiver -- Section inapplicable to rental companies disclosing charges.

(1) No rental company may, in rental agreements of 30 continuous days or less, hold any authorized driver liable for any damage except when:

(a) the damage is caused intentionally by an authorized driver or as a result of his willful and wanton misconduct;

(b) the damage arises out of the authorized driver's operation of the vehicle while illegally intoxicated or under the influence of any illegal drug as defined or determined under the law of the state where the damage occurred;

(c) the damage is caused while the authorized driver is engaged in any speed contest;

(d) the rental transaction is based on information supplied by the renter with the intent to defraud the rental company;

(e) the damage arises out of the use of the vehicle while committing or otherwise engaged in a criminal act in which the use of the motor vehicle is substantially related to the nature of the criminal activity;

(f) the damage arises out of the use of the motor vehicle to carry persons or property for hire; or

(g) the damage arises out of the use of the motor vehicle outside of the United States or Canada unless the use is specifically authorized by the rental agreement.

(2) No security or deposit for damage in any form may be required or requested by the rental company during the rental period, or pending the resolution of any dispute.

(3) No waiver may be offered to provide coverage for any of the exceptions listed in this section.

(4) This section does not apply to any rental company:

(a) whose advertising in this state clearly discloses all charges and costs incidental to the basic daily rental rate; and

(b) that provides written notice to renters clearly printed on the rental agreement and prominently displayed at its place of business, that the renter's own motor vehicle insurance or his credit card agreement may cover any damage or loss to the rental

vehicle.

Enacted by Chapter 251, 1989 General Session

31A-22-314. Mandatory coverage.

(1) As used in this section, "owner's or operator's security" has the same meaning as defined in Section 41-12a-103.

(2) (a) A rental company shall maintain owner's or operator's security meeting the requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act.

(b) Owner's or operator's security maintained by a rental company under Subsection (2)(a) applies only when there is no other valid or collectible insurance or other form of security meeting the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act.

(c) If other valid or collectible insurance or other form of security satisfies the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, on a loss involving a rental vehicle, a rental company's obligation under Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, is satisfied.

(d) When no other valid or collectible insurance or other form of security exists meeting the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, a rental company shall provide security meeting the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, for losses involving a rental vehicle.

(3) Nothing in this section shall be construed to expand or reduce the liability of a rental company or to impair a rental company's right to indemnity, contribution, or both.

Amended by Chapter 391, 2007 General Session

31A-22-315. Motor vehicle insurance reporting -- Penalty.

(1) (a) As used in this section, "commercial motor vehicle insurance coverage" means an insurance policy that:

(i) includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage; and

(ii) is defined by the department.

(b) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules defining commercial motor vehicle insurance coverage.

(2) (a) Except as provided in Subsections (2)(b) and (c), each insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part shall before the seventh and twenty-first day of each calendar month provide to the Department of Public Safety's designated agent selected in accordance with Title 41, Chapter 12a, Part 8, Uninsured Motorist Identification Database Program, a record of each motor vehicle insurance policy in effect for vehicles registered or garaged in Utah as of the

previous submission that was issued by the insurer.

(b) Each insurer that issues commercial motor vehicle insurance coverage shall before the seventh day of each calendar month provide to the Department of Public Safety's designated agent selected in accordance with Title 41, Chapter 12a, Part 8, Uninsured Motorist Identification Database Program, a record of each commercial motor vehicle insurance policy in effect for vehicles registered or garaged in Utah as of the previous month that was issued by the insurer.

(c) An insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part is not required to provide a record of a motor vehicle insurance policy in effect for a vehicle to the Department of Public Safety's designated agent under Subsection (2)(a) or (b) if the policy covers a vehicle that is registered under Section 41-1a-221, 41-1a-222, or 41-1a-301.

(d) This Subsection (2) does not preclude more frequent reporting.

(3) (a) A record provided by an insurer under Subsection (2)(a) shall include:

(i) the name, date of birth, and driver license number, if the insured provides a driver license number to the insurer, of each insured owner or operator, and the address of the named insured;

(ii) the make, year, and vehicle identification number of each insured vehicle; and

(iii) the policy number, effective date, and expiration date of each policy.

(b) A record provided by an insurer under Subsection (2)(b) shall include:

(i) the named insured;

(ii) the policy number, effective date, and expiration date of each policy; and

(iii) the following information, if available:

(A) the name, date of birth, and driver license number of each insured owner or operator, and the address of the named insured; and

(B) the make, year, and vehicle identification number of each insured vehicle.

(4) Each insurer shall provide this information by an electronic means or by another form the Department of Public Safety's designated agent agrees to accept.

(5) (a) The commissioner may, following procedures set forth in Title 63G, Chapter 4, Administrative Procedures Act, assess a fine against an insurer of up to $250 for each day the insurer fails to comply with this section.

(b) If an insurer shows that the failure to comply with this section was inadvertent, accidental, or the result of excusable neglect, the commissioner shall excuse the fine.

Amended by Chapter 382, 2008 General Session

31A-22-315.5. Motor vehicle insurance verification -- Penalty.

(1) (a) Except as provided in Subsection (1)(b), and in addition to the reporting requirements under Section 31A-22-315, each insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part shall, upon request, provide to the Department of Public Safety's designated agent selected in accordance with Title 41, Chapter 12a, Part 8, Uninsured Motorist Identification Database Program, verification of

whether or not a motor vehicle insurance policy is in effect for a specified vehicle.

(b) An insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part is not required to provide verification of a motor vehicle insurance policy in effect for a vehicle to the Department of Public Safety's designated agent under Subsection (1)(a) if:

(i) the policy covers a vehicle that is registered under Section 41-1a-221, 41-1a-222, or 41-1a-301;

(ii) the policy covers a commercial motor vehicle; or

(iii) the insurer issues insurance for less than 500 motor vehicles.

(2) Each insurer shall provide the verification required under Subsection (1) using an electronic service established by the insurers, through the Internet, world wide web, or a similar proprietary or common carrier electronic system that:

(a) is compliant with:

(i) the specifications and standards of the Insurance Industry Committee on Motor Vehicle Administration; and

(ii) other applicable industry standards;

(b) is available 24 hours a day, seven days a week, subject to reasonable allowances for:

(i) scheduled maintenance; or

(ii) temporary system failures; and

(c) includes appropriate security measures, consistent with industry standards, to:

(i) secure its data against unauthorized access; and

(ii) maintain a record of all information requests.

(3) (a) The commissioner may, following procedures set forth in Title 63G, Chapter 4, Administrative Procedures Act, assess a fine against an insurer of up to $250 for each day the insurer fails to comply with this section.

(b) The commissioner shall excuse the fine if an insurer shows that the failure to comply with this section was:

(i) inadvertent;

(ii) accidental; or

(iii) the result of excusable neglect.

Enacted by Chapter 243, 2012 General Session

31A-22-316. Title.

Sections 31A-22-316 through 31A-22-319 are known as the "Aftermarket Crash Parts Act."

Renumbered and Amended by Chapter 8, 1995 General Session

31A-22-317. Definitions.

As used in Sections 31A-22-316 through 31A-22-319:

(1) "Aftermarket crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts that generally constitute the exterior of a motor vehicle,

including inner and outer panels.

(2) "Installer" means an individual who replaces or repairs the parts of a motor vehicle.

(3) "Insurer" means an insurance company and any person authorized to represent the insurer with respect to a claim.

(4) "Nonoriginal equipment manufacturer" or "non-OEM" means a manufacturer of replacement parts for a different manufacturer's equipment.

(5) "Non-OEM aftermarket crash part" means an aftermarket crash part not made for or by the manufacturer of the motor vehicle.

(6) "Repair facility" means any motor vehicle dealer, garage, body shop, or other commercial entity that repairs or replaces those parts that generally constitute the exterior of a motor vehicle.

Renumbered and Amended by Chapter 8, 1995 General Session

31A-22-318. Identification.

(1) Any aftermarket crash part supplied by a nonoriginal equipment manufacturer for use in a motor vehicle in this state shall have the logo or name of the nonoriginal equipment manufacturer affixed or inscribed on the aftermarket crash part.

(2) The nonoriginal equipment manufacturer's logo or name shall be visible after installation whenever practicable.

Renumbered and Amended by Chapter 8, 1995 General Session

31A-22-319. Prohibition on insurer requiring certain parts -- Disclosure.

(1) Unless the insured is given notice in writing an insurer may not specify the use of non-OEM aftermarket crash parts in the repair of an insured's motor vehicle. The notice required by Subsection (1) shall identify non-OEM parts as not made for or by the vehicle manufacturer.

(2) Unless the consumer is given notice in writing prior to installation, a repair facility or installer may not use non-OEM aftermarket parts to repair a vehicle.

(3) In all instances where non-OEM aftermarket crash parts are intended for use by an insurer:

(a) the written estimate shall clearly identify each non-OEM aftermarket crash part; and

(b) a disclosure document containing the following statements in 10 point or larger type shall appear on or be attached to the insured's copy of the estimate: "This estimate has been prepared based on the use of crash parts supplied by a source other than the manufacturer of your motor vehicle. Warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle."

Renumbered and Amended by Chapter 8, 1995 General Session

31A-22-320. Use of credit information.

(1) For purposes of this section:

(a) "Credit information" means:
(i) a consumer report;
(ii) a credit score;
(iii) any information obtained by the insurer from a consumer report;
(iv) any part of a consumer report; or
(v) any part of a credit score.
(b) (i) Except as provided in Subsection (1)(b)(ii), "consumer report" is as defined in 15 U.S.C. 1681a.
(ii) "Consumer report" does not include:
(A) a motor vehicle record obtained from a state or an agency of a state; or
(B) any information regarding an applicant's or insured's insurance claim history.
(c) (i) "Credit score" means a numerical value or a categorization that is:
(A) derived from information in a consumer report;
(B) derived from a statistical tool or modeling system; and
(C) developed to predict the likelihood of:
(I) future insurance claims behavior; or
(II) credit behavior.
(ii) "Credit score" includes:
(A) a risk predictor; or
(B) a risk score.
(iii) A numerical value or a categorization described in Subsection (1)(c)(i) is a credit score if it is developed to predict the behavior described in Subsection (1)(c)(i)(C) regardless of whether it is developed to predict other factors in addition to predicting the behavior described in Subsection (1)(c)(i)(C).
(d) "Motor vehicle related insurance policy" means:
(i) a motor vehicle liability policy;
(ii) a policy that contains uninsured motorist coverage;
(iii) a policy that contains underinsured motorist coverage;
(iv) a policy that contains property damage coverage under this part; or
(v) a policy that contains personal injury coverage under this part.
(2) An insurer that issues a motor vehicle related insurance policy:
(a) except as provided in Subsection (2)(b), may not use credit information for the purpose of determining for the motor vehicle related insurance policy:
(i) renewal;
(ii) nonrenewal;
(iii) termination;
(iv) eligibility;
(v) underwriting; or
(vi) rating; and
(b) notwithstanding Subsection (2)(a), may use credit information for the purpose of:
(i) if risk related factors other than credit information are considered, determining initial underwriting; or
(ii) providing to an insured:
(A) a reduction in rates paid by the insured for the motor vehicle related insurance policy; or

(B) any other discount similar to the reduction in rates described in Subsection (2)(b)(ii)(A).

(3) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules necessary to enforce this section.

Amended by Chapter 382, 2008 General Session

31A-22-321. Use of arbitration in third party motor vehicle accident cases.

(1) A person injured as a result of a motor vehicle accident may elect to submit all third party bodily injury claims to arbitration by filing a notice of the submission of the claim to binding arbitration in a district court if:

(a) the claimant or the claimant's representative has:

(i) previously and timely filed a complaint in a district court that includes a third party bodily injury claim; and

(ii) filed a notice to submit the claim to arbitration within 14 days after the complaint has been answered; and

(b) the notice required under Subsection (1)(a)(ii) is filed while the action under Subsection (1)(a)(i) is still pending.

(2) (a) If a party submits a bodily injury claim to arbitration under Subsection (1), the party submitting the claim or the party's representative is limited to an arbitration award that does not exceed $50,000 in addition to any available personal injury protection benefits and any claim for property damage.

(b) A claim for reimbursement of personal injury protection benefits is to be resolved between insurers as provided for in Subsection 31A-22-309(6)(a)(ii).

(c) A claim for property damage may not be made in an arbitration proceeding under Subsection (1) unless agreed upon by the parties in writing.

(d) A party who elects to proceed against a defendant under this section:

(i) waives the right to obtain a judgment against the personal assets of the defendant; and

(ii) is limited to recovery only against available limits of insurance coverage.

(e) (i) This section does not prevent a party from pursuing an underinsured motorist claim as set out in Section 31A-22-305.3.

(ii) An underinsured motorist claim described in Subsection (2)(e)(i) is not limited to the $50,000 limit described in Subsection (2)(a).

(iii) There shall be no right of subrogation on the part of the underinsured motorist carrier for a claim submitted to arbitration under this section.

(3) A claim for punitive damages may not be made in an arbitration proceeding under Subsection (1) or any subsequent proceeding, even if the claim is later resolved through a trial de novo under Subsection (11).

(4) (a) A person who has elected arbitration under this section may rescind the person's election if the rescission is made within:

(i) 90 days after the election to arbitrate; and

(ii) no less than 30 days before any scheduled arbitration hearing.

(b) A person seeking to rescind an election to arbitrate under this Subsection (4) shall:

(i) file a notice of the rescission of the election to arbitrate with the district court

in which the matter was filed; and

(ii) send copies of the notice of the rescission of the election to arbitrate to all counsel of record to the action.

(c) All discovery completed in anticipation of the arbitration hearing shall be available for use by the parties as allowed by the Utah Rules of Civil Procedure and Utah Rules of Evidence.

(d) A party who has elected to arbitrate under this section and then rescinded the election to arbitrate under this Subsection (4) may not elect to arbitrate the claim under this section again.

(5) (a) Unless otherwise agreed to by the parties or by order of the court, an arbitration process elected under this section is subject to Rule 26, Utah Rules of Civil Procedure.

(b) Unless otherwise agreed to by the parties or ordered by the court, discovery shall be completed within 150 days after the date arbitration is elected under this section or the date the answer is filed, whichever is longer.

(6) (a) Unless otherwise agreed to in writing by the parties, a claim that is submitted to arbitration under this section shall be resolved by a single arbitrator.

(b) Unless otherwise agreed to by the parties or ordered by the court, all parties shall agree on the single arbitrator selected under Subsection (6)(a) within 90 days of the answer of the defendant.

(c) If the parties are unable to agree on a single arbitrator as required under Subsection (6)(b), the parties shall select a panel of three arbitrators.

(d) If the parties select a panel of three arbitrators under Subsection (6)(c):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (6)(d)(i) shall select one additional arbitrator to be included in the panel.

(7) Unless otherwise agreed to in writing:

(a) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (6)(a); and

(b) if an arbitration panel is selected under Subsection (6)(d):

(i) each party shall pay the fees and costs of the arbitrator selected by that party's side; and

(ii) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (6)(d)(ii).

(8) Except as otherwise provided in this section and unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(9) (a) Subject to the provisions of this section, the Utah Rules of Civil Procedure and Utah Rules of Evidence apply to the arbitration proceeding.

(b) The Utah Rules of Civil Procedure and Utah Rules of Evidence shall be applied liberally with the intent of concluding the claim in a timely and cost-efficient manner.

(c) Discovery shall be conducted in accordance with Rules 26 through 37 of the Utah Rules of Civil Procedure and shall be subject to the jurisdiction of the district court in which the matter is filed.

(d) Dispositive motions shall be filed, heard, and decided by the district court

prior to the arbitration proceeding in accordance with the court's scheduling order.

(10) A written decision by a single arbitrator or by a majority of the arbitration panel shall constitute a final decision.

(11) An arbitration award issued under this section shall be the final resolution of all bodily injury claims between the parties and may be reduced to judgment by the court upon motion and notice unless:

(a) either party, within 20 days after service of the arbitration award:

(i) files a notice requesting a trial de novo in the district court; and

(ii) serves the nonmoving party with a copy of the notice requesting a trial de novo under Subsection (11)(a)(i); or

(b) the arbitration award has been satisfied.

(12) (a) Upon filing a notice requesting a trial de novo under Subsection (11):

(i) unless otherwise stipulated to by the parties or ordered by the court, an additional 90 days shall be allowed for further discovery;

(ii) the additional discovery time under Subsection (12)(a)(i) shall run from the notice of appeal; and

(iii) the claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(b) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a request for trial de novo filed under Subsection (11)(a)(i).

(13) (a) If the plaintiff, as the moving party in a trial de novo requested under Subsection (11), does not obtain a verdict that is at least $5,000 and is at least 30% greater than the arbitration award, the plaintiff is responsible for all of the nonmoving party's costs.

(b) Except as provided in Subsection (13)(c), the costs under Subsection (13)(a) shall include:

(i) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(ii) the costs of expert witnesses and depositions.

(c) An award of costs under this Subsection (13) may not exceed $6,000.

(14) (a) If a defendant, as the moving party in a trial de novo requested under Subsection (11), does not obtain a verdict that is at least 30% less than the arbitration award, the defendant is responsible for all of the nonmoving party's costs.

(b) Except as provided in Subsection (14)(c), the costs under Subsection (14)(a) shall include:

(i) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(ii) the costs of expert witnesses and depositions.

(c) An award of costs under this Subsection (14) may not exceed $6,000.

(15) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsections (13) and (14), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(a) was not fully disclosed in writing prior to the arbitration proceeding; or

(b) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(16) If a district court determines, upon a motion of the nonmoving party, that the moving party's use of the trial de novo process was filed in bad faith as defined in Section 78B-5-825, the district court may award reasonable attorney fees to the

nonmoving party.

(17) Nothing in this section is intended to affect or prevent any first party claim from later being brought under any first party insurance policy under which the injured person is a covered person.

(18) (a) If a defendant requests a trial de novo under Subsection (11), in no event can the total verdict at trial exceed $15,000 above any available limits of insurance coverage and in no event can the total verdict exceed $65,000.

(b) If a plaintiff requests a trial de novo under Subsection (11), the verdict at trial may not exceed $50,000.

(19) All arbitration awards issued under this section shall bear postjudgment interest pursuant to Section 15-1-4.

Amended by Chapter 217, 2010 General Session

31A-22-400. Scope of part.

This Part 4 applies to all life insurance policies and contracts, including:

(1) an annuity contract;

(2) a credit life contract;

(3) a franchise contract;

(4) a group contract; and

(5) a blanket contract.

Amended by Chapter 90, 2004 General Session

31A-22-401. Prohibited life insurance policy provisions.

No life insurance company may issue or deliver any life insurance policy subject to this chapter under Section 31A-21-101 which contains any provision:

(1) forfeiting the policy for failure to repay any loan on the policy or to pay interest on the loan while the total indebtedness on the policy is less than its loan value, and in ascertaining the indebtedness due upon policy loans, the interest, if not paid when due, may be added to the principal of those loans and may bear interest at the same rate as the principal;

(2) claiming that the policy was issued or became effective more than one year before the original application for the insurance is executed, if the insured would then be rated at an age more than one year younger than his age at the date of his application, unless the aggregate amount of the annual premiums for the whole term of the back-dated period is paid in cash; or

(3) allowing assessments or calls to be made upon policyholders.

Amended by Chapter 204, 1986 General Session

31A-22-402. Grace period.

(1) (a) Every life insurance policy other than a group policy shall contain a provision entitling the policyholder to a grace period within which the payment of any premium may be made after the first payment of any premium.

(b) During the grace period described in Subsection (1)(a), the policy continues

in full force.

(2) The grace period required by Subsection (1) may not be less than:

(a) 31 days; or

(b) four weeks for policies whose premiums are payable more frequently than monthly.

(3) The insurer may impose an interest charge during the grace period not in excess of the interest rate:

(a) set by the policy for policy loans; or

(b) in the absence of a provision described in Subsection (3)(a), a rate set by the commissioner by rule.

(4) If a claim arises under the policy during the grace period, an insurer may deduct from the policy proceeds:

(a) the amount of any premium due or overdue;

(b) interest at the rate provided in this section; and

(c) any deferred installment of the annual premium.

(5) The insurer shall send written notice of termination of coverage:

(a) to the policyholder's last-known address; and

(b) at least 30 days before the date that the coverage is terminated.

Amended by Chapter 308, 2002 General Session

31A-22-403. Incontestability.

(1) This section does not apply to group policies.

(2) (a) Except as provided in Subsection (3), a life insurance policy is incontestable after the policy has been in force for a period of two years from the policy's date of issue:

(i) during the lifetime of the insured; or

(ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.

(b) A life insurance policy shall state that the life insurance policy is incontestable after the time period described in Subsection (2)(a).

(3) (a) A life insurance policy described in Subsection (2) may be contested for nonpayment of premiums.

(b) A life insurance policy described in Subsection (2) may be contested as to:

(i) provisions relating to accident and health benefits allowed under Section 31A-22-609; and

(ii) additional benefits in the event of death by accident.

(c) If a life insurance policy described in Subsection (2) allows the insured, after the policy's issuance and for an additional premium, to obtain a death benefit that is larger than when the policy was originally issued, the payment of the additional increment of benefit is contestable:

(i) until two years after the incremental increase of benefits; and

(ii) based only on a ground that may arise in connection with the incremental increase.

(4) (a) A reinstated life insurance policy may be contested:

(i) for two years following reinstatement on the same basis as at original

issuance; and

(ii) only as to matters arising in connection with the reinstatement.

(b) Any grounds for contest available at original issuance continue to be available for contest until the policy has been in force for a total of two years:

(i) during the lifetime of the insured; and

(ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.

(5) (a) The limitations on incontestability under this section:

(i) preclude only a contest of the validity of the policy; and

(ii) do not preclude the good faith assertion at any time of defenses based upon provisions in the policy that exclude or qualify coverage, whether or not those qualifications or exclusions are specifically excepted in the policy's incontestability clause.

(b) A provision on which the contestable period would normally run may not be reformulated as a coverage exclusion or restriction to take advantage of this Subsection (5).

(6) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules to implement this section.

Amended by Chapter 382, 2008 General Session

31A-22-404. Suicide.

(1) (a) Suicide is not a defense to a claim under a life insurance policy that is in force for two years from the date of issuance of the later of:

(i) the policy; or

(ii) the certificate.

(b) Subsection (1)(a) applies whether:

(i) the insured's death by suicide is voluntary or involuntary; or

(ii) the insured is sane or insane.

(c) If a suicide occurs within the two-year period described in Subsection (1)(a), the insurer shall pay to the beneficiary an amount not less than the premium paid less the following:

(i) a dividend paid;

(ii) an indebtedness; and

(iii) a partial withdrawal.

(2) (a) If after a life insurance policy is in effect the policy allows the policyholder to purchase a death benefit that is larger than when the policy was originally effective for an additional premium, the payment of the additional increment of benefit may be limited in the event of a suicide within a two-year period beginning on the day on which the increment increase takes effect.

(b) If a suicide occurs within the two-year period described in Subsection (2)(a), the insurer shall pay to the beneficiary an amount not less than the additional premium paid for the additional increment of benefit.

(3) For a survivorship life insurance policy, this section applies when within two years from the day on which the survivorship life insurance policy is issued:

(a) the death of all insureds results from suicide; or

(b) the death of the surviving insured results from suicide.
(4) This section does not apply to:
(a) a policy insuring against death by accident only; or
(b) an accident or double indemnity provision of an insurance policy.

Amended by Chapter 349, 2009 General Session

31A-22-405. Misstated age or gender.

(1) Subject to Subsection (2), if the age or gender of the person whose life is at risk is misstated in an application for a policy of life insurance, and the error is not adjusted during the person's lifetime, the amount payable under the policy is what the premium paid would have purchased if the age or gender had been stated correctly.

(2) If the person whose life is at risk was, at the time the insurance was applied for, beyond the maximum age limit designated by the insurer, the insurer shall refund at least the amount of the premiums collected under the policy.

Amended by Chapter 308, 2002 General Session

31A-22-406. Table of installments.

Any life insurance policy which provides that the proceeds may be payable in installments, which are determinable at the issue of the policy, shall provide in the policy a table showing the amounts and intervals of the guaranteed installments.

Enacted by Chapter 242, 1985 General Session

31A-22-407. Reinstatement.

(1) Except as provided under Subsection (2), life insurance policies, other than group policies, shall be reinstated upon written application made within three years, or within two years in the case of policies with face amounts under $5,000, from the date of premium default. The applicant shall produce evidence of insurability satisfactory to the insurer, pay all premiums in arrears, and pay or reinstate any other indebtedness to the insurer upon the policy, all with interest, compounded annually, at a rate not exceeding the rate set by the policy for policy loans compounded annually. If no rate is set in the policy, the commissioner shall adopt a rule which sets the rate the same as under Section 31A-22-402.

(2) Subsection (1) does not apply if any of these conditions exist:
(a) The policy has been surrendered for its cash surrender value.
(b) The policy's cash surrender value has been exhausted.
(c) The paid-up term insurance, if any, has expired.

Enacted by Chapter 242, 1985 General Session

31A-22-408. Standard Nonforfeiture Law for Life Insurance.

(1) This section is known as the "Standard Nonforfeiture Law for Life Insurance." It does not apply to group life insurance.

(2) In the case of policies issued on or after July 1, 1961, no policy of life

insurance, except as stated in Subsection (8), may 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 (8):

(a) That, in the event of default in any premium payment, after premiums have been paid for at least one full year the company will grant, upon proper request not later than 60 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 such due date, of such amount as is specified in this section. In lieu of that stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than 60 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 60 days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as is specified in this section.

(c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default.

(d) That, if the policy shall have been paid by the 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 company will pay upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value in the amount specified in this section.

(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 benefit, if any, available under the policy on each policy anniversary either during the first 20 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 company on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated

therein, a statement that such method of computation has been filed with the insurance supervisory official of the state 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.

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.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy with the consent of the commissioner; provided, however, that the policy shall remain in full force and effect until the insurer has made the payment.

(3) 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 (2), shall be an amount not less than the excess, if any, of the present value, on such 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 Subsections (5) and (6), corresponding to premiums which would have fallen due on and after such anniversary, and (b) the amount of any indebtedness to the company on the policy.

Provided, however, that for any policy issued on or after the operative date of Subsection (6)(d) 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 the first paragraph of this subsection 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 (6)(d) 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 71, the cash surrender value referred to in the first paragraph of this subsection 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 a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse. Any cash surrender value available within 30 days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by Subsection (2) shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(4) 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 such 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.

(5) (a) This Subsection (5)(a) does not apply to policies issued on or after the operative date of Subsection (6)(d) as defined therein. Except as provided in Subsection (5)(c), 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 any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such 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) 2% of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount if the amount of insurance varies with duration of the policy; (iii) 40% of the adjusted premium for the first policy year; and (iv) 25% 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. Provided, however, that in applying the percentages specified in Subsections (5)(a)(iii) and (iv), no adjusted premium shall be considered to exceed 4% of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(b) 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 section shall be considered 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, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by such policy at age 10.

(c) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to: (i) 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 (ii) the adjusted premiums for such term insurance, the foregoing items (i) and (ii) of this Subsection (5)(c) being calculated separately and as specified in Subsections (5)(a) and (b) except that, for the purposes of (ii), (iii), and (iv) of Subsection (5)(a), the amount of insurance or equivalent uniform amount of insurance used in calculation of the adjusted premiums referred to in (ii) of this Subsection (5)(c) 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 (i) of this Subsection (5)(c).

(d) Except as otherwise provided in Subsection (6), 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 Commissioner's 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 3-1/2% per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, 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 130% of the rates of mortality according to such 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 company and approved by the commissioner.

(6) (a) This Subsection (6)(a) does not apply to ordinary policies issued on or after the operative date of Subsection (6)(d) as defined therein. In the case of ordinary policies issued on or after the operative date of Subsection (6)(a) as defined in Subsection (6)(b), all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioner's 1958 Standard Ordinary Mortality Table and the rate of interest as specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that such rate of interest may not exceed 3-1/2% per annum for policies issued before June 1, 1973, 4% per annum for policies issued on or after May 31, 1973, and before April 2, 1980, and the rate of interest may not exceed 5-1/2% per annum for policies issued after April 2, 1980, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding 6-1/2% per annum may be used, and 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 six years younger than the actual age of the insured. Provided, however, 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 Commissioner's 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 company and approved by the commissioner.

(b) Any company may file with the commissioner a written notice of its election to comply with the provisions of Subsection (6)(a) after a specified date before January 1, 1966. After filing such notice, then upon such specified date, which is the operative date of Subsection (6)(a) for such company, this Subsection (6)(a) shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of Subsection (6)(a) for such company is January 1, 1966.

(c) This Subsection (6)(c) does not apply to industrial policies issued after the operative date of Subsection (6)(d) as defined therein. In the case of industrial policies issued on or after the operative date of this Subsection (6)(c) as defined herein, all

adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioner's 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 may not exceed 3-1/2% per annum for policies issued before June 1, 1973, 4% per annum for policies issued after May 31, 1973, and before April 2, 1980, and 5-1/2% per annum for policies issued after April 2, 1980, except that for any single premium whole life or endowment insurance policy issued after April 2, 1980, a rate of interest not exceeding 6-1/2% per annum may be used. Provided, however, 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 Commissioner's 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 company and approved by the commissioner.

Any company may file with the commissioner a written notice of its election to comply with the provisions of this Subsection (6)(c) after a specified date before January 1, 1968. After filing such notice, then upon that specified date, which is the operative date of this Subsection (6) (c) for such company, this Subsection (6)(c) shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this Subsection (6)(c) for such company shall be January 1, 1968.

(d) (i) This Subsection (6)(d) applies to all policies issued on or after the operative date of this subsection as defined herein. Except as provided in Subsection (6)(d)(vii), 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 policy, of all 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) 1% 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 10 policy years; and (C) 125% of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (C), no nonforfeiture net level premium shall be considered to exceed 4% 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 10 policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(ii) 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.

(iii) 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 change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits 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.

(iv) Except as otherwise provided in Subsection (6)(d)(vii), 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 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 (A) 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 (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(v) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of: (A) 1% of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first 10 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 (B) 125% of the increase, if positive, in the nonforfeiture net level premium.

(vi) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where

(A) equals the sum of:

(I) the nonforfeiture net level premium applicable prior to the change 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 change on which a premium would have fallen due had the change not occurred; and

(II) the present value of the increase in future guaranteed benefits provided for by the policy; and

(B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(vii) Notwithstanding any other provision of this Subsection (6)(d) 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.

(viii) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of: (A) the Commissioner's 1980 Standard Ordinary Mortality Table; or (B) at the election of the company for any one or more specified plans of life insurance, the Commissioner's 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 Commissioner's 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 subsection, for policies issued in that calendar year. Provided, however, 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 the nonforfeiture interest rate, as defined in this subsection, 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 (2), 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 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 Commissioner's 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioner's 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 rules adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the Commissioner's 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioner's 1980 Extended Term Insurance Table.

(VII) Any industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rules adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioner's 1961 Industrial Extended Term Insurance Table.

(ix) The nonforfeiture interest rate per annum for any policy issued in a particular

calendar year shall be equal to 125% of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearest one-fourth of 1%.

(x) Notwithstanding any other provision in this title 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 does not require refiling of any other provisions of that policy form.

(xi) After the effective date of this Subsection (6)(d), any company may, at any time before January 1, 1989, file with the commissioner a written notice of its election to comply with the provisions of this subsection with regard to any number of plans of insurance after a specified date before January 1, 1989, which specified date shall be the operative date of this Subsection (6)(d) for the plan or plans, but if a company elects to make the provisions of this subsection operative before January 1, 1989, for fewer than all plans, the company shall comply with rules adopted by the commissioner. There is no limit to the number of times this election may be made. If the company makes no such election, the operative date of this subsection for such company shall be January 1, 1989.

(7) 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 the estimates of future experience, or in the case of any plan of life insurance which is of such nature that minimum values cannot be determined by the methods described in Subsection (2), (3), (4), (5), (6)(a), (6)(b), (6)(c), or (6)(d) herein, then:

(a) the insurer shall demonstrate to the satisfaction of the commissioner that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by Subsection (2), (3), (4), (5), (6)(a), (6)(b), (6)(c), or (6)(d);

(b) the plan of life insurance shall satisfy the commissioner that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(c) the cash surrender values and paid-up nonforfeiture benefits provided by the plan may not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by rules adopted by the commissioner.

(8) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in Subsections (3), (4), (5), and (6) of this section 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, may not be less than the amounts used to provide such additions. Notwithstanding the provisions of Subsection (3), additional benefits payable: (a) in the event of death or dismemberment by accident or accidental means, (b) in the event of total and permanent disability, (c) as reversionary annuity or deferred reversionary annuity benefits, (d) 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, (e)

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 26, if 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 (f) as other policy benefits additional to life insurance 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.

(9) This Subsection (9), in addition to all other applicable subsections of this section, applies 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 2/10 of 1% 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 10 policy years, from the sum of: (a) the greater of zero and the basic cash value hereinafter specified, and (b) 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, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in Subsection (3) or (5), whichever is applicable, shall be the same as are the effects specified in Subsection (3) or (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 (5) or (6)(d), whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

(a) shall be the same percentage for each policy year between the second policy anniversary and the later of: (i) the fifth policy anniversary and (ii) 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 2/10 of 1% 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 10 policy years; and

(b) shall be such that no percentage after the later of the two policy anniversaries specified in Subsection (9)(a) 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 (5) or Subsection (6)(d), whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic value.

All adjusted premiums and present values referred to in this Subsection (9) 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 law. 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 (2), (3), (4), (5), (6), and (8). 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 Subsections (8)(a) through (f) shall conform with the principles of this Subsection (9).

(10) This section does not apply to any of the following:

(a) reinsurance;

(b) group insurance;

(c) pure endowment;

(d) an annuity or reversionary annuity contract;

(e) a term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(f) a term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in Subsections (5) and (6), is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance, and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(g) a 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 (3), (4), (5), and (6) exceeds 2-1/2% of the amount of insurance at the beginning of the same policy year; or

(h) a 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 of expiry for a joint term insurance policy shall be the age of expiry of the oldest life.

(11) The commissioner may adopt rules interpreting, describing, and clarifying the application of this nonforfeiture law to any form of life insurance for which the interpretation, description, or clarification is considered necessary by the commissioner, including unusual and new forms of life insurance.

Amended by Chapter 297, 2011 General Session

31A-22-409. Standard Nonforfeiture Law for Individual Deferred Annuities.

(1) This section is known as the "Standard Nonforfeiture Law for Individual Deferred Annuities."

(2) This section does not apply to:
(a) reinsurance;
(b) a group annuity purchased under a retirement plan or plan of deferred compensation:
(i) established or maintained by:
(A) an employer, including a partnership or sole proprietorship;
(B) an employee organization; or
(C) both an employer and an employee organization; and
(ii) other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code;
(c) a premium deposit fund;
(d) a variable annuity;
(e) an investment annuity;
(f) an immediate annuity;
(g) a deferred annuity contract after annuity payments have commenced;
(h) a reversionary annuity; or
(i) a contract that is delivered outside this state through an agent or other representative of the company issuing the contract.
(3) (a) If a policy is issued after this section takes effect as set forth in Subsection (15), a contract of annuity, except as stated in Subsection (2), may not be delivered or issued for delivery in this state unless the contract of annuity contains in substance:
(i) the provisions described in Subsection (3)(b); or
(ii) provisions corresponding to the provisions described in Subsection (3)(b) that in the opinion of the commissioner are at least as favorable to the contractholder, governing cessation of payment of consideration under the contract.
(b) Subsection (3)(a)(i) requires the following provisions:
(i) the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such a value as specified in Subsections (7), (8), (9), (10), and (12):
(A) upon cessation of payment of consideration under a contract; or
(B) upon a written request of the contract owner;
(ii) if a contract provides for a lump-sum settlement at maturity, or at any other time, upon surrender of the contract at or before the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in Subsections (7), (8), (10), and (12);
(iii) a statement of the mortality table, if any, and interest rates used in calculating any of the following that are guaranteed under the contract:
(A) minimum paid-up annuity benefit;
(B) cash surrender benefit; or
(C) death benefit;
(iv) sufficient information to determine the amounts of the benefits described in Subsection (3)(b)(iii);
(v) 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 a statute of the state in which the contract is delivered; and
(vi) an explanation of the manner in which a benefit described in Subsection

(3)(b)(v) is altered by the existence of any:

(A) additional amounts credited by the company to the contract;

(B) indebtedness to the company on the contract; or

(C) prior withdrawals from or partial surrender of the contract.

(c) Notwithstanding the requirements of this Subsection (3), a deferred annuity contract may provide that if no consideration is 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 consideration paid before the period would be less than $20 monthly:

(i) the company may at the company's option terminate the contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table specified in the contract, if any, and the interest rate specified in the contract for determining the paid-up annuity benefit; and

(ii) the payment described in Subsection (3)(c)(i), relieves the company of any further obligation under the contract.

(d) A company may reserve the right to defer the payment of cash surrender benefit for a period not to exceed six months after demand for the payment of the cash surrender benefit with surrender of the contract.

(4) For a policy issued before June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (4).

(a) (i) With respect to a contract providing for flexible considerations, the minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at a rate of interest of 3% per annum of percentages of the net considerations paid prior to such time:

(A) decreased by the sum of:

(I) any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 3% per annum; and

(II) the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(B) increased by any existing additional amounts credited by the company to the contract.

(ii) For purposes of this Subsection (4)(a), the net consideration for a given contract year used to define the minimum nonforfeiture amount shall be:

(A) an amount not less than zero; and

(B) equal to the corresponding gross considerations credited to the contract during that contract year less:

(I) an annual contract charge of $30; and

(II) a collection charge of $1.25 per consideration credited to the contract during that contract year.

(iii) The percentages of net considerations shall be:

(A) 65% of the net consideration for the first contract year; and

(B) 87-1/2% of the net considerations for the second and later contract years.

(iv) Notwithstanding Subsection (4)(a)(iii), the percentage shall be 65% of the

portion of the total net consideration for any renewal contract year that 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 65%.

(b) (i) Except as provided in Subsections (4)(b)(ii) and (iii), with respect to a contract providing for fixed scheduled consideration, minimum nonforfeiture amounts shall be:

(A) calculated on the assumption that considerations are paid annually in advance; and

(B) defined as for contracts with flexible considerations that are paid annually.

(ii) The portion of the net consideration for the first contract year to be accumulated shall be equal to an amount that is the sum of:

(A) 65% of the net consideration for the first contract year; and

(B) 22-1/2% of the excess of the net consideration for the first contract year over the lesser of the net considerations for:

(I) the second contract year; and

(II) the third contract year.

(iii) The annual contract charge shall be the lesser of $30 or 10% of the gross annual consideration.

(c) With respect to a contract providing for a single consideration payment, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that:

(i) the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90%; and

(ii) the net consideration shall be the gross consideration less a contract charge of $75.

(5) For a policy issued on or after June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (5).

(a) The minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at rates of interest as indicated in Subsection (5)(b), of 87-1/2% of the gross considerations paid before such time decreased by the sum of:

(i) any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection (5)(b);

(ii) an annual contract charge of $50, accumulated at rates of interest as indicated in Subsection (5)(b);

(iii) any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection (5)(b); and

(iv) the amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) (i) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of:

(A) 3% per annum; and

(B) the five-year Constant Maturity Treasury Rate reported by the Federal Reserve, rounded to the nearest 1/20th of 1%, as of a date or average over a period no

longer than 15 months prior to the contract issue date or redetermination date under Subsection (5)(b)(iii):

(I) reduced by 125 basis points; and

(II) where the resulting interest rate is not less than 1%.

(ii) The interest rate shall apply for an initial period and may be redetermined for additional periods.

(iii) (A) If the interest rate will be reset, the contract shall state:

(I) the initial period;

(II) the redetermination date;

(III) the redetermination basis; and

(IV) the redetermination period.

(B) The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

(c) (i) During the period or term that a contract provides substantive participation in an equity indexed benefit, the reduction described in Subsection (5)(b)(i)(B)(I) may be increased by up to an additional 100 basis points to reflect the value of the equity index benefit.

(ii) The present value of the additional reduction at the contract issue date and at each redetermination date may not exceed the market value of the benefit.

(iii) (A) The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit.

(B) If the demonstration required under Subsection (5)(c)(iii)(A) is not made to the satisfaction of the commissioner, the commissioner may disallow or limit the additional reduction.

(6) Notwithstanding Subsection (4), for a policy issued on or after June 1, 2004 and before June 1, 2006, at the election of a company, on a contract form-by-contract form basis, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract may be based upon minimum nonforfeiture amounts as established in Subsection (5).

(7) (a) A paid-up annuity benefit available under a contract shall be such that the contract's present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date.

(b) The present value described in Subsection (7)(a) 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.

(8) (a) For a contract that provides cash surrender benefits, the cash surrender benefits available before maturity may not be less than the present value as of the date of surrender of that portion of the cash surrender value that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender:

(i) decreased by the amount appropriate to reflect any prior withdrawals from or partial surrender of the contract;

(ii) decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(iii) increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of this Subsection (8), the present value is to be calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value.

(c) In no event shall a cash surrender benefit be less than the minimum nonforfeiture amount at that time.

(d) The death benefit under a contract described in Subsection (8)(a) shall be at least equal to the cash surrender benefit.

(9) (a) For a contract that does 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 may 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 before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of Subsection (9)(a), the present value for the period prior to the maturity date is to be calculated on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value.

(c) For a contract that does not provide a death benefit before 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.

(d) In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(10) (a) For the purpose of determining the benefits calculated under Subsections (8) and (9), the maturity date shall be considered to be:

(i) in the case of an annuity contract issued on or before May 5, 2002, under which an election may be made to have an annuity payment commence at an optional maturity date, the latest date for which an election is permitted by the contract, except that it may not be considered to be later than the later of:

(A) the anniversary of the contract next following the day on which the annuitant becomes 70 years of age; or

(B) the tenth anniversary of the contract; or

(ii) in the case of an annuity contract issued on or after May 6, 2002, the latest date permitted by the contract, except that it may not be considered to be later than the later of:

(A) the anniversary of the contract next following the day on which the annuitant becomes 70 years of age; or

(B) the tenth anniversary of the contract.

(b) In the case of an annuity contract issued on or after May 6, 2002:

(i) for a contract that provides cash surrender benefits, the cash surrender value on or past the maturity date shall be equal to the amount used to determine the annuity benefit payments; and

(ii) a surrender charge may not be imposed on or past maturity.

(11) A contract that does not provide cash surrender benefits or does not provide

death benefits at least equal to the minimum nonforfeiture amount before the commencement of any annuity payments shall include a statement in a prominent place in the contract that these benefits are not provided.

(12) A paid-up annuity, cash surrender, or death benefit available at any time, other than on the contract anniversary under a contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(13) (a) For a contract that provides, within the same contract by rider or supplemental contract provisions, 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:

(i) be equal to the sum of:

(A) the minimum nonforfeiture benefits for the annuity portion; and

(B) the minimum nonforfeiture benefits, if any, for the life insurance portion; and

(ii) computed as if each portion were a separate contract.

(b) (i) Notwithstanding Subsections (7), (8), (9), (10), and (12), additional benefits payable, as described in Subsection (13)(b)(ii), and consideration for the additional benefits payable, shall be disregarded in ascertaining, if required by this section:

(A) the minimum nonforfeiture amounts;

(B) paid-up annuity;

(C) cash surrender; and

(D) death benefits.

(ii) For purposes of this Subsection (13), an additional benefit is a benefit payable:

(A) in the event of total and permanent disability;

(B) as reversionary annuity or deferred reversionary annuity benefits; or

(C) as other policy benefits additional to life insurance, endowment, and annuity benefits.

(iii) The inclusion of the additional benefits described in this Subsection (13) may not be required in any paid-up benefits, unless the additional benefits separately would require:

(A) minimum nonforfeiture amounts;

(B) paid-up annuity;

(C) cash surrender; and

(D) death benefits.

(14) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may adopt rules necessary to implement this section, including:

(a) ensuring that any additional reduction under Subsection (5)(c) is consistent with the requirements imposed by Subsection (5)(c); and

(b) providing for adjustments in addition to the adjustments allowed under Subsection (5)(c) to the calculation of minimum nonforfeiture amounts for:

(i) a contract that provides substantive participation in an equity index benefit; and

(ii) a contract for which the commissioner determines adjustments are justified.

(15) (a) After this section takes effect, a company may file with the commissioner a written notice of its election to comply with this section after a specified date before July 1, 1988.

(b) This section applies to annuity contracts of a company issued on or after the date the company specifies in the notice.

(c) If a company makes no election under Subsection (15)(a), the operative date of this section for such company is July 1, 1988.

Amended by Chapter 345, 2008 General Session
Amended by Chapter 382, 2008 General Session

31A-22-410. Trustee and deposit agreements.

(1) An insurer may hold as a part of its general assets the proceeds of any life insurance policy or annuity under a trust or other agreement, upon the terms and restrictions as to revocation by the policyholder and control by the beneficiary, and with the exemptions from the claims of creditors of the beneficiary as the insurer and the policyholder agree to in writing and as are otherwise recognized by law.

(2) An insurer may also receive funds in amounts and upon conditions which the insurer and the policyholder agree to in writing:

(a) as premiums in advance upon life insurance policies or annuities; or

(b) to accumulate for the purchase of future life insurance policies or annuities.

Enacted by Chapter 242, 1985 General Session

31A-22-411. Insurance policies providing variable benefits.

(1) An insurance policy that provides for payment of a benefit in a variable amount shall contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of the variable benefits.

(2) A variable insurance policy shall contain:

(a) an appropriate nonforfeiture benefit in lieu of those required by either Section 31A-22-408 or 31A-22-409;

(b) an appropriate reinstatement provision in lieu of those required by Section 31A-22-407; and

(c) a grace period provision appropriate to that type of insurance policy in lieu of those required by Section 31A-22-402.

(3) An individual insurance policy and a certificate issued under a group insurance policy shall conspicuously state on its first page that:

(a) the dollar amount may decrease or increase according to investment experience; and

(b) a benefit under the insurance policy is payable on a variable basis.

(4) A life insurance or annuity policy with a variable benefit issued under a separate account shall, on either the application or the insurance policy, state that the insurer's liabilities with respect to a variable benefit under the insurance policy are subject to satisfaction only out of the insurer's variable account assets.

(5)(a) A variable insurance policy shall state whether it may be amended as to:

(i) investment policy;

(ii) voting rights; and
(iii) conduct of the business and affairs of a separate account.
(b) Subject to any preemptive provision of federal law, an amendment of the type described in this Subsection (5) is subject to:
(i) filing under Section 31A-21-201; and
(ii) approval by a majority of the policyholders in the separate account.

Amended by Chapter 10, 2010 General Session

31A-22-412. Assignment of life insurance rights

(1) Except as provided under Subsection (3), the owner of any rights in a life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary and the rights secured under Sections 31A-22-517 through 31A-22-521 and any other provision of this title. An assignment, valid under general contract law, vests the assigned rights in the assignee, subject, so far as reasonably necessary for the protection of the insurer, to any provisions in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.
(2) The rights of a beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee, unless the beneficiary was designated as an irrevocable beneficiary prior to the assignment.
(3) Assignment of insurance rights may be expressly prohibited by an annuity contract which provides annuities as retirement benefits related to employment contracts.
(4) When a life insurance policy or annuity is, after July 1, 1986, assigned in writing as security for an indebtedness, the insurer shall, in any case in which it has received written notice of the assignment, the name and address of the assignee, and a request for cancellation notice by the assignee, mail to the assignee a copy of any cancellation notice sent with respect to the policy. This notice shall be sent, postage prepaid, and addressed to the assignee's address filed with the insured. The notice shall be mailed not less than 10 days prior to the final termination of the policy and each time the insured has failed or refused to transmit a premium payment to the insurer before the commencement of the policy's grace period. The insurer may charge the insured directly or charge against the policy the reasonable cost of complying with this section, but in no event to exceed $5 for each notice. As used in this section, "final termination of the policy" means the date after which the policy will not be reinstated by the insurer without requiring evidence of insurability or written application.
(5) In lieu of providing notices to assignees of final termination of the policy under Subsection (4), an insurer may provide an assignee with an identical copy of all notices sent to the owner of the life insurance policy, provided these notices comply with the other requirements of this title.

Amended by Chapter 204, 1986 General Session

31A-22-413. Designation of beneficiary.

(1) Subject to Subsection 31A-22-412(2), no life insurance policy or annuity contract may restrict the right of a policyholder or certificate holder:

(a) to make an irrevocable designation of beneficiary effective immediately or at some subsequent time; or

(b) if the designation of beneficiary is not explicitly irrevocable, to change the beneficiary without the consent of the previously designated beneficiary. Subsection 75-6-201(1)(c) applies to designations by will or by separate writing.

(2) (a) An insurer may prescribe formalities to be complied with for the change of beneficiaries, but those formalities may only be designed for the protection of the insurer. Notwithstanding Section 75-2-804, the insurer discharges its obligation under the insurance policy or certificate of insurance if it pays the properly designated beneficiary unless it has actual notice of either an assignment or a change in beneficiary designation made pursuant to Subsection (1)(b).

(b) The insurer has actual notice if the formalities prescribed by the policy are complied with, or if the change in beneficiary has been requested in the form prescribed by the insurer and delivered to an agent representing the insurer at least three days prior to payment to the earlier properly designated beneficiary.

Amended by Chapter 264, 2013 General Session

31A-22-414. Evidence as to death.

The rules relating to determination of death under Section 75-1-107 are applicable to life insurance.

Amended by Chapter 30, 1992 General Session

31A-22-415. Simultaneous death.

Section 75-2-702 applies to all policies of life and accident and health insurance.

Amended by Chapter 116, 2001 General Session

31A-22-416. Reserved.

Enacted by Chapter 242, 1985 General Session

31A-22-417. Physical examination and autopsy.

A life insurer may, at its own expense, examine the body of the insured when and as often as the insurer reasonably requires during the pendency of a claim, and it may make an autopsy in case of death where it is reasonably necessary and not forbidden by law.

Enacted by Chapter 242, 1985 General Session

31A-22-418. Participating and nonparticipating policies.

(1) (a) A stock insurer and a mutual insurer may issue both participating and nonparticipating life insurance policies and annuity contracts, subject to this section.

(b) A fraternal insurer issuing life insurance policies in this state may only issue

participating policies, except for the following nonparticipating policies:

(i) paid-up, temporary, pure endowment insurance, and annuity settlements provided in exchange for lapsed, surrendered, or matured policies;

(ii) annuities beginning within one year of the making of the contract; and

(iii) those term insurance policies which the commissioner exempts by rule.

(2) Every participating policy shall by its terms give its holder full right to participate annually in the surplus accumulations from the participating business of the insurer that are distributed.

(3) Every insurer issuing both participating and nonparticipating policies shall separately account for the two classes of business.

(4) (a) No life insurance policy or certificate may be issued in which the accounting, apportionment, and distribution of surplus is deferred for a period longer than three years.

(b) Every insurer doing a participating business shall annually ascertain the surplus over required reserves and other liabilities. After setting aside the contingency reserves it considers necessary and as are required by law, the reasonable nondistributable surplus needed to permit orderly growth, making provision for the payment of reasonable dividends upon capital stock and those sums as are required by prior contracts to be held for deferred dividend policies, the remaining surplus shall be equitably apportioned and returned as a dividend to the participating policyholders or certificate-holders entitled to share in the dividend. A dividend may be conditioned on the payment of the succeeding year's premium only on the first and second anniversaries of the policy.

Amended by Chapter 204, 1986 General Session

31A-22-419. Insurer's purchase of and loans on policies.

Any life insurer may purchase for its own benefit any policy of insurance or other obligation of the company and any claim of its policyholders. The insurer may also lend to the holders of policies of the company a sum which does not exceed the sum of the cash value of the policies and the surplus or dividend additions to the policies. The policies and all additions to them shall be security for payment of the loan. An insurer's security interest in a policy under this section need not be filed under Title 70A, Chapter 9a, Uniform Commercial Code -- Secured Transactions, to be perfected.

Amended by Chapter 252, 2000 General Session

31A-22-420. Policy loans.

(1) This section applies to all life insurance policies and annuity contracts, including certificates issued by fraternal insurers, which contain policy loan provisions. A "policy loan" includes any arrangement by which a premium is paid to the life insurer after the normal due date.

(2) As used in this section, "published monthly average" means:

(a) The monthly average of the composite yield on Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc., or any successor to that publication; or

(b) in the event that Moody's Corporate Bond Yield Average--Monthly Average Corporates is no longer published, a substantially similar average, established by the commissioner by rule.

(3) (a) Policies issued on or after May 12, 1981, shall provide for policy loan interest rates by:

(i) a provision permitting a maximum interest rate of not more than 8% per annum; or

(ii) a provision permitting an adjustable maximum interest rate calculated under this section.

(b) The rate of interest charged on a policy loan made under Subsection (3)(a)(ii) may not exceed the higher of:

(i) the published monthly average for the calendar month ending two months before the date on which the rate is determined; or

(ii) the rate used to compute cash surrender values under the policy during the same period, plus 1% per annum.

(c) If the maximum rate of interest is determined under Subsection (3)(a)(ii), the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(d) The maximum rate under Subsection (3)(a)(ii) for each policy shall be determined at regular intervals at least once every 12 months, but not more frequently than once in any three-month period. At the intervals specified in the policy:

(i) the rate being charged may be increased whenever the increase determined under Subsection (3)(b) would increase that rate by 1/2% or more per annum; and

(ii) the rate being charged shall be reduced whenever the reduction determined under Subsection (3)(b) would decrease that rate by 1/2% or more per annum.

(e) Every life insurer shall:

(i) notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(ii) 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, but notice need not be given to the policyholder when a further premium loan is added, except as provided in Subsection (3)(e)(iii);

(iii) send to policyholders with loans, reasonable advance notice of any increase in the rate; and

(iv) include in the notices required by Subsection (3)(e)(i), (ii), and (iii) the substance of the pertinent provisions of Subsections (3)(a) and (c).

(f) No policy may terminate during a policy year solely because of a change in the interest rate during that policy year. Coverage shall continue during that policy year until it would have terminated if there had been no change in interest rate during that policy year.

(g) The pertinent provisions of Subsections (3)(a) and (c) shall be set forth in the policies to which they apply.

(4) This section applies to an insurance policy issued before May 12, 1981, only if the policyholder agrees to its application in writing, after receiving explicit disclosure of the provisions regarding premiums, dividends, and nonforfeiture cash values of the existing and amended insurance policies prior to execution of the written agreement.

No other rights of the policyholder under the insurance policy are affected by this agreement.

(5) The policy shall contain a provision permitting the insurer, upon the commissioner's approval, to defer granting a policy loan for up to six months after application for the loan. Policy loans for the payment of premium to the insurer may not be deferred under this subsection.

Amended by Chapter 204, 1986 General Session

31A-22-421. Facility of payment under certain life insurance policies.

A life insurance policy with a face value of $5,000 or less may provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within a period stated in the policy, which may not be less than 30 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 any payment under the policy to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled to the payment by reason of having incurred expense for the maintenance, medical attention, or burial of the insured, or for other reasons. The policy may also include a similar provision applicable to any other payment due under the policy.

Enacted by Chapter 242, 1985 General Session

31A-22-422. Conditional coverage.

Conditional or binding receipts or other documents issued by a life insurer, whatever they are named, which conditionally grant life insurance coverage prior to physical delivery of the policy are subject to the form filing requirements under Section 31A-21-201.

Enacted by Chapter 242, 1985 General Session

31A-22-423. Policy and annuity examination period.

(1) (a) Except as provided under Subsection (2), a life insurance policy, life insurance certificate, annuity contract, or annuity certificate shall contain a notice prominently printed on or attached to the cover or front page of the policy, contract, or certificate stating that the policyholder, contract holder, or certificate holder has the right to return the policy, contract, or certificate for any reason on or before:

(i) 10 days after the day on which the policy, contract, or certificate is delivered; or

(ii) in case of a replacement policy, contract, or certificate, 30 days after the day on which the replacement policy, contract, or certificate is delivered.

(b) For purposes of this section, "return" means a writing that:

(i) the policy, contract, or certificate is being returned for termination of coverage;

(ii) is:
(A) a written statement on the policy, contract, or certificate; or
(B) a writing that accompanies the policy, contract, or certificate; and
(iii) is delivered to or mailed first class to the insurer or the insurer's agent.
(c) A policy, contract, or certificate returned under this section is void from the date of issuance.
(d) A policyholder, contract holder, or certificate holder returning a policy or certificate is entitled to a refund of any premium paid.
(2) This section does not apply to:
(a) group term life insurance issued under Section 31A-22-502;
(b) a group master policy;
(c) a noncontributory certificate;
(d) a credit life insurance certificate; and
(e) other classes of life insurance policies that the commissioner specifies by rule after finding that a right to return those life insurance policies would be impracticable or unnecessary to protect the policyholder's interests.

Amended by Chapter 307, 2007 General Session

31A-22-424. Documents constituting entire life insurance policy.
(1) A life insurance policy shall contain a provision that defines the documents and agreements that constitute the entire contract between the parties.
(2) Except as permitted by Section 31A-21-106, all documents and agreements defined under Subsection (1) shall be attached to the policy.

Enacted by Chapter 116, 2001 General Session

31A-22-425. Rulemaking authority for standards related to life insurance and annuities.
In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules to establish standards for any of the following:
(1) if used in connection with the solicitation or sale of life insurance policies and contracts:
(a) a buyer's guide;
(b) a disclosure;
(c) an illustration;
(d) a policy summary; or
(e) a recommendation; and
(2) in a life insurance policy, annuity contract, or life insurance or annuity certificate:
(a) a definition of a term;
(b) a disclosure;
(c) an exclusion; or
(d) a limitation.

Amended by Chapter 382, 2008 General Session

31A-22-426. Coverage description.

(1) Each life insurance policy, annuity contract, and certificate of life insurance shall contain a brief description printed on the cover page.

(2) The description shall include:

(a) the type of insurance;

(b) whether it is participating or nonparticipating;

(c) a significant limitation stated or included in the filed policy, contract, or certificate; and

(d) a significant specific feature stated or included in the filed policy, contract, or certificate.

Enacted by Chapter 125, 2005 General Session

31A-22-427. Life insurance and annuity policy records.

A life insurer, and its successors, shall maintain all records that affect the legal effect of a life insurance policy, annuity contract, or certificate of life insurance for the term of the insurance plus five years.

Enacted by Chapter 125, 2005 General Session

31A-22-428. Interest payable on life insurance proceeds.

(1) For a life insurance policy delivered or issued for delivery in this state on or after May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the insured.

(2) (a) Except as provided in Subsection (4), for the period beginning on the date of death and ending the day before the day described in Subsection (3)(b), interest under Subsection (1) shall accrue at a rate no less than:

(i) the rate applicable to policy funds left on deposit; or

(ii) if there is no rate described in Subsection (2)(a)(i), at the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve.

(b) The rate described in Subsection (2)(a) is the rate in effect on the day on which the death occurs.

(c) Interest is payable until the day on which the claim is paid.

(3) (a) Unless the claim is paid and except as provided in Subsection (4), beginning on the day described in Subsection (3)(b) and ending the day on which the claim is paid, interest shall accrue at the rate in Subsection (2) plus additional interest at the rate of 10% annually.

(b) Interest accrues under Subsection (3)(a) beginning with the day that is 31 days from the latest of:

(i) the day on which the insurer receives proof of death;

(ii) the day on which the insurer receives sufficient information to determine:

(A) liability;

(B) the extent of the liability; and

(C) the appropriate payee legally entitled to the proceeds; and

(iii) the day on which:

(A) legal impediments to payment of proceeds that depend on the action of

parties other than the insurer are resolved; and

(B) the insurer receives sufficient evidence of the resolution of the legal impediments described in Subsection (3)(b)(iii)(A).

(4) A court of competent jurisdiction may require payment of interest from the date of death to the day on which a claim is paid at a rate equal to the sum of:

(a) the rate specified in Subsection (2); and

(b) the legal rate identified in Subsection 15-1-1(2).

Enacted by Chapter 345, 2008 General Session

31A-22-429. Producer's duties related to replacement of life insurance or annuity.

(1) In connection with or as part of each application for life insurance or annuities, the applicant shall complete and the producer shall submit to the insurer the statements required by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as to:

(a) whether the applicant has existing policies or contracts; and

(b) whether the proposed life insurance or annuity will replace, discontinue, or change an existing policy or contract.

(2) If an applicant for life insurance or an annuity answers "yes" to the question regarding replacement, discontinuance, or change of an existing policy or contract referred to in Subsection (1), the producer shall present to the applicant, not later than at the time of taking the application, the notice regarding replacements in the form adopted by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, or other substantially similar document filed with the commissioner.

(3) (a) The notice described in Subsection (2) shall:

(i) list each existing policy or contract contemplated to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and

(ii) include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract.

(b) If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(4) In connection with a replacement transaction, the producer shall leave with the applicant by no later than at the time of policy or contract delivery the original or a copy of all printed sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract holder in printed form no later than at the time of policy or contract delivery.

(5) Except as provided in rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, in connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented:

(a) a copy of each document required by this section;

(b) a statement identifying any preprinted or electronically presented company approved sales materials used; and

(c) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Enacted by Chapter 319, 2013 General Session

31A-22-501. Eligible groups.

A group or blanket policy of life insurance may not be delivered in Utah unless the insured group:

(1) falls within at least one of the classifications under Sections 31A-22-501.1 through 31A-22-509; and

(2) is formed for a reason other than the purchase of insurance.

Amended by Chapter 125, 2005 General Session

31A-22-501.1. Employer groups.

(1) The lives of a group of individuals may be insured under a policy:

(a) issued as a policyholder, to:

(i) an employer; or

(ii) an employer sponsored trust for the benefit of the employer's employees;

(b) having an insurable interest as stated in Subsection 31A-21-104(3)(d); and

(c) subject to the requirement of Subsection 31A-21-104(3)(d)(v).

(2) A policy issued under this section is not subject to:

(a) Section 31A-21-311; and

(b) Sections 31A-22-516 through 31A-22-522.

Amended by Chapter 263, 2008 General Session

31A-22-502. Employee groups.

(1) As used in this section:

(a) "Employees" includes:

(i) for one or more affiliated corporations, proprietorships, or partnerships under common control, their:

(A) officers;

(B) managers;

(C) retired employees; and

(D) individual proprietors or partners; and

(ii) for a trusteeship, if their duties are primarily connected with the trusteeship:

(A) trustees;

(B) employees of trustees; or

(C) both Subsection (1)(a)(ii)(A) and (B).

(b) "Employer" includes a Utah public agency.

(c) (i) "Utah public agency" means a public institution that:

(A) derives its authority from this state; and

(B) is not privately owned.

(ii) "Utah public agency" includes:

(A) a local political subdivision as defined in Section 11-14-102;

(B) the state;
(C) a department or agency of the state; and
(D) all public educational institutions.
(2) The lives of a group of individuals may be insured under a policy:
(a) issued as policyholder, to:
(i) an employer; or
(ii) the trustees of a fund established by an employer;
(b) insuring employees of the employer for the benefit of persons other than the employer; and
(c) subject to the requirements of Subsections (3) through (5).
(3) (a) All the employer's employees or all of any class of employees of the employer shall be eligible for insurance under the policy described in Subsection (2).
(b) A policy issued to insure the employees of a public body may include elected or appointed officials.
(4) A Utah public agency may pay or authorize the payment out of the Utah public agency's corporate revenue, the premiums required to maintain the group insurance in force.
(5) (a) The premiums for the policy described in Subsection (2) shall be paid by the policyholders:
(i) from the employer's funds;
(ii) funds contributed by the insured employees; or
(iii) both the funds described in Subsections (5)(a)(i) and (ii).
(b) Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the insured employees shall insure all eligible employees.

Amended by Chapter 105, 2005 General Session

31A-22-503. Labor union or similar employee organization groups.

The lives of a group of individuals may be insured under a policy issued to a labor union or similar employee organization as policyholder. This policy shall insure members of the union or organization for the benefit of persons other than the union or organization or of any of its officials, representatives, or agents, subject to the following requirements:
(1) The members eligible for the insurance are all of the members or all of any classes of the members.
(2) The premium for the policy shall be paid by the policyholder, either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both. Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the insured members specifically for their insurance shall insure all eligible members.

Enacted by Chapter 242, 1985 General Session

31A-22-504. Trustee groups.

Group life insurance policies may be issued to policyholders who are the trustees of a fund established by two or more employers, by one or more labor unions, or similar

employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, to insure employees of the employers or members of the unions or the organizations for the benefit of persons other than the employers, the unions, or the organizations. These policies are subject to the following requirements:

(1) The persons eligible for insurance are all of the employees of the employers or all of the members of the unions or organizations, or all of any classes of employees or members. The policy may include retired employees, elected and appointed officials of a public agency if the employees of the agency are insured, and individual proprietors or partners who are employers. The policy may include the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(2) The premiums for the policy are paid by the policyholders from funds contributed by the employers, unions, or similar employee organizations, or from funds contributed by the insured persons, or any combination of these. Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the insured persons specifically for their insurance is required to insure all eligible persons.

Enacted by Chapter 242, 1985 General Session

31A-22-505. Association groups.

A policy issued as policyholder to an association or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations with a minimum membership of 100 persons, a constitution and bylaws, and which has been in active existence for at least two years, is subject to the following requirements:

(1) The policy may insure members and employees of the association, employees of the members, one or more of the preceding entities, or all of any classes of these named entities for the benefit of persons other than the employees' employer, or any officials, representatives, trustees, or agents of the employer or association.

(2) The premiums shall be paid by the policyholder from funds contributed by the associations, by employer members, from funds contributed by the covered persons, or from any combination of these. Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the covered persons, specifically for their insurance, is required to insure all eligible persons.

Enacted by Chapter 242, 1985 General Session

31A-22-506. Creditor groups to insure debtors.

(1) To insure debtors of a creditor, a group life insurance policy may be issued to a policyholder who is any of the following:

(a) the creditor;

(b) the creditor's parent holding company; or

(c) trustees or agents designated by two or more creditors.

(2) A policy described in Subsection (1) is subject to the requirements of this Subsection (2).

(a) (i) The persons eligible for insurance are:

(A) all of the debtors of the creditors; or
(B) all of any classes of debtors.
(ii) The policy may provide that "debtors" includes:
(A) borrowers of money, or purchasers or lessees of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction; and
(B) the debtors of one or more affiliated corporations, proprietorships, or partnerships under common control with the policyholder.
(b) (i) The premiums shall be paid by the policyholder, from:
(A) the creditor's funds;
(B) charges collected from the insured debtors; or
(C) from both Subsections (2)(b)(i)(A) and (B).
(ii) Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by insured debtors specifically for their insurance shall insure all eligible debtors.
(c) (i) To the extent of the creditor's interest, the insurance may be payable to the creditor or to any successor to the right, title, and interest of the creditor.
(ii) The payment shall reduce or extinguish the obligation of the debtor to the extent of the payment.
(iii) When the amount of insurance exceeds the debt, the excess is payable to a beneficiary other than the creditor named by the debtor, or to the debtor's estate.
(d) Group policies issued under this section are not subject to Sections 31A-22-516 through 31A-22-521.

Amended by Chapter 125, 2005 General Session

31A-22-507. Credit union groups.
(1) The lives of a group of individuals may be insured under a policy issued to a policyholder who is:
(a) a credit union; or
(b) trustees or agents designated by two or more credit unions.
(2) A policy described in Subsection (1) shall insure members of a credit union for the benefit of persons other than:
(a) the credit union;
(b) trustees of the credit union;
(c) agents of the credit union; or
(d) an official of an entity described in Subsections (2)(a) through (c).
(3) The policies are subject to the requirements of this Subsection (3).
(a) The persons eligible for insurance are:
(i) all of the members of the credit union; or
(ii) all of any classes of the members of the credit union.
(b) The premiums shall be paid by the policyholder. Except as provided in Section 31A-22-512, a policy on which no part of the premium is collected from the covered members specifically for their insurance shall insure all eligible members.
(c) A group policy issued under this section is not subject to Sections 31A-22-517 through 31A-22-521.

Amended by Chapter 125, 2005 General Session

31A-22-508. National Guard groups.

A policy of group life insurance may be issued on the lives of members of the Utah National Guard under Section 39-1-62.

Enacted by Chapter 242, 1985 General Session

31A-22-509. Commissioner's authority to approve other groups.

A policy may be issued to a group other than those specified under Sections 31A-22-502 through 31A-22-508, if specifically authorized by the commissioner and if granting the permission is not contrary to public policy. The commissioner may not grant permission to issue these types of policies unless the insurer demonstrates to the commissioner's satisfaction that the proposed group would be actuarially sound, would result in economies of acquisition and administration which justify a group rate, and would not present hazards of adverse selection. The premiums for the policy shall be paid by the policyholder, either from the policyholder's funds or from funds contributed by the covered persons, or from both. Premiums for the policy and any contributions by or on behalf of the insured persons shall be reasonable in relation to the benefits provided.

Enacted by Chapter 242, 1985 General Session

31A-22-510. Requirements for group life insurance delivered in another jurisdiction.

(1) A Utah resident may not be enrolled in a policy of group life insurance delivered in another jurisdiction in violation of Subsection (2) or (3), notwithstanding any contrary provision in Subsection 31A-1-103(3).

(2) Unless specifically authorized by the commissioner under Section 31A-22-509, coverage under a group life insurance policy delivered in another jurisdiction may not be initially provided to any person unless the policy conforms substantially to one of the types of groups specified under Sections 31A-22-502 through 31A-22-508.

(3) Coverage may not be initially provided to any person in Utah under a group life policy issued in another jurisdiction by an insurer not authorized to engage in life insurance business in Utah unless the policyholder conforms substantially to the type of group specified under Section 31A-22-502, 31A-22-503, or 31A-22-504.

Amended by Chapter 116, 2001 General Session

31A-22-511. Dependents' coverage.

Any group life policy issued under Sections 31A-22-502 through 31A-22-505 or Section 31A-22-509 may insure the employees or members against loss due to the death of their spouses and dependent children, or any classes of the employees or members. The premiums for the insurance shall be paid by the policyholder from funds contributed by the person to whom the policy has been issued, from funds contributed

by the covered persons, or from both. Except as provided under Section 31A-22-512, a policy on which no part of the premium for the dependent's coverage is contributed by the covered persons shall insure all insured persons, including their spouses and dependent or minor children.

Enacted by Chapter 242, 1985 General Session

31A-22-512. Individual insurability.

(1) An insurer may exclude or limit the coverage under a group life policy on any person, including a group member's dependent, as to whom the evidence of individual insurability is not satisfactory to the insurer.

(2) The group life insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish satisfactory evidence to the insurer of the individual insurability as a condition to part or all of his coverage.

Enacted by Chapter 242, 1985 General Session

31A-22-513. Grace period.

(1) (a) Every group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first payment of premium.

(b) During the grace period described in Subsection (1)(a) the death benefit coverage continues in force, unless the policyholder gives the insurer written notice of discontinuance:

(i) in advance of the date of discontinuance; and

(ii) in accordance with the policy terms.

(2) The policy may require the policyholder to pay the pro rata premium for the time the policy is in force during the grace period.

Amended by Chapter 114, 2000 General Session

31A-22-514. Incontestability.

The group life insurance policy shall contain a provision that the validity of the policy may not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. This provision shall also state that no statement made by any person insured under the policy relating to his insurability may 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 person's lifetime, nor may the statement be used unless it is contained in a written instrument signed by him. This type of provision does not preclude the assertion of defenses based upon provisions in the policy which relate to eligibility for coverage.

Enacted by Chapter 242, 1985 General Session

31A-22-515. Nonforfeiture.

If the group life insurance policy is not a term policy, it shall contain nonforfeiture provisions which the commissioner determines to be equitable to the insured persons and to the policyholder. The commissioner may not require that group life insurance policies contain the same nonforfeiture provisions which are required for individual life insurance policies.

Enacted by Chapter 242, 1985 General Session

31A-22-516. Payment of benefits.

Any sum which is due because of the death of the person insured is payable to the beneficiary designated by the insured person, unless the policy contains conditions providing that the beneficiary is a family member designated by the policy terms. The insurer may reserve in the policy the right, if there is no designated beneficiary living at the death of the person insured as to all or any part of the sum, to pay a part of the sum not exceeding $5,000 to any person appearing to the insurer to be equitably entitled to that money by reason of having incurred expense for the maintenance, medical attention, or burial of the insured or for other reasons.

Enacted by Chapter 242, 1985 General Session

31A-22-517. Conversion on termination of eligibility.

(1) A person is entitled to be issued by an insurer, without evidence of insurability, an individual policy of life insurance without accident and health or other supplementary benefits, if:

(a) any portion of insurance on a person covered by a policy ceases because of:

(i) termination of employment; or

(ii) termination of membership in the classes eligible for coverage;

(b) an application for the individual policy is made; and

(c) the first premium is paid to the insurer within 31 days after the termination described in Subsection (1)(a).

(2) The individual policy described in Subsection (1) shall, at the option of the person entitled to the policy, be on any form then customarily provided by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect:

(a) term insurance; or

(b) flexible premium insurance.

(3) (a) The individual policy described in Subsection (1) shall be for an amount equal to or, at the election of the person entitled, less than the life insurance that ceases because of the termination, less the amount of any group life insurance for which the person is eligible within 30 days after the termination.

(b) Any amount of insurance that matures on or before the termination, as an endowment payable to the person insured, is not included in the amount that is considered to cease because of the termination whether the endowment payment is in:

(i) one sum;

(ii) installments; or

(iii) the form of an annuity.

(4) The premium on the individual policy described in Subsection (1) shall be at the insurer's customary rate at the time of termination, which is applicable to:

(a) the form and amount of the individual policy;

(b) the class of risk to which the person belonged when terminated from the group policy; and

(c) the age attained on the effective date of the individual policy.

(5) Subject to the conditions of this section, the conversion privilege described in this section is available:

(a) to a surviving dependent, if any, at the death of the employee or member, with respect to the survivor's coverage under the group policy that terminates by reason of the death; and

(b) to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured, because the dependent ceases to be a qualified dependent under the group policy.

Amended by Chapter 175, 2006 General Session

31A-22-518. Conversion on termination of policy.

(1) Subject to Subsection (2), if the group policy terminates or is amended to terminate the insurance of any class of covered persons, every insured person whose insurance terminates, including the insured dependent of a covered person who has been insured for at least five years prior to the termination date, is entitled to have the insurer issue to the person an individual policy of life insurance, subject to the conditions and limitations in Section 31A-22-517.

(2) The group policy described in Subsection (1) shall provide that the amount of the individual policy may not be less than the smaller of:

(a) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is eligible under any group policy issued or reinstated by the same or another insurer within 30 days after the termination; or

(b) $10,000.

Amended by Chapter 116, 2001 General Session

31A-22-519. Death pending conversion.

If a person insured under a group life insurance policy, or the insured dependent of that person, dies during the period of eligibility for conversion under Section 31A-22-517 or 31A-22-518 and before the individual policy becomes effective, the amount of life insurance to which the insured would have been entitled to have issued under the individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.

Amended by Chapter 319, 2013 General Session

31A-22-520. Continuation of coverage during total disability.

(1) An insured person in a group life insurance policy may continue coverage during the total disability of the insured person or dependent by timely payment to the policyholder of that portion, if any, of the premium that would have been required on behalf of the insured person in the absence of total disability.

(2) The continuation shall be on a premium paying basis until the earlier of:

(a) six months from the date of total disability;

(b) approval by the insurer of continuation of the coverage under any disability provision the group insurance policy may contain; or

(c) the discontinuance of the group insurance policy.

(3) If the group policy has a waiting period for an accident and health benefit, the continuation extends to the end of the waiting period, even if the group policy is otherwise discontinued.

Amended by Chapter 116, 2001 General Session

31A-22-521. Notice of right to convert under group policy.

Certificates of insurance evidencing coverage under a group life insurance policy shall prominently notify individuals of conversion rights and contain information concerning the time and manner in which conversion to an individual life insurance policy may be made.

Repealed and Re-enacted by Chapter 316, 1994 General Session

31A-22-522. Required provision for notice of termination.

(1) A policy for group or blanket life insurance coverage issued or renewed after July 1, 2001, shall include a provision that obligates the policyholder to notify each employee or group member:

(a) in writing;

(b) 30 days before the date the coverage is terminated; and

(c) (i) that the group or blanket life insurance coverage is being terminated; and

(ii) the rights the employee or group member has to convert coverage upon termination.

(2) For a policy for group or blanket life insurance coverage described in Subsection (1), an insurer shall:

(a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's monthly notice to the policyholder of premium payments due; and

(b) provide a sample notice to the policyholder at least once a year.

Amended by Chapter 308, 2002 General Session

31A-22-600. Scope of Part 6.

(1) Except where a provision's application is otherwise specifically limited, this part applies to all:

(a) accident and health insurance contracts, including credit accident and health;

(b) franchise;

(c) group contracts; and

(d) a life insurance and annuity policy, but only if:
(i) it includes supplemental benefits and riders including accelerated benefits; and
(ii) receipt of benefits is contingent on morbidity requirements.
(2) Nothing in this part applies to or affects:
(a) workers' compensation insurance;
(b) reinsurance; or
(c) accident and health insurance when it is part of or supplemental to liability, steam boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided the loss, damage, or expense arises out of a hazard directly related to the other insurance.
(3) Except as provided in Subsection (1), this part does not apply to or affect a life insurance or annuity policy including a life insurance policy:
(a) with a rider or supplemental benefit that accelerates the death benefit contingent upon a mortality risk specifically for one or more of the qualifying events of:
(i) terminal illness;
(ii) medical conditions requiring extraordinary medical intervention; or
(iii) permanent institutional confinement; and
(b) that provides the option of a lump-sum payment for those benefits.

Amended by Chapter 116, 2001 General Session

31A-22-601. Applicability of life insurance provisions.
Sections 31A-22-412 through 31A-22-417 apply to death benefits in accident and health insurance policies.

Amended by Chapter 116, 2001 General Session

31A-22-602. Premium rates.
(1) This section does not apply to group accident and health insurance.
(2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged.
(3) The commissioner shall prohibit the use of an accident and health insurance policy form or rates if the form or rates do not satisfy Subsection (2).

Amended by Chapter 308, 2002 General Session

31A-22-603. Persons insured under an individual accident and health policy.
A policy of individual accident and health insurance may insure only one person, except that originally or by subsequent amendment, upon the application of an adult policyholder, a policy may insure any two or more eligible members of the policyholder's family, including husband, wife, dependent children, and any other person dependent upon the policyholder.

Amended by Chapter 116, 2001 General Session

31A-22-604. Reimbursement by insurers of Medicaid benefits.

(1) As used in this section, "Medicaid" means the program under Title XIX of the federal Social Security Act.

(2) Any accident and health insurer, including a group accident and health insurance plan, as defined in Section 607(1), Federal Employee Retirement Income Security Act of 1974, or health maintenance organization as defined in Section 31A-8-101, is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) Title 26, Chapter 19, Medical Benefits Recovery Act, applies to reimbursement of insurers of Medicaid benefits.

Amended by Chapter 116, 2001 General Session

31A-22-605. Accident and health insurance standards.

(1) The purposes of this section include:

(a) reasonable standardization and simplification of terms and coverages of individual and franchise accident and health insurance policies, including accident and health insurance contracts of insurers licensed under Chapters 7 and 8, to facilitate public understanding and comparison in purchasing;

(b) elimination of provisions contained in individual and franchise accident and health insurance contracts that may be misleading or confusing in connection with either the purchase of those types of coverages or the settlement of claims; and

(c) full disclosure in the sale of individual and franchise accident and health insurance contracts.

(2) As used in this section:

(a) "Direct response insurance policy" means an individual insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary.

(b) "Medicare" is defined in Subsection 31A-22-620(1)(e).

(c) "Medicare supplement policy" is defined in Subsection 31A-22-620(1)(f).

(3) This section applies to all individual and franchise accident and health policies.

(4) The commissioner shall adopt rules relating to the following matters:

(a) standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this section, dealing with at least the following matters:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage provisions;

(iv) coverage of dependents;
(v) preexisting conditions;
(vi) termination of insurance;
(vii) probationary periods;
(viii) limitations;
(ix) exceptions;
(x) reductions;
(xi) elimination periods;
(xii) requirements for replacement;
(xiii) recurrent conditions;
(xiv) coverage of persons eligible for Medicare; and
(xv) definition of terms;
(b) minimum standards for benefits under each of the following categories of coverage in policies covered in this section:
(i) basic hospital expense coverage;
(ii) basic medical-surgical expense coverage;
(iii) hospital confinement indemnity coverage;
(iv) major medical expense coverage;
(v) income replacement coverage;
(vi) accident only coverage;
(vii) specified disease or specified accident coverage;
(viii) limited benefit health coverage; and
(ix) nursing home and long-term care coverage;
(c) the content and format of the outline of coverage, in addition to that required under Subsection (6);
(d) the method of identification of policies and contracts based upon coverages provided; and
(e) rating practices.
(5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories of coverage in that subsection provided that any combination of categories meets the standards of a component category of coverage.
(6) The commissioner may adopt rules relating to the following matters:
(a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy;
(b) (i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare Supplement coverages;
(ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and certificates sold to persons eligible for Medicare; and
(c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, upon his request or, in any event, no later than the time of the policy delivery.
(7) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection (4), an outline of

coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline of coverage shall include:

(a) a statement identifying the applicable categories of coverage provided by the policy as prescribed under Subsection (4);

(b) a description of the principal benefits and coverage;

(c) a statement of the exceptions, reductions, and limitations contained in the policy;

(d) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(e) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(f) any other contents the commissioner prescribes.

(8) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.

(9) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to persons eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

Amended by Chapter 78, 2005 General Session

31A-22-605.1. Preexisting condition limitations.

(1) Any provision dealing with preexisting conditions shall be consistent with this section, Section 31A-22-609, and rules adopted by the commissioner.

(2) Except as provided in this section, an insurer that elects to use an application form without questions concerning the insured's health or medical treatment history shall provide coverage under the policy for any loss which occurs more than 12 months after the effective date of coverage due to a preexisting condition which is not specifically excluded from coverage.

(3) (a) An insurer that issues a specified disease policy may not deny a claim for loss due to a preexisting condition that occurs more than six months after the effective date of coverage.

(b) A specified disease policy may impose a preexisting condition exclusion only if the exclusion relates to a preexisting condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(4) (a) Except as provided in this Subsection (4), a health benefit plan may impose a preexisting condition exclusion only if:

(i) the exclusion relates to a preexisting condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date from an individual licensed or similarly authorized to provide those services under state law and operating within the scope of practice

authorized by state law;

(ii) the exclusion period ends no later than 12 months after the enrollment date, or in the case of a late enrollee, 18 months after the enrollment date; and

(iii) the exclusion period is reduced by the number of days of creditable coverage the enrollee has as of the enrollment date, in accordance with Subsection (4)(b).

(b) (i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is determined by counting all the days on which the individual has one or more types of creditable coverage.

(ii) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(A) Days in a waiting period or affiliation period are not taken into account in determining whether a significant break in coverage has occurred.

(B) For an individual who elects federal COBRA continuation coverage during the second election period provided under the federal Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(c) A group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy.

(d) (i) An insurer imposing a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion as part of any written application materials.

(ii) The general notice shall include:

(A) a description of the existence and terms of any preexisting condition exclusion under the plan, including the six-month period ending on the enrollment date, the maximum preexisting condition exclusion period, and how the insurer will reduce the maximum preexisting condition exclusion period by creditable coverage;

(B) a description of the rights of individuals:

(I) to demonstrate creditable coverage, including any applicable waiting periods, through a certificate of creditable coverage or through other means; and

(II) to request a certificate of creditable coverage from a prior plan;

(C) a statement that the current plan will assist in obtaining a certificate of creditable coverage from any prior plan or issuer if necessary; and

(D) a person to contact, and an address and telephone number for the person, for obtaining additional information or assistance regarding the preexisting condition exclusion.

(e) An insurer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(f) This Subsection (4) does not preclude application of any waiting period applicable to all new enrollees under the plan.

Enacted by Chapter 78, 2005 General Session

31A-22-605.5. Application.

(1) For purposes of this section "insurance mandate":

(a) means a mandatory obligation with respect to coverage, benefits, or the number or types of providers imposed on policies of accident and health insurance; and

(b) does not mean:

(i) an administrative rule imposing a mandatory obligation with respect to coverage, benefits, or providers unless that mandatory obligation was specifically imposed on policies of accident and health insurance by statute; or

(ii) an insurance mandate in an essential health benefits package imposed pursuant to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and federal rules related to their implementation.

(2) (a) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), the following shall apply to health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a):

(i) any law enacted under this title that becomes effective after January 1, 2002, which provides for an insurance mandate for policies of accident and health insurance; and

(ii) in accordance with Section 31A-22-613.5, disclosure requirements for coverage limitations.

(b) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), a health insurance mandate enacted under this title after January 1, 2012, shall apply to:

(i) health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a); and

(ii) health coverage offered to public school districts, charter schools, and institutions of higher education under Subsection 49-20-201(1)(b).

(c) If health coverage offered to the state employees' risk pool under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) offers coverage in the same manner and to the same extent as the coverage required by an insurance mandate enacted under this title or coverage that is greater than the insurance mandate enacted under this title, the coverage offered to state employees under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) will be considered in compliance with the insurance mandate.

(d) The programs regulated under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) shall report to the Retirement and Independent Entities Committee created under Section 63E-1-201 by November 30 of each year in which a mandate is enacted under the provisions of this section. The report shall include the costs and benefits of the particular mandatory obligation.

(3) (a) An insurance mandate for policies of accident and health insurance enacted under this title after January 1, 2012, shall apply to a health plan offered by a public school district, a charter school, or a state funded institution of higher education that is not insured through the Public Employees' Benefit and Insurance Program.

(b) If an insurance mandate for policies of accident and health insurance is enacted under this title after January 1, 2012, the state shall determine whether each entity described in Subsections (2) and (3)(a) offers coverage in the same manner and to the same extent, or greater than the insurance coverage required in the mandate enacted after January 1, 2012.

(c) Before enacting an insurance mandate, the state shall, for each entity that does not offer coverage in accordance with Subsection (3)(b):

(i) determine the cost to the entity of implementing the insurance mandate; and
(ii) appropriate money necessary to fund the full cost to the entity of implementing the insurance mandate.

Amended by Chapter 127, 2012 General Session

31A-22-606. Policy examination period.

(1) (a) Except as provided in Subsection (2), all accident and health policies shall contain a notice prominently printed on or attached to the cover or front page stating that the policyholder has the right to return the policy for any reason within 10 days after its delivery.

(b) "Return" means delivery to the insurer or its agent or mailing of the policy to either, properly addressed and stamped for first class handling, with a written statement on the policy or an accompanying communication that it is being returned for termination of coverage. A policy returned under this Subsection (1) is void from the beginning and a policyholder returning his policy is entitled to a refund of any premium paid.

(2) This section does not apply to:

(a) group policies;

(b) policies issued to persons entitled to a 30-day examination period under Subsection 31A-22-605(9);

(c) single premium nonrenewable policies issued for terms not longer than 60 days;

(d) policies covering accidents only or accidental bodily injury only; and

(e) other classes of policies which the commissioner by rule specifies after a finding that a right to return those policies would be impracticable or unnecessary to protect the policyholder's interests.

Amended by Chapter 78, 2005 General Session

31A-22-607. Grace period.

(1) (a) An individual or franchise accident and health insurance policy shall contain one or more clauses providing for a grace period for premium payment only of:

(i) at least 15 days for a weekly or monthly premium policy; and

(ii) 30 days for a policy that is not a weekly or monthly premium policy, for each premium after the first premium payment.

(b) An insurer may elect to include a grace period that is longer than 15 days for a weekly or monthly policy.

(c) An individual or franchise accident and health insurance policy is not in force during a grace period.

(d) If an insurer receives payment before a grace period expires, the individual or franchise accident and health insurance policy continues in force with no gap in coverage.

(e) If an insurer does not receive payment before a grace period expires, the individual or franchise accident and health insurance policy is terminated as of the last date for which the premium is paid in full.

(f) A grace period is not required if the policyholder has requested that the individual or franchise accident and health insurance policy be discontinued.

(2) (a) A group or blanket accident and health insurance policy shall provide for a grace period of at least 30 days, unless the policyholder gives written notice of discontinuance before the date of discontinuance, in accordance with the policy terms.

(b) A group or blanket accident and health insurance policy is in force during a grace period.

(c) If an insurer does not receive payment before a grace period expires, the group or blanket accident and health insurance policy is terminated as of the last day of the grace period.

(d) A group or blanket accident and health insurance policy may provide for payment of a pro rata premium for the period the group or blanket accident and health insurance policy is in effect during a grace period under this Subsection (2).

(3) If an insurer has not guaranteed the insured a right to renew an accident and health insurance policy, a grace period beyond the expiration or anniversary date may, if provided in the accident and health insurance policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).

Amended by Chapter 284, 2011 General Session

31A-22-608. Reinstatement of individual or franchise accident and health insurance policies.

(1) Every individual or franchise accident and health insurance policy shall contain a provision which reads as follows:

"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 the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(2) The last sentence of the provision set forth in Subsection (1) may be omitted from any policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50, or in the case of a policy issued after age 44, for at least five years from its date of issue.

Amended by Chapter 116, 2001 General Session

31A-22-609. Incontestability for accident and health insurance.

(1) (a) A statement made by an applicant relating to the person's insurability, except fraudulent misrepresentation, may not be a basis for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years.

(b) The insurer has the burden of proving fraud by clear and convincing evidence.

(2) Except as provided under Section 31A-22-605.1, a claim for loss incurred or disability commencing after two years from the date of issue of the policy may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description in a provision that was in effect on the date of loss.

(3) Except as provided in Subsection (1)(a), a specified disease policy may not include wording that provides a defense based upon a disease or physical condition that existed prior to the effective date of coverage except as allowed under Subsection 31A-22-605.1(2).

Amended by Chapter 78, 2005 General Session

31A-22-610. Dependent coverage from moment of birth or adoption.

(1) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years of age as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

(2) (a) Except as provided in Subsection (5), if an accident and health insurance policy provides coverage for any members of the policyholder's or certificate holder's family, the policy shall provide that any health insurance benefits applicable to dependents of the insured are applicable on the same basis to:

(i) a newly born child from the moment of birth; and

(ii) an adopted child:

(A) beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth; or

(B) beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

(b) The coverage described in this Subsection (2):

(i) is not subject to any preexisting conditions; and

(ii) includes any injury or sickness, including the necessary care and treatment of medically diagnosed:

(A) congenital defects;

(B) birth abnormalities; or

(C) prematurity.

(c) (i) Subject to Subsection (2)(c)(ii), a claim for services for a newly born child or an adopted child may be denied until the child is enrolled.

(ii) Notwithstanding Subsection (2)(c)(i), an otherwise eligible claim denied under Subsection (2)(c)(i) is eligible for payment and may be resubmitted or reprocessed once a child is enrolled pursuant to Subsection (2)(d) or (e).

(d) If the payment of a specific premium is required to provide coverage for a child of a policyholder or certificate holder, for there to be coverage for the child, the policyholder or certificate holder shall enroll:

(i) a newly born child within 30 days after the date of birth of the child; or

(ii) an adopted child within 30 days after the day of placement of adoption.

(e) If the payment of a specific premium is not required to provide coverage for a child of a policyholder or certificate holder, for the child to receive coverage the policyholder or certificate holder shall enroll a newly born child or an adopted child no later than 30 days after the first notification of denial of a claim for services for that child.

(3) (a) The coverage required by Subsection (2) as to children placed for the purpose of adoption with a policyholder or certificate holder continues in the same manner as it would with respect to a child of the policyholder or certificate holder unless:

(i) the placement is disrupted prior to legal adoption; and

(ii) the child is removed from placement.

(b) The coverage required by Subsection (2) ends if the child is removed from placement prior to being legally adopted.

(4) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.

(5) If an accident and health insurance policy that is not subject to the special enrollment rights described in 45 C.F.R. Sec. 146.117(b) provides coverage for one individual, the insurer may choose to:

(a) provide coverage according to this section; or

(b) allow application, subject to the insurer's underwriting criteria for:

(i) a newborn;

(ii) an adopted child; or

(iii) a child placed for adoption.

Amended by Chapter 307, 2007 General Session

31A-22-610.1. Adoption indemnity benefit.

(1) (a) (i) If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the insured, only one adoption indemnity benefit is required.

(ii) This section does not prevent an accident and health insurer from:

(A) adjusting the benefit payable under this section for cost sharing measures imposed under the policy or contract for maternity benefit coverage; or

(B) providing additional adoption indemnity benefits including:

(I) extending the period of time after birth in which a child must be placed with an insured; or

(II) providing a benefit in excess of the amount specified in Subsection (1)(c).

(b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a) may seek reimbursement of the benefit if:

(i) the postplacement evaluation disapproves the adoption placement; and

(ii) a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

(c) The amount of the adoption indemnity benefit provided under Subsection (1) is $4,000 subject to the adjustments permitted by Subsection (1)(a)(ii).

(d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each adoptive parent:

(i) has coverage for maternity benefits with a different insurer; and

(ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).

(2) If a policy offers optional maternity benefits, it shall also offer coverage for adoption indemnity benefits if:

(a) a child is placed for adoption with the insured within 90 days of the child's birth; and

(b) the adoption is finalized within one year of the child's birth.

(3) If an insured qualifies for the adoption indemnity benefit under this section and receives services from a health care provider under contract with his insurer, the contracting health care provider may only collect from the insured the amount that the contracting health care provider is entitled to receive for such services under the contract, including any applicable copayment.

(4) For purposes of this section, "contracting health care provider" means:

(a) a "participating provider" as defined in Section 31A-8-101; or

(b) a "preferred health care provider" as described in Section 31A-22-617.

Amended by Chapter 94, 2006 General Session

31A-22-610.2. Maternity stay minimum limits.

(1) (a) If an insured has coverage for maternity benefits, the policy may not be limited to a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.

(b) If an insured has coverage for maternity benefits, the policy may not be limited to a less than 96-hour benefit for both mother and newborn with a caesarean section delivery.

(2) Subsection (1) applies to an accident and health insurer who offers maternity coverage.

Amended by Chapter 116, 2001 General Session

31A-22-610.5. Dependent coverage.

(1) As used in this section, "child" has the same meaning as defined in Section 78B-12-102.

(2) (a) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent may not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday and shall, upon application, provide coverage for all unmarried dependents up to age 26.

(b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included in the premium on the same basis as other dependent coverage.

(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.

(d) An individual health insurance policy, group health insurance policy, or health maintenance organization shall continue in force coverage for a dependent through the last day of the month in which the dependent ceases to be a dependent:

(i) if premiums are paid; and

(ii) notwithstanding Section 31A-8-402.3, 31A-8-402.5, 31A-22-721, 31A-30-107.1, or 31A-30-107.3.

(3) An individual or group accident and health insurance policy or health maintenance organization contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations, shall treat the dependent as if the coverage had been in force since it was terminated; if:

(a) the dependent has not reached the age of 26 by July 1, 1995;

(b) the dependent had coverage prior to July 1, 1994;

(c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of the dependent; and

(d) the policy has not been terminated since the dependent's coverage was terminated.

(4) (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:

(i) was born out of wedlock and is entitled to coverage under Subsection (5);

(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;

(iii) is not claimed as a dependent on the parent's federal tax return; or

(iv) does not reside with the parent or in the insurer's service area.

(b) A child enrolled as required under Subsection (4)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an insurer's service area. A health maintenance organization shall comply with Section 31A-8-502.

(5) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:

(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (5)(a), whether the information is provided pursuant to a verbal or written request;

(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) make payments on claims submitted in accordance with Subsection (5)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.

(6) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program; and

(c) (i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect; or

(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or

(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (9)(c)(i), (ii) or (iii) has happened.

(7) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(8) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

(9) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:

(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program;

(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:

(i) the court order is no longer in effect;

(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(10) An order issued under Section 62A-11-326.1 may be considered a "qualified medical support order" for the purpose of enrolling a dependent child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(11) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer with adequate information to comply with this section; and

(c) the premium shall be paid when due.

(12) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.

(13) The commissioner shall adopt rules interpreting and implementing this section with regard to out-of-area court ordered dependent coverage.

Amended by Chapter 297, 2011 General Session

31A-22-610.6. Special enrollment for individuals receiving premium assistance.

(1) As used in this section:

(a) "Premium assistance" means assistance under Title 26, Chapter 18, Medical Assistance Act, in the payment of premium.

(b) "Qualified beneficiary" means an individual who is approved to receive premium assistance.

(2) Subject to the other provisions in this section, an individual may enroll under this section at a time outside of an employer health benefit plan open enrollment period, regardless of previously waiving coverage, if the individual is:

(a) a qualified beneficiary who is eligible for coverage as an employee under the employer health benefit plan; or

(b) a dependent of the qualified beneficiary who is eligible for coverage under the employer health benefit plan.

(3) To be eligible to enroll outside of an open enrollment period, an individual described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30 days from the day on which the qualified beneficiary receives initial written notification, after July 1, 2008, that the qualified beneficiary is eligible to receive premium assistance.

(4) An individual described in Subsection (2) may enroll under this section only in an employer health benefit plan that is available at the time of enrollment to similarly situated eligible employees or dependents of eligible employees.

(5) Coverage under an employer health benefit plan for an individual described in Subsection (2) may begin as soon as the first day of the month immediately following enrollment of the individual in accordance with this section.

(6) This section does not modify any requirement related to premiums that applies under an employer health benefit plan to a similarly situated eligible employee or dependent of an eligible employee under the employer health benefit plan.

(7) An employer health benefit plan may require an individual described in Subsection (2) to satisfy a preexisting condition waiting period that:

(a) is allowed under the Health Insurance Portability and Accountability Act; and

(b) is not longer than 12 months.

Amended by Chapter 284, 2011 General Session

31A-22-611. Coverage for children with a disability.

(1) For the purposes of this section:

(a) "Dependent with a disability" means a child who is and continues to be both:

(i) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and

(ii) chiefly dependent upon an insured for support and maintenance since the child reached the age specified in Subsection 31A-22-610.5(2).

(b) "Mental impairment" means a mental or psychological disorder such as:

(i) an intellectual disability;

(ii) organic brain syndrome;

(iii) emotional or mental illness; or

(iv) specific learning disabilities as determined by the insurer.

(c) "Physical impairment" means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following body systems:

(i) neurological;

(ii) musculoskeletal;

(iii) special sense organs;

(iv) respiratory organs;

(v) speech organs;

(vi) cardiovascular;

(vii) reproductive;

(viii) digestive;

(ix) genito-urinary;

(x) hemic and lymphatic;

(xi) skin; or

(xii) endocrine.

(2) The insurer may require proof of the incapacity and dependency be furnished by the person insured under the policy within 30 days of the effective date or the date the child attains the age specified in Subsection 31A-22-610.5(2), and at any time thereafter, except that the insurer may not require proof more often than annually after the two-year period immediately following attainment of the limiting age by the dependent with a disability.

(3) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or

certificate holder's dependent shall, upon application, provide coverage for all unmarried dependents with a disability who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age specified in Subsection 31A-22-610.5(2).

(4) Every accident and health insurance policy or contract that provides coverage of a dependent with a disability may not terminate the policy due to an age limitation.

Amended by Chapter 297, 2011 General Session
Amended by Chapter 366, 2011 General Session

31A-22-612. Conversion privileges for insured former spouse.

(1) An accident and health insurance policy, which in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce or annulment between the parties.

(2) Every policy which contains this type of provision shall provide that upon the entry of the divorce decree the spouse is entitled to have issued an individual policy of accident and health insurance without evidence of insurability, upon application to the company and payment of the appropriate premium. The policy shall provide the coverage being issued which is most nearly similar to the terminated coverage. Probationary or waiting periods in the policy are considered satisfied to the extent the coverage was in force under the prior policy.

(3) When the insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid. The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided. If the spouse applies and tenders the first monthly premium to the insurer within 30 days after receiving the notice provided by this subsection, the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.

(4) This section does not apply to accident and health insurance policies offered on a group blanket basis.

Amended by Chapter 319, 2013 General Session

31A-22-613. Permitted provisions for accident and health insurance policies.

The following provisions may be contained in an accident and health insurance policy, but if they are in that policy, they shall conform to at least the minimum requirements for the policyholder in this section.

(1) Any provision respecting change of occupation may provide only for a lower maximum benefit payment and for reduction of loss payments proportionate to the change in appropriate premium rates, if the change is to a higher rated occupation, and

this provision shall provide for retroactive reduction of premium rates from the date of change of occupation or the last policy anniversary date, whichever is the more recent, if the change is to a lower rated occupation.

(2) Section 31A-22-405 applies to misstatement of age in accident and health policies, with the appropriate modifications of terminology.

(3) Any policy which contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy is not effective, and if that date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force, subject to any right of cancellation, until the end of the period for which the premium was accepted. This Subsection (3) does not apply if the acceptance of premium would not have occurred but for a misstatement of age by the insured.

(4) (a) If an insured is otherwise eligible for maternity benefits, a policy may not contain language which requires an insured to obtain any additional preauthorization or preapproval for customary and reasonable maternity care expenses or for the delivery of the child after an initial preauthorization or preapproval has been obtained from the insurer for prenatal care. A requirement for notice of admission for delivery is not a requirement for preauthorization or preapproval, however, the maternity benefit may not be denied or diminished for failure to provide admission notice. The policy may not require the provision of admission notice by only the insured patient.

(b) This Subsection (4) does not prohibit an insurer from:

(i) requiring a referral before maternity care can be obtained;

(ii) specifying a group of providers or a particular location from which an insured is required to obtain maternity care; or

(iii) limiting reimbursement for maternity expenses and benefits in accordance with the terms and conditions of the insurance contract so long as such terms do not conflict with Subsection (4)(a).

(5) (a) An insurer may only represent that a policy offers a vision benefit if the policy provides reimbursement for materials or services provided under the policy.

(b) An insurer may only represent that a policy covers laser vision correction, whether photorefractive keratectomy, laser assisted in-situ keratomelusis, or related procedure, if the procedure is at least a partially covered benefit.

(6) If a policy excludes coverage for the diagnosis and treatment of autism spectrum disorders, the insurer may not deny a claim for a procedure or service that is otherwise covered in the accident and health insurance policy unless the autism spectrum disorder is the primary diagnosis or reason for the service or procedure in the particular claim.

Amended by Chapter 279, 2012 General Session

31A-22-613.5. Price and value comparisons of health insurance.

(1) (a) This section applies to all health benefit plans.

(b) Subsection (2) applies to:

(i) all health benefit plans; and

(ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

(2) (a) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to:

(i) provide to all enrollees, prior to enrollment in the health benefit plan written disclosure of:

(A) restrictions or limitations on prescription drugs and biologics including:

(I) the use of a formulary;

(II) co-payments and deductibles for prescription drugs; and

(III) requirements for generic substitution;

(B) coverage limits under the plan; and

(C) any limitation or exclusion of coverage including:

(I) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and

(II) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition; and

(ii) provide the commissioner with:

(A) the information described in Subsections 31A-22-635(5) through (7) in the standardized electronic format required by Subsection 63M-1-2506(1); and

(B) information regarding insurer transparency in accordance with Subsection (4).

(b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to the commissioner:

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):

(A) treatment policies;

(B) practice standards;

(C) restrictions;

(D) coverage limits of the insurer's health benefit plan or health insurance policy; or

(E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

(c) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):

(i) either:

(A) in writing; or

(B) on the insurer's website; and

(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.

(d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may

result from the use of an excluded drug.

(e) (i) The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(a)(i)(C).

(ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(3) The commissioner:

(a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to the Health Insurance Exchange created under Section 63M-1-2504; and

(b) may request information from an insurer to verify the information submitted by the insurer under this section.

(4) The commissioner shall:

(a) convene a group of insurers, a member representing the Public Employees' Benefit and Insurance Program, consumers, and an organization that provides multipayer and multiprovider quality assurance and data collection, to develop information for consumers to compare health insurers and health benefit plans on the Health Insurance Exchange, which shall include consideration of:

(i) the number and cost of an insurer's denied health claims;

(ii) the cost of denied claims that is transferred to providers;

(iii) the average out-of-pocket expenses incurred by participants in each health benefit plan that is offered by an insurer in the Health Insurance Exchange;

(iv) the relative efficiency and quality of claims administration and other administrative processes for each insurer offering plans in the Health Insurance Exchange; and

(v) consumer assessment of each insurer or health benefit plan;

(b) adopt an administrative rule that establishes:

(i) definition of terms;

(ii) the methodology for determining and comparing the insurer transparency information;

(iii) the data, and format of the data, that an insurer shall submit to the commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(iv) the dates on which the insurer shall submit the data to the commissioner in order for the commissioner to transmit the data to the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(c) implement the rules adopted under Subsection (4)(b) in a manner that protects the business confidentiality of the insurer.

Amended by Chapter 279, 2012 General Session

31A-22-614. Claims under accident and health policies.

(1) Section 31A-21-312 applies generally to claims under accident and health policies.

(2) (a) Subject to Subsection (1), an accident and health insurance policy may not contain a claim notice requirement less favorable to the insured than one which

requires written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the policy. The policy shall specify to whom claim notices may be given.

(b) If a loss of time benefit under a policy may be paid for a period of at least two years, an insurer may require periodic notices that the insured continues to have a disability, unless the insured is legally incapacitated. The insured's delay in giving that notice does not impair the insured's or beneficiary's right to any indemnity which would otherwise have accrued during the six months preceding the date on which that notice is actually given.

(3) An accident and health insurance policy may not contain a time limit on proof of loss which is more restrictive to the insured than a provision requiring written proof of loss, delivered to the insurer, within the following time:

(a) for a claim where periodic payments are contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable; or

(b) for any other claim, within 90 days after the date of the loss.

(4) (a) (i) Section 31A-26-301 applies generally to the payment of claims.

(ii) Indemnity for loss of life is paid in accordance with the beneficiary designation effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the insured's estate.

(b) Reasonable facility of payment clauses, specified by the commissioner by rule or in approving the policy form, are permitted. Payment made in good faith and in accordance with those clauses discharges the insurer's obligation to pay those claims.

(c) All or a portion of any indemnities provided under an accident and health 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 the services.

Amended by Chapter 366, 2011 General Session

31A-22-614.5. Uniform claims processing -- Electronic exchange of health information.

(1) (a) Except as provided in Subsection (1)(c), all insurers offering health insurance shall use a uniform claim form and uniform billing and claim codes.

(b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans, shall provide for the electronic exchange of uniform:

(i) eligibility and coverage information; and

(ii) coordination of benefits information.

(c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or certificate that provides benefits solely for:

(i) income replacement; or

(ii) long-term care.

(2) (a) The uniform electronic standards and information required in Subsection (1) shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) When adopting rules under this section the commissioner:

(i) shall:

(A) consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to develop the standards for the use and electronic exchange of uniform:

(I) claim forms;

(II) billing and claim codes;

(III) insurance eligibility and coverage information; and

(IV) coordination of benefits information; and

(B) meet federal mandatory minimum standards following the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act;

(ii) may not require an insurer or administrator to use a specific software product or vendor; and

(iii) may require an insurer who participates in the all payer database created under Section 26-33a-106.1 to allow data regarding demographic and insurance coverage information to be electronically shared with the state's designated secure health information master person index to be used:

(A) in compliance with data security standards established by:

(I) the federal Health Insurance Portability and Accountability Act; and

(II) the electronic commerce agreements established in a business associate agreement; and

(B) for the purpose of coordination of health benefit plans.

(3) (a) The commissioner shall coordinate the administrative rules adopted under the provisions of this section with the administrative rules adopted by the Department of Health for the implementation of the standards for the electronic exchange of clinical health information under Section 26-1-37. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Department of Health is given the opportunity to comment on proposed rules.

(b) (i) The commissioner may provide information to health care providers regarding resources available to a health care provider to verify whether a health care provider's practice management software system meets the uniform electronic standards for data exchange required by this section.

(ii) The commissioner may provide the information described in Subsection (3)(b)(i) by partnering with:

(A) a not-for-profit, broad based coalition of state health care insurers and health care providers who are involved in the electronic exchange of the data required by this section; or

(B) some other person that the commissioner determines is appropriate to provide the information described in Subsection (3)(b)(i).

(c) The commissioner shall regulate any fees charged by insurers to the providers for:

(i) uniform claim forms;

(ii) electronic billing; or

(iii) the electronic exchange of clinical health information permitted by Section 26-1-37.

Amended by Chapter 284, 2011 General Session

31A-22-614.7. Uniform claims processing -- Electronic exchange of prescription drug pre-authorization.

(1) The commissioner shall consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to study and review:

(a) the process of prior authorization of prescription drugs; and

(b) the standards for the use and electronic exchange of a uniform prescription drug prior authorization form that meet federal mandatory minimum standards and follow the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act.

(2) The commissioner and the organization described in Subsection (1) shall report their progress and findings to the Legislature's Business and Labor Interim Committee before October 1, 2013 and before November 1, 2014.

Enacted by Chapter 361, 2013 General Session

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) (i) A health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person.

(ii) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.

(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;
(iii) coinsurance;
(iv) other copayments; or
(v) any other reasonable manner.
(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f):
(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
(A) require the health care provider to continue to provide health care services under the contract until the earlier of:
(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or
(II) the date the term of the contract ends; and
(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);
(ii) the provider is required to:
(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
(A) sums owed by the insolvent managed care organization; or
(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):
(A) a provider;
(B) an agent;
(C) a trustee; or
(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
(v) notwithstanding Subsection (1)(c)(i):
(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and
(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:
(I) a petition for rehabilitation; or
(II) a petition for liquidation.
(2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred

health care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on or after January 1, 2014.

(b) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(c) An insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(d) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(e) For purposes of this section, unfair discrimination between classes of health care providers includes:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly used by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract, and if requested their business locations and specialties;

(b) a description of the insured benefits, including any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the adverse benefit determination procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning

alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Except as provided in Subsection 31A-22-618.5(3)(a), insurers are subject to Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

(12) Notwithstanding the provisions of Subsection (1), Subsection (7)(b), and Section 31A-22-618, an insurer or third party administrator is not required to, but may, enter into contracts with licensed athletic trainers, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

Amended by Chapter 104, 2013 General Session
Amended by Chapter 319, 2013 General Session

31A-22-617.1. Objective criteria for adding or terminating participating providers -- Termination of contracts -- Review process.

(1) (a) Every insurer, including a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, shall establish criteria for adding health care providers to a new or existing provider panel.

(b) Criteria under Subsection (1)(a) may include, but are not limited to:

(i) training, certification, and hospital privileges;

(ii) number of physicians needed to adequately serve the insurer's population; and

(iii) any other factor that is reasonably related to promote or protect good patient care, address costs, take into account on-call and cross-coverage relationships between providers, or serve the lawful interests of the insurer.

(c) An insurer shall make such criteria available to any provider upon request

and shall file the same with the department.

(d) Upon receipt of a provider application and upon receiving all necessary information, an insurer shall make a decision on a provider's application for participation within 120 days.

(e) If the provider applicant is rejected, the insurer shall inform the provider of the reason for the rejection relative to the criteria established in accordance with Subsection (1)(b).

(f) An insurer may not reject a provider applicant based solely on:

(i) the provider's staff privileges at a general acute care hospital not under contract with the insurer; or

(ii) the provider's referral patterns for patients who are not covered by the insurer.

(g) Criteria set out in Subsection (1)(b) may be modified or changed from time to time to meet the business needs of the market in which the insurer operates and, if modified, will be filed with the department as provided in Subsection (1)(c).

(h) With the exception of Subsection (1)(f), this section does not create any new or additional private right of action for redress.

(2) (a) For the first two years, an insurer may terminate its contract with a provider with or without cause upon giving the requisite amount of notice provided in the agreement, but in no case shall it be less than 60 days.

(b) An agreement may be terminated for cause as provided in the contract established between the insurer and the provider. Such contract shall contain sufficiently certain criteria so that the provider can be reasonably informed of the grounds for termination for cause.

(c) Prior to termination for cause, the insurer shall:

(i) inform the provider of the intent to terminate and the grounds for doing so;

(ii) at the request of the provider, meet with the provider to discuss the reasons for termination;

(iii) if the insurer has a reasonable basis to believe that the provider may correct the conduct giving rise to the notice of termination, the insurer may, at its discretion, place the provider on probation with corrective action requirements, restrictions, or both, as necessary to protect patient care; and

(iv) if the insurer has a reasonable basis to believe that the provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, the insurer may immediately suspend the provider from further performance under the contract, provided that the remaining provisions of this Subsection (2) are followed in a timely manner before termination may become final.

(d) Each insurer shall establish an internal appeal process for actions that may result in terminated participation with cause and make known to the provider the procedure for appealing such termination.

(i) Providers dissatisfied with the results of the appeal process may, if both parties agree, submit the matters in dispute to mediation.

(ii) If the matters in dispute are not mediated, or should mediation be unsuccessful, the dispute shall be subject to binding arbitration by an arbitrator jointly selected by the parties, the cost of which shall be jointly shared. Each party shall bear its own additional expenses.

(e) A termination under Subsection (2)(a) or (b) may not be based on:
(i) the provider's staff privileges at a general acute care hospital not under contract with the insurer; or
(ii) the provider's referral patterns for patients who are not covered by the insurer.
(3) Notwithstanding any other section of this title, an insurer may not take adverse action against or reduce reimbursement to a contracted provider who is not under a capitated reimbursement arrangement because of the decision of an insured to access health care services from a noncontracted provider in a manner permitted by the insured's health insurance plan, regardless of how the plan is designated.

Enacted by Chapter 3, 2005 Special Session 1

31A-22-618. Nondiscrimination among health care professionals.
(1) Except as provided under Section 31A-22-617, and except as to insurers licensed under Chapter 8, no insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions which exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice and the illness, injury, or condition falls within the coverage of the contract. Upon the written request of an insured alleging an insurer has violated this section, the commissioner shall hold a hearing to determine if the violation exists. The commissioner may consolidate two or more related alleged violations into a single hearing.
(2) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

Amended by Chapter 267, 2000 General Session

31A-22-618.5. Health benefit plan offerings.
(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.
(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:
(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and
(b) may offer to a potential purchaser one or more health benefit plans that:
(i) are not subject to one or more of the following:
(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);
(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or
(D) coverage mandates enacted after January 1, 2009 that are not required by

federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from nonaffiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) notwithstanding Subsection 31A-22-617(9), may offer a health benefit plan that is not subject to Section 31A-22-618;

(b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and

(c) is not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsection (3)(a) shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Amended by Chapter 319, 2013 General Session

31A-22-619. Coordination of benefits.

(1) The commissioner shall:

(a) adopt rules concerning the coordination of benefits between accident and health insurance policies;

(b) publish a coordination of benefits guide;

(c) post the coordination of benefits guide on the state insurance exchange; and

(d) work with the Health Data Authority, health care provider groups, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims to develop standardized language regarding coordination of benefits for the purpose of including the standardized language in an insurer's explanation of benefits.

(2) Rules adopted by the commissioner under Subsection (1):

(a) may not prohibit coordination of benefits with individual accident and health insurance policies;

(b) shall apply equally to all accident and health insurance policies without

regard to whether the policies are group or individual policies; and

(c) shall include standardized language regarding the coordination of benefits process that shall be included in each insurer's accident and health insurance policy.

Amended by Chapter 285, 2010 General Session

31A-22-620. Medicare Supplement Insurance Minimum Standards Act.

(1) As used in this section:

(a) "Applicant" means:

(i) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(ii) in the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in this state, Medicare supplement policies or certificates.

(e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(f) "Medicare Supplement Policy":

(i) means a group or individual policy of disability insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), that 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; and

(ii) does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

(g) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(2) (a) Except as otherwise specifically provided, this section applies to:

(i) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this section;

(ii) all certificates issued under group Medicare supplement policies, that have been delivered or issued for delivery in this state on or after the effective date of this section; and

(iii) policies or certificates that were in force prior to the effective date of this section, with respect to requirements for benefits, claims payment, and policy reporting practice under Subsection (3)(d), and loss ratios under Subsection (4).

(b) This section does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or

labor organizations, or a combination of employers and labor unions, for employees or former employees or a combination of employees and former employees, or for members or former members of the labor organizations, or a combination of members and former members of labor organizations.

(c) This section does not prohibit, nor does it apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held out to be Medicare supplement policies or benefit plans.

(3) (a) A Medicare supplement policy or certificate in force in the state may not contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate may not exclude or limit benefits for loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may 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."

(c) The commissioner shall adopt rules to establish specific standards for policy provisions of Medicare supplement policies and certificates. The standards adopted shall be in addition to and in accordance with applicable laws of this state. A requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section, may not apply to Medicare supplement policies and certificates. The standards may include:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage;

(iv) probationary periods;

(v) benefit limitations, exceptions, and reductions;

(vi) elimination periods;

(vii) requirements for replacement;

(viii) recurrent conditions; and

(ix) definitions of terms.

(d) The commissioner shall adopt rules establishing minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies and certificates.

(e) The commissioner may adopt rules to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:

(i) requiring refunds or credits if the policies do not meet loss ratio requirements;

(ii) establishing a uniform methodology for calculating and reporting loss ratios;

(iii) assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;

(iv) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(v) establishing a policy for holding public hearings prior to approval of premium increases;

(vi) establishing standards for Medicare select policies and certificates; and

(vii) nondiscrimination for genetic testing or genetic information.

(f) The commissioner may adopt rules that prohibit policy provisions not otherwise specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

(4) Medicare supplement policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The commissioner shall make rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service basis rather than on a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(5) (a) To provide for full and fair disclosure in the sale of Medicare supplement policies, a Medicare supplement policy or certificate may not be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe the format and content of the outline of coverage required by Subsection (5)(a).

(c) For purposes of this section, "format" means style arrangements and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(i) a description of the principal benefits and coverage provided in the policy;

(ii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(iii) 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.

(d) The commissioner may make rules for captions or notice if the commissioner finds that the rules are:

(i) in the public interest; and

(ii) designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than:

(A) a medicare supplement policy; or

(B) a disability income policy.

(e) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, that 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 concurrently with delivery of the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(f) The commissioner may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

(6) Notwithstanding Subsection (1), Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to the front page, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(7) Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state, whether through written or broadcast medium, to the commissioner for review.

(8) The commissioner may adopt rules to conform Medicare and Medicare supplement policies and certificates to the marketing requirements of federal law and regulation.

Amended by Chapter 349, 2009 General Session

31A-22-623. Coverage of inborn metabolic errors.

(1) As used in this section:

(a) "Dietary products" means medical food or a low protein modified food product that:

(i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism;

(ii) is not a natural food that is naturally low in protein; and

(iii) is used under the direction of a physician.

(b) "Inborn errors of amino acid or urea cycle metabolism" means a disease caused by an inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more amino acid.

(2) The commissioner shall establish, by rule, minimum standards of coverage for dietary products used for the treatment of inborn errors of amino acid or urea cycle metabolism at levels consistent with the major medical benefit provided under an accident and health insurance policy.

Amended by Chapter 116, 2001 General Session

31A-22-624. Primary care physician.

An accident and health insurance policy that requires an insured to select a primary care physician to receive optimum coverage:

(1) shall permit an insured to select a participating provider who:

(a) is an:

(i) obstetrician;

(ii) gynecologist; or

(iii) pediatrician; and

(b) is qualified and willing to provide primary care services, as defined by the health care plan, as the insured's provider from whom primary care services are received;

(2) shall clearly state in literature explaining the policy the option available to insureds under Subsection (1); and

(3) may not impose a higher premium, higher copayment requirement, or any other additional expense on an insured because the insured selected a primary care physician in accordance with Subsection (1).

Amended by Chapter 308, 2002 General Session

31A-22-625. Catastrophic coverage of mental health conditions.

(1) As used in this section:

(a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, before reaching a maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on:

(A) episodic limits;

(B) inpatient or outpatient service limits; or

(C) maximum out-of-pocket limits.

(c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(d) (i) "Mental health condition" means a condition or disorder involving mental illness that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) a marital or family problem;

(B) a social, occupational, religious, or other social maladjustment;

(C) a conduct disorder;

(D) a chronic adjustment disorder;

(E) a psychosexual disorder;

(F) a chronic organic brain syndrome;

(G) a personality disorder;

(H) a specific developmental disorder or learning disability; or

(I) an intellectual disability.

(e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer that it insures or seeks to insure a choice between:

(i) (A) catastrophic mental health coverage; or

(B) federally qualified mental health coverage as described in Subsection (3); and

(ii) 50/50 mental health coverage.

(b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, regardless of the employer's previous coverage for mental health conditions, choose either:

(i) coverage offered under Subsection (2)(a)(i);

(ii) 50/50 mental health coverage; or

(iii) coverage offered under Subsection (2)(b).

(d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that the employer chooses coverage that meets or exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(4) (a) An insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of

health care providers.

(iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition shall be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility:

(A) licensed or otherwise authorized to provide mental health services pursuant to:

(I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

(B) that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.

(6) The commissioner shall:

(a) adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this section; and

(b) provide general figures on the percentage of insurance policies that include:

(i) no mental health coverage;

(ii) 50/50 mental health coverage;

(iii) catastrophic mental health coverage; and

(iv) coverage that exceeds the minimum requirements of this section.

(7) This section may not be construed as discouraging or otherwise preventing an insurer from providing mental health coverage in connection with an individual insurance policy.

Amended by Chapter 253, 2012 General Session

31A-22-626. Coverage of diabetes.

(1) As used in this section, "diabetes" includes individuals with:

(a) complete insulin deficiency or type 1 diabetes;

(b) insulin resistant with partial insulin deficiency or type 2 diabetes; and

(c) elevated blood glucose levels induced by pregnancy or gestational diabetes.

(2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes for accident and health insurance policies that provide a health insurance benefit before July 1, 2000.

(3) In making rules under Subsection (2), the commissioner shall require rules:

(a) with durational limits, amount limits, deductibles, and coinsurance for the treatment of diabetes equitable or identical to coverage provided for the treatment of other illnesses or diseases; and

(b) that provide coverage for:

(i) diabetes self-management training and patient management, including medical nutrition therapy as defined by rule, provided by an accredited or certified program and referred by an attending physician within the plan and consistent with the health plan provisions for self-management education:

(A) recognized by the federal Health Care Financing Administration; or
(B) certified by the Department of Health; and
(ii) the following equipment, supplies, and appliances to treat diabetes when medically necessary:
(A) blood glucose monitors, including those for the legally blind;
(B) test strips for blood glucose monitors;
(C) visual reading urine and ketone strips;
(D) lancets and lancet devices;
(E) insulin;
(F) injection aides, including those adaptable to meet the needs of the legally blind, and infusion delivery systems;
(G) syringes;
(H) prescriptive oral agents for controlling blood glucose levels; and
(I) glucagon kits.

Amended by Chapter 167, 2013 General Session

31A-22-627. Coverage of emergency medical services.

(1) A health insurance policy or health maintenance organization contract may not:
(a) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized; or
(b) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured.
(2) A health insurance policy or health maintenance organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized. If such authorization is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.
(3) For purposes of this section:
(a) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention at a hospital emergency department to result in:
(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
(ii) serious impairment to bodily functions; or
(iii) serious dysfunction of any bodily organ or part; and
(b) "hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.
(4) Nothing in this section may be construed as:
(a) altering the level or type of benefits that are provided under the terms of a

contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

Amended by Chapter 188, 2006 General Session

31A-22-628. Standing referral to a specialist.

(1) With respect to a health insurance policy or health maintenance organization contract that does not allow an insured to have direct access to a health care specialist, the insurer shall establish and implement a procedure by which an insured may obtain a standing referral to a health care specialist.

(2) The procedure established under Subsection (1):

(a) shall provide for a standing referral to a specialist if the insured's primary care provider determines, in consultation with the specialist, that the insured needs continuing care from the specialist; and

(b) may require the insurer's approval of a treatment plan designed by the specialist, in consultation with the primary care provider and the insured, which may include:

(i) a limit on the number of visits to the specialist;

(ii) a time limit on the duration of the referral; and

(iii) mandatory updates on the insured's condition.

Enacted by Chapter 37, 2000 General Session

31A-22-629. Adverse benefit determination review process.

(1) As used in this section:

(a) (i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

(B) denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; or

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) is a voluntary option for the resolution of an adverse benefit determination;

(ii) is conducted at the discretion of the claimant;

(iii) is conducted by an independent review organization designated by the

insurer;

(iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Independent review organization" means a person, subject to Subsection (6), who conducts an independent external review of adverse determinations.

(d) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

(e) "Insurer" is as defined in Section 31A-1-301 and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.

(f) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.

(2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.

(3) (a) An insured may submit an adverse benefit determination to the insurer.

(b) The insurer shall conduct an internal review of the insured's adverse benefit determination.

(c) An insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves:

(i) payment of a claim regarding medical necessity; or

(ii) denial of a claim regarding medical necessity.

(4) The commissioner shall adopt rules that establish minimum standards for:

(a) internal reviews;

(b) independent reviews to ensure independence and impartiality;

(c) the types of adverse benefit determinations that may be submitted to an independent review; and

(d) the timing of the review process, including an expedited review when medically necessary.

(5) Nothing in this section may be construed as:

(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;

(b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;

(c) restricting the use of arbitration in connection with or subsequent to an independent review; or

(d) altering the legal rights of any party to seek court or other redress in connection with:

(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the insured related to the action and court costs; or

(ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.

(6) (a) An independent review organization in relation to the insurer may not be:

(i) the insurer;

(ii) the health plan;

(iii) the health plan's fiduciary;

(iv) the employer; or

(v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).

(b) An independent review organization may not have a material professional, familial, or financial conflict of interest with:

(i) the health plan;

(ii) an officer, director, or management employee of the health plan;

(iii) the enrollee;

(iv) the enrollee's health care provider;

(v) the health care provider's medical group or independent practice association;

(vi) a health care facility where service would be provided; or

(vii) the developer or manufacturer of the service that would be provided.

Amended by Chapter 253, 2012 General Session

31A-22-630. Mastectomy coverage.

(1) If an insured has coverage that provides medical and surgical benefits with respect to a mastectomy, it shall provide coverage, with consultation of the attending physician and the patient, for:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the breast on which the mastectomy was not performed to produce symmetrical appearance; and

(c) prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.

(2) (a) This section does not prevent an accident and health insurer from imposing cost-sharing measures for health benefits relating to this coverage, if cost-sharing measures are not greater than those imposed on any other medical condition.

(b) For purposes of this Subsection (2), cost-sharing measures include imposing a deductible or coinsurance requirement.

(3) Written notice of the availability of the coverage described in Subsection (1) shall be delivered to the participant:

(a) upon enrollment; and

(b) annually after the enrollment.

Amended by Chapter 116, 2001 General Session

31A-22-631. Policy summary or illustration.

(1) (a) Except as provided in Subsection (1)(b), at the time a life insurance policy is delivered, a policy summary or illustration shall be delivered for the life insurance policy if:

(i) the life insurance policy includes riders or supplemental benefits, including accelerated benefits; and

(ii) receipt of benefits under the life insurance policy is contingent upon morbidity requirements.

(b) In the case of a direct response solicitation, the insurer shall deliver the policy summary or illustration at the sooner of:

(i) the applicant's request; or

(ii) at the time of policy delivery regardless of whether the applicant requests a policy summary or illustration.

(2) In addition to complying with all applicable requirements, the policy summary or illustration shall include:

(a) a clear and prominent disclosure of how the rider or supplemental benefit interacts with other components of the policy, including deductions from death benefits and policy values;

(b) an illustration for each covered person of:

(i) the amount of benefits;

(ii) the length of benefits; and

(iii) the guaranteed lifetime benefits, if any;

(c) a disclosure of the maximum premiums for the rider or supplemental benefit;

(d) any exclusions, reductions, or limitations on the benefits of the rider or supplemental benefit; and

(e) if applicable to the policy type:

(i) a disclosure of the effects of exercising other rights under the policy; and

(ii) guaranteed maximum lifetime benefits.

Enacted by Chapter 116, 2001 General Session

31A-22-632. Report to policy holder.

(1) An insurer shall provide the policyholder a monthly report if an accident and health rider or supplemental benefit is:

(a) funded through a life insurance vehicle by acceleration of the death benefit; and

(b) in benefit payment status.

(2) The report required by Subsection (1) shall include:

(a) any rider or supplemental benefits paid out during the month;

(b) an explanation of any changes in the policy due to rider or supplemental benefits being paid out such as:

(i) death benefits; or

(ii) cash values; and

(c) the amount of the rider or supplemental benefits existing or remaining.

Enacted by Chapter 116, 2001 General Session

31A-22-633. Exemptions from standards.

Notwithstanding the provisions of Title 31A, Insurance Code, any accident and health insurer or health maintenance organization may offer a choice of coverage that

is less or different than is otherwise required by applicable state law if:

(1) the Department of Health offers a choice of coverage as part of a Medicaid waiver under Title 26, Chapter 18, Medical Assistance Act, which includes:

(a) less or different coverage than the basic coverage;

(b) less or different coverage than is otherwise required in an insurance policy or health maintenance organization contract under applicable state law; or

(c) less or different coverage than required by Subsection 31A-22-605(4)(b); and

(2) the choice of coverage offered by the carrier:

(a) is the same or similar coverage as the coverage offered by the Department of Health under Subsection (1);

(b) is offered to the same or similar population as the coverage offered by the Department of Health under Subsection (1); and

(c) contains an explanation for each insured of coverage exclusions and limitations.

Amended by Chapter 167, 2013 General Session

31A-22-634. Prohibition against certain use of Social Security number -- Exceptions -- Applicability of section.

(1) As used in this section:

(a) "Insurer" means:

(i) insurers governed by this part as described in Section 31A-22-600, and includes:

(A) a health maintenance organization; and

(B) a third-party administrator that is subject to this title; and

(ii) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, dental, medical, Medicare supplement, or conversion program offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(b) "Publicly display" or "publicly post" means to intentionally communicate or otherwise make available to the general public.

(2) An insurer or its subcontractors, including a pharmacy benefit manager, may not do any of the following:

(a) publicly display or publicly post in any manner an individual's Social Security number; or

(b) print an individual's Social Security number on any card required for the individual to access products or services provided or covered by the insurer.

(3) This section does not prevent the collection, use, or release of a Social Security number as required by state or federal law, or the use of a Social Security number for internal verification or administrative purposes, or the release of a Social Security number to a health care provider for claims administration purposes, or as part of the verification, eligibility, or payment process.

(4) If a federal law takes effect requiring the United States Department of Health and Human Services to establish a national unique patient health identifier program, an insurer that complies with the federal law shall be considered in compliance with this section.

(5) An insurer shall comply with the provisions of this section by July 1, 2004.

(6) (a) An insurer may obtain an extension for compliance with the requirements of this section in accordance with Subsections (6)(b) and (c).

(b) The request for extension:

(i) shall be submitted in writing to the department prior to July 1, 2004; and

(ii) shall provide an explanation as to why the insurer cannot comply with the requirements of this section by July 1, 2004.

(c) The commissioner shall grant a request for extension:

(i) for a period of time not to exceed March 1, 2005; and

(ii) if the commissioner finds that the explanation provided under Subsection (6)(b)(ii) is a reasonable explanation.

Amended by Chapter 297, 2011 General Session

31A-22-635. Uniform application -- Uniform waiver of coverage -- Information on Health Insurance Exchange.

(1) For purposes of this section, "insurer":

(a) is defined in Subsection 31A-22-634(1); and

(b) includes the state employee's risk pool under Section 49-20-202.

(2) (a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.

(b) The uniform application form:

(i) except for cancer and transplants, may not include questions about an applicant's health history prior to the previous five years; and

(ii) shall be shortened and simplified in accordance with rules adopted by the commissioner.

(c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions other than pregnancy, and is limited to:

(i) information that identifies the employee;

(ii) proof of the employee's insurance coverage; and

(iii) a statement that the employee declines coverage with a particular employer group.

(3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may, if the combination or modification is approved by the commissioner, be combined or modified to facilitate a more efficient and consumer friendly experience for:

(a) enrollees using the Health Insurance Exchange; or

(b) insurers using electronic applications.

(4) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(5) (a) An insurer who offers a health benefit plan in either the group or individual market on the Health Insurance Exchange created in Section 63M-1-2504, shall:

(i) accept and process an electronic submission of the uniform application or uniform waiver from the Health Insurance Exchange using the electronic standards

adopted pursuant to Section 63M-1-2506;

(ii) if requested, provide the applicant with a copy of the completed application either by mail or electronically;

(iii) post all health benefit plans offered by the insurer in the defined contribution arrangement market on the Health Insurance Exchange; and

(iv) post the information required by Subsection (6) on the Health Insurance Exchange for every health benefit plan the insurer offers on the Health Insurance Exchange.

(b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans on the Health Insurance Exchange may not directly or indirectly offer products on the Health Insurance Exchange that are not health benefit plans.

(c) Notwithstanding Subsection (5)(b):

(i) an insurer may offer a health savings account on the Health Insurance Exchange; and

(ii) an insurer may offer dental and vision plans on the Health Insurance Exchange if:

(A) the department determines, after study and consultation with the Health System Reform Task Force, that the department is able to establish standards for dental and vision policies offered on the Health Insurance Exchange, and the department determines whether a risk adjuster mechanism is necessary for a defined contribution vision and dental plan market on the Health Insurance Exchange; and

(B) the department, in accordance with recommendations from the Health System Reform Task Force, adopts administrative rules to regulate the offer of dental and vision plans on the Health Insurance Exchange.

(6) An insurer shall provide the commissioner and the Health Insurance Exchange with the following information for each health benefit plan submitted to the Health Insurance Exchange, in the electronic format required by Subsection 63M-1-2506(1):

(a) plan design, benefits, and options offered by the health benefit plan including state mandates the plan does not cover;

(b) information and Internet address to online provider networks;

(c) wellness programs and incentives;

(d) descriptions of prescription drug benefits, exclusions, or limitations;

(e) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and

(f) the claims denial and insurer transparency information developed in accordance with Subsection 31A-22-613.5(4).

(7) The department shall post on the Health Insurance Exchange the department's solvency rating for each insurer who posts a health benefit plan on the Health Insurance Exchange. The solvency rating for each insurer shall be based on methodology established by the department by administrative rule and shall be updated each calendar year.

(8) (a) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the department and to the Health Insurance Exchange.

(b) The commissioner shall regulate any fees charged by insurers to an enrollee

for a uniform application form or electronic submission of the application forms.

Amended by Chapter 253, 2012 General Session
Amended by Chapter 279, 2012 General Session

31A-22-636. Standardized health benefit plan cards.

(1) As used in this section, "insurer" means:

(a) an insurer governed by this part as described in Section 31A-22-600;

(b) a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Benefit Plans;

(c) a third party administrator; and

(d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(2) In accordance with Subsection (3), an insurer shall use and issue a health benefit plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment in, a health benefit plan on or after July 1, 2010.

(3) The health benefit plan card shall include:

(a) the covered person's name;

(b) the name of the carrier and the carrier network name;

(c) the contact information for the carrier or health benefit plan administrator;

(d) general information regarding copayments and deductibles; and

(e) an indication of whether the health benefit plan is regulated by the state.

(4) (a) The commissioner shall work with the Department of Health, the Health Data Authority, health care providers groups, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims or uniform standards for the electronic exchange of clinical health records.

(b) When the commissioner determines that the groups described in Subsection (4)(a) have reached a consensus regarding the electronic technology and standards necessary to electronically exchange insurance enrollment and coverage information, the commissioner shall begin the rulemaking process under Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt standardized electronic interchange technology.

(c) After rules are adopted under Subsection (4)(a), health care providers and their licensing boards under Title 58, Occupations and Professions, and health facilities licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, shall work together to implement the adoption of card swipe technology.

Amended by Chapter 297, 2011 General Session

31A-22-637. Health care provider payment information -- Notice of admissions.

(1) For purposes of this section, "insurer" is as defined in Section 31A-22-636.

(2) (a) An insurer shall provide its health care providers who are under contract with the insurer access to current information necessary for the health care provider to determine:

(i) the effect of procedure codes on payment or compensation before a claim is submitted for a procedure;

(ii) the plans and carrier networks that the health care provider is subject to as part of the contract with the carrier; and

(iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms under which the provider will be paid for health care services.

(b) The information required by Subsection (2)(a) may be provided through a website, and if requested by the health care provider, notice of the updated website shall be provided by the carrier.

(3) (a) An insurer may not require a health care provider by contract, reimbursement procedure, or otherwise to notify the insurer of a hospital in-patient emergency admission within a period of time that is less than one business day of the hospital in-patient admission, if compliance with the notification requirement would result in notification by the health care provider on a weekend or federal holiday.

(b) Subsection (3)(a) does not prohibit the applicability or administration of other contract provisions between an insurer and a health care provider that require pre-authorization for scheduled in-patient admissions.

Amended by Chapter 297, 2011 General Session

31A-22-638. Coverage for prosthetic devices.

(1) For purposes of this section:

(a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck.

(b) (i) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

(ii) "Prosthetic device" does not include an orthotic device.

(2) (a) Beginning January 1, 2011, an insurer, other than an insurer described in Subsection (2)(b), that provides a health benefit plan shall offer at least one plan, in each market where the insurer offers a health benefit plan, that provides coverage for benefits for prosthetics that includes:

(i) a prosthetic device;

(ii) all services and supplies necessary for the effective use of a prosthetic device, including:

(A) formulating its design;

(B) fabrication;

(C) material and component selection;

(D) measurements and fittings;

(E) static and dynamic alignments; and

(F) instructing the patient in the use of the prosthetic device;

(iii) all materials and components necessary to use the prosthetic device; and

(iv) any repair or replacement of a prosthetic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(b) Beginning January 1, 2011, an insurer that is subject to Title 49, Chapter 20,

Public Employees' Benefit and Insurance Program Act, shall offer to a covered employer at least one plan that:

(i) provides coverage for prosthetics that complies with Subsections (2)(a)(i) through (iv); and

(ii) requires an employee who elects to purchase the coverage described in Subsection (2)(b)(i) to pay an increased premium to pay the costs of obtaining that coverage.

(c) At least one of the plans with the prosthetic benefits described in Subsections (2)(a) and (b) that is offered by an insurer described in this Subsection (2) shall have a coinsurance rate, that applies to physical injury generally and to prosthetics, of 80% to be paid by the insurer and 20% to be paid by the insured, if the prosthetic benefit is obtained from a person that the insurer contracts with or approves.

(d) For policies issued on or after July 1, 2010 until July 1, 2015, an insurer is exempt from the 30% index rating restrictions in Section 31A-30-106.1, and for the first year only that coverage under this section is chosen, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds the coverage under this section.

(3) The coverage described in this section:

(a) shall, except as otherwise provided in this section, be made subject to cost-sharing provisions, including dollar limits, deductibles, copayments, and co-insurance, that are not less favorable to the insured than the cost-sharing provisions of the health benefit plan that apply to physical illness generally; and

(b) may limit coverage for the purchase, repair, or replacement of a microprocessor component for a prosthetic device to $30,000, per limb, every three years.

(4) If the coverage described in this section is provided through a managed care plan, offered under Chapter 8, Health Maintenance Organizations and Limited Health Plans, or under a preferred provider plan under this chapter, the insured shall have access to medically necessary prosthetic clinical care, and to prosthetic devices and technology, from one or more prosthetic providers in the managed care plan's provider network.

Enacted by Chapter 360, 2010 General Session

31A-22-639. Statement of preauthorization.

(1) An insurer who requires preauthorization or preapproval for coverage under accident and health insurance shall, beginning January 1, 2011, provide an enrollee with a statement of preauthorization if:

(a) the applicable CPT codes have been submitted to the insurer to determine whether a particular procedure is covered under the terms of the accident and health insurance policy;

(b) the enrollee has met the requirements for preauthorization of the procedure or encounter; and

(c) the enrollee requests a statement of preauthorization.

(2) A statement of preauthorization under Subsection (1) may be sent:

(a) by mail; or
(b) electronically.
(3) A statement of preauthorization shall include a statement that the preauthorization is:
(a) not a guarantee of payment by an insurer; and
(b) subject to the policy and contract provisions of the accident and health insurance contract.

Enacted by Chapter 204, 2010 General Session

31A-22-640. Insurer and pharmacy benefit management services -- Audit restrictions.
(1) For purposes of this section "pharmacy benefits manager or coordinator" means a person or entity that provides pharmacy benefit management services as defined in Section 49-20-502 on behalf of an insurer as defined in Subsection 31A-22-636(1).
(2) An insurer and an insurer's pharmacy benefits manager or coordinator is subject to the pharmacy audit provisions of Section 58-17b-622.

Enacted by Chapter 265, 2012 General Session

31A-22-641. Cancer treatment parity.
(1) For purposes of this section:
(a) "Cost sharing" means the enrollee's maximum out-of-pocket costs as defined by the health benefit plan.
(b) "Health insurer" is as defined in Subsection 31A-22-634(1).
(c) "Intravenously administered chemotherapy" means a physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is administered through injection directly into the patient's circulatory system by a physician, physician assistant, nurse practitioner, nurse, or other medical personnel under the supervision of a physician, and in a hospital, medical office, or other clinical setting.
(d) "Oral chemotherapy" means a United States Food and Drug Administration-approved, physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is taken orally in the form of a tablet or capsule, and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.
(2) This section applies to health benefit plans renewed or entered into on or after October 1, 2013.
(3) A health benefit plan that covers prescribed oral chemotherapy and intravenously administered chemotherapy shall:
(a) except as provided in Subsection (3)(b), ensure that the cost sharing applied to the covered oral chemotherapy is no more restrictive than the cost sharing applied to the covered intravenously administered chemotherapy; or
(b) if the cost sharing for oral chemotherapy is more restrictive than the cost

sharing for intravenous chemotherapy, the health benefit plan may not apply cost sharing for the oral chemotherapy that exceeds $300 per filled prescription.

(4) (a) A health insurer shall not increase the cost sharing for intravenously administered chemotherapy for the purpose of achieving compliance with this section.

(b) The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to enforce the provisions of this section.

Enacted by Chapter 164, 2013 General Session

31A-22-701. Groups eligible for group or blanket insurance.

(1) As used in this section, "association group" means a lawfully formed association of individuals or business entities that:

(a) purchases insurance on a group basis on behalf of members; and

(b) is formed and maintained in good faith for purposes other than obtaining insurance.

(2) A group accident and health insurance policy may be issued to:

(a) a group:

(i) to which a group life insurance policy may be issued under Sections 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, 31A-22-507, and 31A-22-509; and

(ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;

(b) an association group that:

(i) has been actively in existence for at least five years;

(ii) has a constitution and bylaws;

(iii) is formed and maintained in good faith for purposes other than obtaining insurance;

(iv) does not condition membership in the association group on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(v) makes accident and health insurance coverage offered through the association group available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;

(vi) does not make accident and health insurance coverage offered through the association group available other than in connection with a member of the association group; and

(vii) is actuarially sound; or

(c) a group specifically authorized by the commissioner under Section 31A-22-509, upon a finding that:

(i) authorization is not contrary to the public interest;

(ii) the group is actuarially sound;

(iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs;

(iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are otherwise available to similar groups;

(v) the group would not present hazards of adverse selection;

(vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and

(vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance.

(3) A blanket accident and health insurance policy:

(a) covers a defined class of persons;

(b) may not be offered or underwritten on an individual basis;

(c) shall cover only a group that is:

(i) actuarially sound; and

(ii) formed and maintained in good faith for a purpose other than obtaining insurance; and

(d) may be issued only to:

(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;

(ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;

(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(vii) a newspaper or other publisher, as policyholder, covering its carriers;

(viii) an association, including a labor union, that has a constitution and bylaws and that is organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; and

(ix) any other class of risks that, in the judgment of the commissioner, may be properly eligible for blanket accident and health insurance.

(4) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) a class of risks; or

(c) both Subsections (4)(a) and (b).

Amended by Chapter 284, 2011 General Session

31A-22-702. Adjustment of premium rate and application of dividends or rate reductions.

Any group accident and health insurance policy may provide for the adjustment of the rate of premium based upon the experience under the contract. If a policy dividend is declared or a reduction in rate is made or continued for the first or any subsequent year of insurance under any policy of group accident and health insurance, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under those policies made from funds contributed by the policyholder, including expenditures made in connection with the administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members unless the insured employee or member explicitly elects otherwise.

Amended by Chapter 116, 2001 General Session

31A-22-715. Optional rider for alcohol and drug dependency treatment.

Each group accident and health insurance policy shall contain an optional rider allowing certificate holders to obtain coverage for alcohol or drug dependency treatment in programs licensed by the Department of Human Services, under Title 62A, Chapter 2, inpatient hospitals accredited by the joint commission on the accreditation of hospitals, or facilities licensed by the Department of Health.

Amended by Chapter 116, 2001 General Session

31A-22-716. Required provision for notice of termination.

(1) Every policy for group or blanket accident and health coverage issued or renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days prior written notice of termination to each employee or group member and to notify each employee or group member of the employee's or group member's rights to continue coverage upon termination.

(2) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers shall provide a sample notice to the policyholder at least once a year.

(3) For the purpose of compliance with federal law and the Health Insurance Portability and Accountability Act, all health benefit plans, health insurers, and student health plans shall provide a certificate of creditable coverage to each covered person upon the person's termination from the plan as soon as reasonably possible.

Amended by Chapter 284, 2011 General Session
Amended by Chapter 297, 2011 General Session

31A-22-717. Provisions pertaining to service members and their families affected by mobilization into the armed forces.

For any group or blanket accident and health coverage, an insurer:

(1) may not refuse to reinstate an insured or his family whose coverage lapsed due to the insured's mobilization into the United States armed forces provided

application is made within 180 days of release from active duty;

(2) shall reinstate an insured in full upon payment of the first premium without the requirement of a waiting period or exclusion for preexisting conditions or any other underwriting requirements that were covered previously; and

(3) may not increase the insured's premium in excess of what it would have been increased in the normal course of time had the insured not been mobilized into the United States armed forces.

Amended by Chapter 108, 2004 General Session

31A-22-718. Dependent coverage.

No group policy that provides coverage to children of group members may deny eligibility for coverage to a child solely because the child does not reside with the group member or solely because the child is solely dependent on a former spouse of the group member rather than on the group member. A child who does not reside with the group member may be excluded on the same basis as children who do reside with the group member.

Enacted by Chapter 344, 1995 General Session

31A-22-719. Mastectomy coverage.

(1) A group policy subject to Section 31A-22-630 may not deny a person's eligibility or continued eligibility to enroll or renew coverage under the terms of the group policy plan solely for the purpose of avoiding the requirements of this section or Section 31A-22-630.

(2) A group policy subject to Section 31A-22-630 may not do any of the following to induce a provider to provide care to an insured in a manner inconsistent with this section or Section 31A-22-630:

(a) penalize or otherwise reduce or limit the reimbursement of an attending provider; or

(b) provide incentives to an attending provider whether or not the incentives are monetary.

Enacted by Chapter 114, 2000 General Session

31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(A) the service area of the insurer; or
(B) the area for which the insurer is authorized to do business; and
(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or
(b) for coverage made available in the small or large employer market only through an association, if:
(i) the employer's membership in the association ceases; and
(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.
(3) A health benefit plan for a plan sponsor may be discontinued if:
(a) a condition described in Subsection (2) exists;
(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;
(c) the plan sponsor:
(i) performs an act or practice that constitutes fraud; or
(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
(d) the insurer:
(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state;
(ii) (A) provides notice of the discontinuation in writing:
(I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
(II) at least 90 days before the date the coverage will be discontinued;
(B) provides notice of the discontinuation in writing:
(I) to the commissioner; and
(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of plan sponsors or employees;
(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered:
(I) by the insurer in the market; or
(II) in the case of a large employer, any other health benefit plan currently being offered in that market; and
(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, the insurer acts uniformly without regard to:
(I) the claims experience of a plan sponsor;
(II) any health status-related factor relating to any covered participant or beneficiary; or
(III) any health status-related factor relating to a new participant or beneficiary who may become eligible for coverage; or
(e) the insurer:
(i) elects to discontinue all of the insurer's health benefit plans:
(A) in the small employer market; or
(B) the large employer market; or
(C) both the small and large employer markets; and

(ii) (A) provides notice of the discontinuance in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 business days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of a plan sponsor or employee;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A large employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's employer contribution requirements.

(6) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's minimum participation requirements.

(7) (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (7) because of a fraud or misrepresentation that relates to health status.

(8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new business in such market in this state for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The commissioner may waive the prohibition under Subsection (8)(a) when the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(9) If an insurer is doing business in one established geographic service area of the state, this section applies only to the insurer's operations in that geographic service area.

(10) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with a particular product or service.

(11) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(12) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average less than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

(13) An insurer offering employer sponsored health benefit plans shall comply with the Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.

Amended by Chapter 284, 2011 General Session

31A-22-722. Utah mini-COBRA benefits for employer group coverage.

(1) An insured may extend the employee's coverage under the current employer's group policy for a period of 12 months, except as provided in Subsections (2) and 31A-22-722.5(4). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) a disability;

(i) leave of absence; or

(j) reduction of hours.

(2) (a) Notwithstanding Subsection (1), an employee may not extend coverage

under the current employer's group insurance policy if the employee:

(i) fails to pay premiums or contributions in accordance with the terms of the insurance policy;

(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;

(iii) performs an act or practice that constitutes fraud in connection with the coverage;

(iv) makes an intentional misrepresentation of material fact under the terms of the coverage;

(v) is terminated from employment for gross misconduct;

(vi) is not continuously covered under the current employer's group policy for a period of three months immediately before the termination of the insurance policy due to an event set forth in Subsection (1);

(vii) is eligible for an extension of coverage required by federal law;

(viii) establishes residence outside of this state;

(ix) moves out of the insurer's service area;

(x) is eligible for similar coverage under another group insurance policy; or

(xi) has the employee's coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).

(b) The right to extend coverage under Subsection (1) applies to spouse or dependent coverage, including a surviving spouse or dependents whose coverage under the insurance policy terminates by reason of the death of the employee or member.

(3) (a) The employer shall notify the following in writing of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made:

(i) a terminated insured;

(ii) an ex-spouse of an insured; or

(iii) if Subsection (2)(b) applies:

(A) a surviving spouse; and

(B) the guardian of surviving dependents, if different from a surviving spouse.

(b) The notification required in Subsection (3)(a) shall be sent first class mail within 30 days after the termination date of the group coverage to:

(i) the terminated insured's home address as shown on the records of the employer;

(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;

(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and

(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in Subsection (5) if:

(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and

(b) the employee or other individual eligible for extension contacts the insurer

within 60 days of coverage termination.

(5) A premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.

(6) Except as provided in this Subsection (6), coverage extends without interruption for 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

(a) elects to extend group coverage within 60 days of losing group coverage; and

(b) tenders the amount required to the employer or insurer.

(7) The insured's coverage may be terminated before 12 months if the terminated insured:

(a) establishes residence outside of this state;

(b) moves out of the insurer's service area;

(c) fails to pay premiums or contributions in accordance with the terms of the insurance policy, including any timeliness requirements;

(d) performs an act or practice that constitutes fraud in connection with the coverage;

(e) makes an intentional misrepresentation of material fact under the terms of the coverage;

(f) becomes eligible for similar coverage under another group insurance policy; or

(g) has the coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).

(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group insurance policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:

(a) for the balance of the period the terminated insured would have extended coverage under the replaced group insurance policy; and

(b) if the terminated insured is otherwise eligible for extension of coverage.

Amended by Chapter 319, 2013 General Session

31A-22-722.5. Mini-COBRA election -- American Recovery and Reinvestment Act.

(1) (a) If the provisions of Subsection (1)(b) are met, an individual has a right to contact the individual's employer or the insurer for the employer to participate in a transition period for mini-COBRA benefits under Section 31A-22-722 in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended.

(b) An individual has the right under Subsection (1)(a) if the individual:

(i) was involuntarily terminated from employment during the period of time identified in Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended;

(ii) is eligible for COBRA premium assistance under Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended;

(iii) was eligible for Utah mini-COBRA as provided in Section 31A-22-722 at the time of termination;

(iv) elected Utah mini-Cobra; and

(v) voluntarily dropped coverage, which includes dropping coverage through non-payment of premiums, between December 1, 2009 and February 1, 2010.

(2) (a) An individual or the employer of the individual shall contact the insurer and inform the insurer that the individual wants to maintain coverage and pay retroactive premiums under a transition period for mini-COBRA coverage in accordance with the provisions of Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended.

(b) An individual or an employer on behalf of an eligible individual shall submit the applicable forms and premiums for coverage under Subsection (1) to the insurer in accordance with the provisions of Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended.

(3) An insured has the right to extend the employee's coverage under mini-cobra with the current employer's group policy beyond the 12 months to the period of time the insured is eligible to receive assistance in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5) as amended.

(4) An insurer that violates this section is subject to penalties in accordance with Section 31A-2-308.

Amended by Chapter 297, 2011 General Session
Amended by Chapter 340, 2011 General Session

31A-22-725. Special enrollment periods relating to Medicaid and Children's Health Insurance Program.

(1) A person is eligible to enroll for coverage under the terms of an employer's group health benefit plan if:

(a) the person is:

(i) an employee who is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; or

(ii) a dependent of an employee, if the dependent is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; and

(b) the conditions of either Subsection (2) or (3) are met.

(2) Subsection (1) applies if:

(a) the employee or dependent is covered under:

(i) a Medicaid health benefit plan under Title XIX of the Social Security Act; or

(ii) a state child health benefit plan under Title XXI of the Social Security Act;

(b) coverage of the employee or dependent described in Subsection (2)(a) is terminated as a result of loss of eligibility for the coverage; and

(c) the employee requests coverage under the employer's group health plan no later than 60 days after the date of termination of the coverage described in Subsection (2)(a).

(3) Subsection (1) applies if:

(a) the employee or dependent becomes eligible for assistance, with respect to coverage under the employer's group health plan under a plan described in Subsection (2)(a), including under a waiver or demonstration project conducted under or in relation to a plan described in Subsection (2)(a); and

(b) the employee requests coverage under the employer's group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for the assistance described in Subsection (3)(a).

Enacted by Chapter 10, 2010 General Session

31A-22-726. Abortion coverage restriction in health benefit plan and on health insurance exchange.

(1) As used in this section, "permitted abortion coverage" means coverage for abortion:

(a) that is necessary to avert:

(i) the death of the woman on whom the abortion is performed; or

(ii) a serious risk of substantial and irreversible impairment of a major bodily function of the woman on whom the abortion is performed;

(b) of a fetus that has a defect that is documented by a physician or physicians to be uniformly diagnosable and uniformly lethal; or

(c) where the woman is pregnant as a result of:

(i) rape, as described in Section 76-5-402;

(ii) rape of a child, as described in Section 76-5-402.1; or

(iii) incest, as described in Subsection 76-5-406(10) or Section 76-7-102.

(2) A person may not offer coverage for an abortion in a health benefit plan, unless the coverage is a type of permitted abortion coverage.

(3) A person may not offer a health benefit plan that provides coverage for an abortion in a health insurance exchange created under Title 63M, Chapter 1, Part 25, Health System Reform Act, unless the coverage is a type of permitted abortion coverage.

(4) A person may not offer a health benefit plan that provides coverage for an abortion in a health insurance exchange created under the federal Patient Protection and Affordable Care Act, 111 P.L. 148, unless the coverage is a type of permitted abortion coverage.

Enacted by Chapter 278, 2011 General Session

31A-22-801. Scope of part.

(1) Except as provided under Subsection (2), all life insurance and accident and health insurance in connection with loans or other credit transactions are subject to this part.

(2) (a) Insurance in connection with a loan or other credit transaction of more than 10 years duration is not subject to this part, but is subject to other provisions of this title.

(b) Isolated transactions on the part of an insurer that are not related to an agreement or plan for insuring debtors of the creditor are not subject to this part.

Amended by Chapter 116, 2001 General Session

31A-22-802. Definitions.

As used in this part:

(1) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor has a disability.

(2) "Credit life insurance" means life insurance on the life of a debtor in connection with a specific loan or credit transaction.

(3) "Credit transaction" means any transaction under which the payment for money loaned or for goods, services, or properties sold or leased is to be made on future dates.

(4) "Creditor" means the lender of money or the vendor or lessor of goods, services, or property, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any lender or vendor.

(5) "Debtor" means a borrower of money or a purchaser, including a lessee under a lease intended as security, of goods, services, or property, for which payment is arranged through a credit transaction.

(6) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a credit transaction, including principal finance charges and interest.

(7) "Net indebtedness" means the total amount required to liquidate the indebtedness, exclusive of any unearned interest, any insurance on the monthly outstanding balance coverage, or any finance charge.

(8) "Net written premiums" means gross written premiums minus refunds on termination.

Amended by Chapter 366, 2011 General Session

31A-22-803. Forms of insurance permitted.

Credit life insurance and credit accident and health insurance may be issued only in the following forms:

(1) individual policies of term life insurance issued to debtors;

(2) individual policies of term accident and health insurance issued to debtors, or accident and health benefit provisions in individual policies of credit life insurance;

(3) group policies of term life insurance issued to creditors, providing insurance upon the lives of debtors;

(4) group policies of term accident and health insurance issued to creditors insuring debtors, or accident and health benefit provisions in group credit life insurance policies.

Amended by Chapter 116, 2001 General Session

31A-22-804. Limitations on amounts of insurance.

(1) Except as provided under Subsection (2), the initial amount of credit life insurance on the life of any one debtor may not exceed the total amount repayable

under the contract of indebtedness. Where an indebtedness is repayable in substantially equal periodic installments, the amount of insurance may not exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(2) Subsection (1) does not apply to:

(a) insurance on agricultural credit transaction commitments not exceeding the commitment period, which may be written for the amount of the commitment on a nondecreasing or level term plan;

(b) insurance on educational credit transaction commitments, which may be written to include the portion of the commitment that has not been advanced by the creditor;

(c) insurance on preauthorized lines of credit not exceeding the commitment period which may be written for the preauthorized amount on a nondecreasing or level term plan, whether secured or unsecured; and

(d) insurance on any other class of lawful credit transaction or commitment, which in the commissioner's opinion does not require the application of the restrictions under Subsection (1), in which case the commissioner may authorize by rule a class exception to Subsection (1).

(3) The total amount of indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, may not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness. The amount of each periodic indemnity payment may not exceed the total amount repayable under the contract of indebtedness divided by the number of periodic installments.

Amended by Chapter 116, 2001 General Session

31A-22-805. Beginning date of insurance.

(1) Except as provided under Subsection (2), any credit life insurance or credit accident and health insurance, subject to acceptance by the insurer, commences on the date when the debtor becomes obligated to the creditor.

(2) (a) Where a group policy provides coverage for existing obligations, the insurance on a debtor with respect to that indebtedness commences on the effective date of the policy.

(b) Where evidence of insurability is required and the evidence is furnished more than 30 days after the debtor becomes obligated to the creditor, the insurance may commence when the insurance company determines the evidence of insurability to be satisfactory. In this event, the insurer shall make an appropriate refund or adjustment of any charge to the debtor for insurance.

(3) The insurance may not extend more than 15 days beyond the scheduled maturity date of the indebtedness, unless it does so at no additional cost to the debtor.

(4) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall terminate 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 31A-22-808.

Amended by Chapter 116, 2001 General Session

31A-22-806. Provisions of policies and certificates.

(1) All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy, or, in the case of group insurance, by a certificate of insurance delivered to the debtor.

(2) Each of these types of policies or certificates shall, in addition to satisfying the requirements of Chapter 21, Insurance Contracts in General, set forth:

(a) the name and home office address of the insurer;

(b) the identity, by name or otherwise, of the persons insured;

(c) the rate, premium, or amount of payment by the debtor, if any, given separately for credit life insurance and credit accident and health insurance;

(d) a description of the amount, term, and coverage, including any exceptions, limitations, and restrictions;

(e) that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness; and

(f) that whenever the amount of insurance exceeds the unpaid indebtedness, that excess is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.

(3) Except as provided in Subsection (4), the policy or certificate shall be delivered to the debtor within 30 days after the date when the indebtedness is incurred.

(4) (a) If the policy or certificate is not delivered to the debtor within 30 days after the date the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance shall be delivered to the debtor.

(b) The application or the notice shall be signed by the debtor and shall set forth:

(i) the name and home office address of the insurer;

(ii) the name of the debtor;

(iii) the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance; and

(iv) the amount, term, and a brief description of the coverage provided.

(c) The copy of the application for or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate from the loan, sale, or other credit statement of account or instrument, unless the information required by this Subsection (4)(c) is prominently set forth therein.

(d) Upon acceptance of the insurance by the insurer and within 60 days after the later of the date on which the indebtedness is incurred or the date on which the credit life or credit accident and health policy was purchased, the insurer shall deliver the individual policy or group certificate of insurance to the debtor.

(e) The application or notice shall state that upon acceptance by the insurer, the insurance is effective as provided in Section 31A-22-805.

(5) 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. If the premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made.

(6) If a creditor makes available to the debtors more than one plan of credit life or credit accident and health insurance, all debtors shall be informed of the plans

applicable to the specific type of loan transaction for which the debtor is applying.

Amended by Chapter 297, 2011 General Session

31A-22-807. Filing and approval of forms -- Loss ratio standards.

(1) A policy, certificate of insurance, statement of insurance, or endorsement form intended for use in Utah is subject to Section 31A-21-201.

(2) In addition to the grounds for prohibiting use of a form under Subsection 31A-21-201(3), it is a ground to prohibit the use of a form that the benefits provided in the form are not reasonable in relation to the premium charge.

(3) (a) In ascertaining whether the benefits are reasonable in relation to the premium charged, the commissioner shall consider:

(i) the mortality cost of the life insurance;

(ii) the morbidity cost of the accident and health insurance; and

(iii) the reserves set up for the payment of claims unreported or in the process of settlement.

(b) For purposes of this section, benefits are considered reasonable in relation to the premium charged if, given the costs described in this Subsection (3), the premium rate charged develops or may reasonably be expected to develop a loss ratio of:

(i) not less than 50% for credit life insurance; and

(ii) not less than 55% for credit accident and health insurance.

(4) Benefits are considered reasonable in relation to premium charged if the ratio of claims incurred to premium earned during the most recent four-year period at the rates in use produces a loss ratio that is equal to or exceeds the minimum loss ratio standard specified in Subsection (3).

(5) If the minimum loss ratio test produces a loss ratio that exceeds the minimum loss ratio standard in Subsection (4) by five percentage points or more, the insurer may file for approval and use a rate that is higher than the prima facie rate, if it can be expected that the use of the higher rate will continue to produce a loss ratio for an account to which it is applied that will satisfy the minimum loss ratio test.

(6) If the minimum loss ratio test produces a loss ratio that is lower than the minimum loss standard in Subsection (4) by five percentage points or more, the commissioner may require that the insurer:

(a) file an adjusted rate that can be expected to produce a loss ratio that will satisfy the minimum loss ratio test; or

(b) submit reasons acceptable to the commissioner why the insurer should not be required to file an adjusted rate.

Amended by Chapter 345, 2008 General Session

31A-22-808. Premiums and refunds.

(1) Each policy, certificate, or statement of 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 insurance shall be paid or credited promptly to the person entitled to it. The formula used in computing the refund

shall be filed with and approved by the commissioner under Chapter 21, Part 2, Approval of Forms. No refund is required if it would be less than $5.

(2) If a creditor requires a debtor to make any payment for credit life or credit accident and health insurance and an individual policy, certificate, or statement of insurance is not issued, the creditor shall immediately give written notice to the debtor and credit the account.

(3) The amount charged the debtor for credit life or accident and health insurance may not exceed the premiums charged by the insurer as computed at the time the charge to the debtor is determined.

Amended by Chapter 90, 2004 General Session

31A-22-809. Right of debtor to choose insurer.

When credit life insurance or credit accident and health insurance is required as security for any indebtedness, the creditor shall inform the debtor of the debtor's option to furnish the required insurance through existing policies of insurance owned or controlled by the debtor or to procure and furnish the required coverage through any insurer authorized to transact life or accident and health insurance in Utah.

Amended by Chapter 116, 2001 General Session

31A-22-901. Laws applicable to contracts of fraternal insurers.

Except as otherwise provided under this part, or in Chapter 9, insurance contracts issued by fraternal insurers are subject to the contract provisions of the Insurance Code in the same manner as contracts issued by any other insurer.

Enacted by Chapter 242, 1985 General Session

31A-22-902. Fraternal contract.

(1) A fraternal shall issue to each benefit member a policy or certificate specifying the benefits provided and containing at least the substance of all sections of the laws of the fraternal which might result in the termination of coverage or the reduction of benefits. The policy or certificate, any riders or endorsements attached to them, the laws of the fraternal, and the application and declarations made in connection with these which are signed by the applicant, constitute the agreement between the fraternal and the member, and the policy or certificate shall state this.

(2) Any changes in the laws of a fraternal which are made subsequent to the issuance of a policy or certificate bind the member and beneficiary as if they had been in force at the time of the application, so long as they do not destroy or diminish any benefits provided in the policy or certificate.

(3) Copies of any documents mentioned in Subsections (1) and (2), certified by the secretary or corresponding officer of the fraternal, are evidence of the terms and conditions of the contract.

(4) Section 31A-21-106 does not apply to fraternal contracts.

(5) If a fraternal's laws provide for expulsion or suspension of a member for any reason other than nonpayment of premium, the fraternal's insurance certificate shall

contain a provision that if a member is expelled or suspended for any reason other than nonpayment of premium, the expelled member has the right to maintain the policy in force by continuing to pay the required premium.

(6) The policy or certificate shall contain a maintenance of solvency provision pursuant to Subsection 31A-9-209(2).

(7) This section applies to all contracts made by a fraternal beginning July 1, 1986. A fraternal may elect to have this section apply at an earlier date, as long as it applies simultaneously to all of its contracts and the fraternal gives the commissioner at least 30 days notice of its intention to apply this section.

Amended by Chapter 204, 1986 General Session

31A-22-903. Fraud in obtaining membership.

Subject to Sections 31A-22-403 and 31A-22-405, any certificate of membership secured by misrepresentation with reference to any application for membership, document, or other proof, for the purpose of obtaining membership in, or an insurance benefit from, the fraternal is void, if the fraternal relied on it and it is either material or fraudulent.

Enacted by Chapter 242, 1985 General Session

31A-22-904. Beneficiaries in fraternal contracts.

(1) Any member may designate as beneficiary any person permitted by the laws of the fraternal. Those laws shall allow the designation of the member's estate as beneficiary.

(2) Subject to Subsection (1), Section 31A-22-413 applies.

Enacted by Chapter 242, 1985 General Session

31A-22-1001. Obligation to write workers' compensation insurance.

The Workers' Compensation Fund created under Chapter 33, shall write all workers' compensation insurance for which application is made to the Workers' Compensation Fund. This requirement does not apply to any other insurer.

Amended by Chapter 222, 2000 General Session

31A-22-1002. Duration of coverage.

(1) Any insurer assuming a workers' compensation risk shall carry it until the policy is canceled, either:

(a) by agreement between the Division of Industrial Accidents in the Labor Commission, the insurer, and the employer; or

(b) after:

(i) notice by the insurer to the employer as provided in Section 31A-21-303; and

(ii) notice to the Division of Industrial Accidents in the Labor Commission as provided in Section 34A-2-205.

(2) Subsection (1) does not affect the requirements of Section 31A-22-1001.

Amended by Chapter 116, 2001 General Session

31A-22-1003. Comprehensive coverage.

Every insurance policy covering the liability of an employer under Title 34A, Chapter 2, Workers' Compensation Act, shall cover all types of workers' compensation benefits required to be provided under that chapter. This section does not preclude primary and excess coverage being provided under different contracts.

Amended by Chapter 375, 1997 General Session

31A-22-1004. Direct enforcement by employees.

All workers' compensation insurance policies shall contain a provision that employees may enforce, in their own names, the liability of the insurer.

Enacted by Chapter 242, 1985 General Session

31A-22-1005. Payment as bar to recovery.

Payment of compensation under a workers' compensation insurance policy, whether in whole or in part, by either the employer or the insurer, bars recovery by the employee or his dependents to the extent of the payment.

Enacted by Chapter 242, 1985 General Session

31A-22-1006. Insurer's constructive knowledge.

Every workers' compensation policy or contract shall contain a provision that, as between the employee and the insurer, notice to or knowledge of the occurrence of the injury on the part of the employer is considered to be notice or knowledge to the insurer. This provision shall also state that the insurer is bound by and subject to the orders, findings, decisions, and awards rendered against the employer for the payment of compensation on account of compensable accidental injuries or occupational disease disability.

Enacted by Chapter 242, 1985 General Session

31A-22-1007. Employer's insolvency.

Every workers' compensation policy or contract shall contain a provision that the insolvency of the employer and his discharge does not relieve the insurer from the payment of compensation for injuries or death sustained by an employee during the life of that policy or contract.

Enacted by Chapter 242, 1985 General Session

31A-22-1008. Employer's breach of safety rules.

No condition in a workers' compensation policy requiring the insured employer to comply with certain safety rules may excuse the workers' compensation insurer from

paying the required benefits to an employee injured as a result of the employer's breach of a safety rule that is a condition to the workers' compensation policy. However, the insurer may bring a claim against the insured employer for breach of the policy condition.

Enacted by Chapter 242, 1985 General Session

31A-22-1009. Other applicable provisions.

Workers' compensation insurance contracts are subject to any applicable requirements of Title 34A, Chapter 2, Workers' Compensation Act.

Amended by Chapter 375, 1997 General Session

31A-22-1010. Workers' compensation deductible policies.

(1) An insurer authorized to transact the business of workers' compensation in this state may issue a workers' compensation insurance policy that provides for the insured to participate in the payment of the insurance claims and losses covered by the policy in accordance with rules made by the department.

(2) Notwithstanding Subsection (1), an insurer:

(a) shall assume responsibility to pay all claims and losses under a workers' compensation insurance policy in accordance with Title 34A, Chapters 2 and 3;

(b) may not permit the insured to participate in the payment of the insurance claims and losses by any means except reimbursement of the insurer; and

(c) may not permit an employee to participate in the payment of claims or losses.

(3) For policies issued under this section, the department shall make rules consistent with this section governing:

(a) the terms of the policies; and

(b) reporting requirements for the policies.

Enacted by Chapter 277, 1998 General Session

31A-22-1012. Workers' compensation insurance availability.

(1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules to monitor the following related to employers who can only obtain workers' compensation insurance pursuant to Section 31A-22-1001 because of an underwriting standard or guideline described in Subsection (2):

(a) the number of employers;

(b) the type of employers;

(c) the underwriting standard or guideline that causes the employer to obtain workers' compensation under Section 31A-22-1001; or

(d) similar information to the information described in Subsections (1)(a) through (c).

(2) An underwriting standard or guideline described in Subsection (1) includes a standard or guideline regarding:

(a) premium size;

(b) class code and risk characteristics;
(c) payroll and loss experience;
(d) another factor identified by the department; or
(e) a combination of the factors listed in Subsections (2)(a) through (d).

Enacted by Chapter 348, 2008 General Session

31A-22-1013. Department report on workers' compensation.

The department shall report annually to the Business and Labor Interim Committee by no later than its October interim meeting on the following:

(1) the cost and availability of workers' compensation insurance coverage in Utah;

(2) the results of the monitoring provided for in Section 31A-22-1012;

(3) the size of the residual market as a percentage of the overall workers' compensation insurance market in Utah;

(4) which workers' compensation insurers in the state are the top 10 that held the largest market shares of Utah's workers' compensation insurance market during the three calendar years preceding the report; and

(5) any recommendations of the department to the Legislature to improve the cost and availability of workers' compensation to Utah businesses.

Enacted by Chapter 348, 2008 General Session

31A-22-1101. Combination of lines.

(1) Legal expense insurance may be transacted alone or together with life insurance, accident and health insurance, or casualty insurance.

(2) An insurer may not transact liability insurance and also issue legal expense insurance policies providing coverage for the expense of enforcing claims against third persons, unless the requirements of Subsection (3) are met and the commissioner is satisfied that the interests of policyholders of legal expense insurance policies are not endangered by potential conflicts of interest within the insurer.

(3) Adequate precautions shall be taken to make sure that the handling of an insured's claim for legal assistance in enforcing a claim against a third person is not affected by the insurer's actual or potential obligation as a liability insurer to pay the claim for the third person. These precautions may include:

(a) a provision in the policy that claims against third persons shall be handled exclusively by attorneys selected by the insureds themselves rather than by the insurer, that no information about the case other than the name of the defendant and the nature of the claim may be made available to the insurer, and that the insurer may not interfere with the handling of the case; or

(b) organizational separation between the legal expense and the liability insurance departments with respect to management, accounting, record keeping, and claims handling, with appropriate rules and procedures, satisfactory to the commissioner, to prevent the exchange of information between the two departments about details of cases.

Amended by Chapter 116, 2001 General Session

31A-22-1102. Policy and certificate forms.

(1) Legal expense insurance may be written as individual, group, blanket, or franchise insurance. Each contractual obligation for legal expense insurance shall be evidenced by a policy. Each person insured under a group policy shall be issued a certificate of coverage.

(2) Policies and certificates of legal expense insurance are subject to Section 31A-21-201.

(3) The commissioner may not approve any form that does not meet all of the following requirements:

(a) Policies shall contain a list and description of the legal services promised or the legal matters for which expenses are to be reimbursed, and any limits on the amounts to be reimbursed.

(b) Certificates issued under group policies shall contain a full statement of the benefits provided, but may summarize the other terms of the master policy.

(c) Policies promising legal services to be provided by a limited number of attorneys who have concluded provider contracts with the insurer, whether the attorney in an individual case is to be selected by the insured or by the insurer, shall provide for alternative benefits in case the insured is unable to find a participating attorney willing to perform the promised services or the attorney selected by the insurer is disqualified or otherwise unable to perform the promised services. The alternative benefit may consist of furnishing the services of an attorney selected and paid by the insurer or paying the fee of an attorney selected by the insured. The policy shall also provide a procedure that includes impartial review for settling disagreements about the grounds for demanding an alternative benefit.

(d) No policy, except one issued by a mutual insurance company, may provide for assessments on policyholders or for reductions of benefits to maintain the insurer's solvency.

(4) The commissioner may disapprove a policy or certificate form if he finds that it:

(a) is unfair, unfairly discriminatory, misleading, or encourages misrepresentation or misunderstanding of the contract;

(b) provides coverage or benefits or contains other provisions that would endanger the solidity of the insurer; or

(c) is contrary to law.

(5) The commissioner may require the submission of relevant information he considers to be reasonably necessary in determining whether to approve or disapprove a filing.

Amended by Chapter 261, 1989 General Session

31A-22-1201. Assumption agreement.

(1) Subject to Subsection (2), a credit for reinsurance ceded under Section 31A-17-404, 31A-17-404.1, or 31A-17-404.2, is not allowed unless, in addition to meeting the requirements of Section 31A-17-404, 31A-17-404.1, or 31A-17-404.2, the

reinsurance agreement provides in substance that if the ceding insurer is insolvent, the reinsurance is payable by the assuming insurer:

(a) on the basis of the liability of the ceding insurer under the contract or contracts reinsured;

(b) without diminution because of the insolvency of the ceding insurer; and

(c) directly to the ceding insurer or to its domiciliary liquidator or receiver.

(2) Subsection (1) applies except if:

(a) a contract specifically provides another payee of the insurance in the event of the insolvency of the ceding insurer; or

(b) the assuming insurer, with the consent of the one or more direct insureds, assumes the policy obligations of the ceding insurer:

(i) as direct obligations of the assuming insurer to the payees under the policies; and

(ii) in substitution for the obligations of the ceding insurer to the payees.

Amended by Chapter 257, 2008 General Session

31A-22-1202. Other reinsurance contracts.

(1) If there is no assumption agreement under Subsection 31A-22-1201(2), the reinsurer's sole obligation is to the ceding insurer.

(2) No guaranty fund, security fund, or any other person, except the estate of the ceding insurer, has a claim against a reinsurer.

(3) Subject to contractual rights of offset, if a ceding insurer is put into receivership, the reinsurer shall pay any amount due under the contract in full, without reduction because of the receivership:

(a) to the domiciliary receiver if there is one; or

(b) if there is not domiciliary receiver, to a Utah receiver.

Amended by Chapter 257, 2008 General Session

31A-22-1203. Right of reinsurer to defend claim.

A reinsurance contract may provide that the receiver of a ceding insurer shall, within a specified or reasonable time after the claim is filed in court or in the receivership, give written notice to an assuming reinsurer of all or part of the claim against the ceding insurer. During the pendency of the claim, any assuming reinsurer may investigate the claim and unless forbidden to do so by the reinsurance agreement, may intervene in the proceeding in which the claim is pending and interpose any defenses it considers available which have not been raised by the ceding insurer or its receiver. The expenses incurred by the assuming reinsurer in this type of action are payable up to the amount of the expenses or the amount of the benefit produced, whichever is less, as expenses of the receivership. If two or more assuming reinsurers have potential liability because of the same claim, the expenses shall be apportioned among them in proportion to the benefit received.

Enacted by Chapter 242, 1985 General Session

31A-22-1204. Approval required for bulk insurance.

Reinsurance credit is not allowed to a domestic insurer for reinsurance ceded when such reinsurance constitutes all or substantially all of the insurance in force of the domestic insurer, unless the agreement purporting to transfer the reinsurance is in writing and:

(1) approved by the commissioner prior to execution of the agreement; or

(2) provides that the agreement is subject to the approval of the commissioner.

Enacted by Chapter 258, 1992 General Session

31A-22-1300. Aircraft liability insurance.

Subsections 72-10-117(5) and (6) apply to aircraft liability insurance.

Amended by Chapter 270, 1998 General Session

31A-22-1301. Liability insurance for armored car companies and contract security companies.

Section 58-63-302 applies to liability insurance for armored car companies and contract security companies.

Amended by Chapter 246, 2008 General Session

31A-22-1302. Insurance requirements for vehicles of unusual physical nature.

Section 72-9-103 applies to the insurance requirements for vehicles of an unusual physical nature.

Amended by Chapter 270, 1998 General Session

31A-22-1303. Liability insurance for motor carriers.

Motor carrier safety regulations adopted under Section 72-9-103 specify liability insurance for motor carriers.

Amended by Chapter 270, 1998 General Session

31A-22-1305. Persons authorized to issue annuities.

No person may issue an annuity to another person unless the issuer is:

(1) an insurer authorized to issue annuities under Chapter 5, 9, or 14;

(2) a domestic corporation created under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, or other applicable law, or a foreign corporation conducted without profit, which is engaged solely in bona fide charitable, religious, missionary, educational, medical, or philanthropic activities; or

(3) a natural person who issues an annuity to his spouse, children, grandchildren, great-grandchildren, parents, grandparents, uncles, aunts, brothers, sisters, nieces, or nephews, whether those relationships are by birth, marriage, or legal adoption.

Amended by Chapter 300, 2000 General Session

31A-22-1306. Transition provision for existing policy forms.

Insurance policy forms need not conform to the requirements of this chapter until July 1, 1987. However, insurance policies issued after July 1, 1986, are subject to Section 31A-21-107.

Amended by Chapter 204, 1986 General Session

31A-22-1307. Use of consumer reports by residential dwelling liability insurers.

(1) An insurer who uses consumer reports in connection with the underwriting of residential dwelling liability insurance shall establish and adhere to written procedures that:

(a) identify the circumstances under which the insurer may request and the manner in which it will use consumer reports in its underwriting decisions;

(b) provide prior notice of the possible or intended use of a consumer report to an applicant for a residential liability insurance policy; and

(c) ensure compliance with the Consumer Credit Reporting Act, 15 U.S.C. Sec. 1681 et seq., including the duties that arise from taking adverse action based on information contained in a consumer report.

(2) An insurer that requests or uses a consumer report in connection with an application for a residential dwelling liability insurance policy shall maintain evidence of its compliance with the written procedures established by the insurer under Subsection (1).

(3) An insurer shall submit to the commissioner, upon request, evidence of compliance maintained in accordance with Subsection (2).

(4) As used in this section, the terms "consumer report" and "adverse action" are defined in 15 U.S.C. Sec. 1681a.

Enacted by Chapter 105, 1997 General Session

31A-22-1308. Use of loss history by insurers.

(1) For purposes of this section:

(a) "Adverse eligibility or rate decision" means:

(i) declining insurance coverage;

(ii) terminating insurance coverage;

(iii) not renewing insurance coverage; or

(iv) the charging of a higher rate for insurance coverage.

(b) (i) "Loss reporting agency" means any person who regularly engages, in whole or in part, in the business of assembling or collecting information for the primary purpose of providing the information to insurers or insurance producers for insurance transactions including assembling or collecting loss or claims information.

(ii) Notwithstanding Subsection (1)(b)(i), the following persons are not loss reporting agents:

(A) a governmental entity;
(B) an insurer;
(C) an insurance producer;
(D) an insurance consultant;
(E) a medical care institution or professional; or
(F) a peer review committee.
(iii) Notwithstanding Subsection (1)(b)(i), the following are not considered a report from a loss reporting agency:
(A) a report specifically provided for fraud prevention; and
(B) that portion of a report that includes information related to consumer credit behavior.
(iv) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may define by rule what constitutes:
(A) a report specifically provided for fraud prevention; and
(B) information related to consumer credit behavior.
(c) (i) "Score" means a numerical value, categorization, or classification that is:
(A) derived from a statistical tool, modeling system, or method; and
(B) developed to predict the likelihood of future insurance claims.
(ii) A numerical value, categorization, or classification described in Subsection (1)(c)(i) is a score if it is developed to predict the likelihood of future insurance claims regardless of whether it is developed to predict other factors in addition to predicting future insurance claims.
(2) (a) An insurer may not make an adverse eligibility or rate decision related to personal lines insurance in whole or in part on the basis of:
(i) a report by a loss reporting agency of a loss if the loss did not result in the insured requesting the payment of a claim;
(ii) a telephone call or other inquiry by an insured of a loss if the loss did not result in the insured requesting payment of a claim;
(iii) a loss that occurred when real property covered by the personal lines insurance was owned by a person other than the:
(A) insured; or
(B) person seeking insurance; or
(iv) a score if the score is determined in whole or in part on the basis of information described in Subsection (2)(a)(i), (ii), or (iii).
(b) Notwithstanding Subsection (2)(a), an insurer may:
(i) use the information described in Subsection (2)(a)(iii) to require a review of the condition of the premises; and
(ii) make an adverse eligibility or rate decision on the basis of the condition of the premises.
(3) (a) If an insurer uses a score that is derived from information obtained from a loss reporting agency or an insured, the insurer shall file with the department a certification that the method used to derive the score complies with the provisions of Subsection (2)(a)(iv).
(b) the insurer shall file a certification required under Subsection (3)(a) within 30 days of the day on which the score described in Subsection (3)(a) is first used by the insurer.

(c) The department shall classify a certification filed under this Subsection (3) as a protected record under Subsection 63G-2-305(2) except that the insurer is not required to file the information specified in Section 63G-2-309.

(d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall make rules providing for the form and procedure of filing the certification required by Subsection (3)(a).

Amended by Chapter 382, 2008 General Session

31A-22-1309. Return of unearned premium upon cancellation of errors and omissions insurance.

(1) As used in this section, "unearned premium" means the amount of the premium that is collected by the insurer in excess of premium earned as of the date of the cancellation of the errors and omissions insurance policy.

(2) For an errors and omissions policy issued on or after May 14, 2013:

(a) the policyholder may cancel the errors and omissions insurance policy before its expiration or renewal date according to the procedure for cancellation set forth in the errors and omissions policy; and

(b) an insurer may not issue an errors and omissions policy that has fully earned premium upon issuance of the errors and omissions policy.

(3) If the errors and omissions insurance policy is cancelled as provided in Subsection (2), the insurer shall refund the unearned premium to the policyholder minus any charge imposed by the insurer.

Enacted by Chapter 205, 2013 General Session

31A-22-1401. Application.

(1) The requirements of this part apply to individual policies and to group policies and certificates marketed in this state on or after July 1, 2001, other than employee and labor union group policies and certificates.

(2) Entities subject to this part shall comply with other applicable insurance laws and rules unless they are in conflict with this part.

(3) The laws, regulations, and rules designed and intended to apply to Medicare supplement insurance policies may not be applied to long-term care insurance.

(4) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this part.

Amended by Chapter 116, 2001 General Session

31A-22-1402. Definitions.

Unless the context requires otherwise, the following definitions apply in this part:

(1) "Applicant" means:

(a) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(b) in the case of a group long-term care insurance policy, the proposed certificate holder.

(2) Notwithstanding Section 31A-1-301,"certificate" means a certificate issued under a group long-term care insurance policy if the group long-term care insurance policy is delivered or issued for delivery in this state.

(3) Notwithstanding Section 31A-1-301, "policy" means a policy, contract subscriber agreement, rider, or endorsement, if the policy, contract subscriber agreement, rider, or endorsement is delivered or issued:

(a) in this state; and

(b) by:

(i) an insurer;

(ii) a fraternal benefit society;

(iii) a nonprofit health, hospital, or medical service corporation;

(iv) a prepaid health plan;

(v) a health maintenance organization; or

(vi) an entity similar to an entity described in Subsections (3)(b)(i) through (v).

Amended by Chapter 116, 2001 General Session

31A-22-1403. Filing required for policies issued in another state.

Group long-term care insurance coverage may not be offered to a resident of this state under a group policy issued in another state unless the policy and certificate have been filed with the commissioner.

Enacted by Chapter 243, 1991 General Session

31A-22-1404. Rulemaking authority.

The commissioner may adopt rules that may permit or include:

(1) the increase of benefits over time;

(2) standards for full and fair disclosure of the manner, content, and required disclosures for the sale of long-term care insurance policies;

(3) terms of renewability;

(4) initial and subsequent conditions of eligibility;

(5) nonduplication of coverage provisions;

(6) coverage of dependents;

(7) termination of coverage;

(8) continuation or conversion;

(9) probationary periods;

(10) limitations, exceptions, and reductions of coverage;

(11) preexisting conditions;

(12) elimination and waiting periods;

(13) requirements for replacement;

(14) recurrent conditions;

(15) definition of terms;

(16) loss ratio requirements;

(17) post claim underwriting;

(18) waiver of premium;

(19) inflation protection benefits; and

(20) premium rate filing and review.

Amended by Chapter 344, 1995 General Session

31A-22-1405. Restrictions on terms of coverage.

No long-term care insurance policy may:

(1) be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

Enacted by Chapter 243, 1991 General Session

31A-22-1406. Preexisting conditions.

(1) A long-term care insurance policy or certificate may not use a definition of a preexisting condition which is more restrictive than the following: "Preexisting condition means a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person."

(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The commissioner may extend the preexisting condition periods provided in Subsections (1) and (2) as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(4) (a) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and from underwriting in accordance with that insurer's established underwriting standards on the basis of the answers on that application.

(b) Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Subsection (2) expires.

(c) A long-term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical condition beyond the waiting period described in Subsection (2).

Amended by Chapter 297, 2011 General Session

31A-22-1407. Restricted conditional terms.

(1) A long-term care insurance policy may not contain a provision that conditions eligibility:

(a) for any benefits on a prior hospitalization requirement;

(b) for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) for any benefits on a prior institutionalization requirement except for eligibility for:

(i) waiver of premium;

(ii) post confinement;

(iii) post-acute care; or

(iv) recuperative benefits.

(2) A long-term care insurance policy containing post confinement, post-acute care, or recuperative benefits shall clearly label the limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy or certificate that is entitled "Limitations or Conditions on Eligibility for Benefits."

(3) A long-term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

Amended by Chapter 116, 2001 General Session

31A-22-1408. Right of return -- Notice.

Individual long-term care insurance policyholders and certificate holders other than employee and labor union certificate holders have the right to return the policy within 30 days of its delivery and to have the premium refunded if the policyholder is not satisfied for any reason after examination of the policy. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached to the policy stating in substance that the policyholder has the right to return the policy within 30 days of its delivery and to have the premium refunded if the policyholder is not satisfied for any reason after examination of the policy.

Enacted by Chapter 243, 1991 General Session

31A-22-1409. Statements of coverage.

(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the applicant to the document and its purpose.

(2) The commissioner may prescribe a standard format of an outline of coverage, including style, arrangement, and overall appearance, and the content.

(3) In the case of agent solicitations an agent shall deliver the outline of coverage prior to the presentation of any application or enrollment form.

(4) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(5) An outline of coverage under this section shall include:

(a) a description of the principal benefits and coverage provided in the policy;

(b) a statement of the principal exclusions, reductions, and limitations contained

in the policy;

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium;

(d) a specific description of continuation or conversion provisions of group coverage;

(e) a statement that the outline of coverage is not a contract of insurance but a summary only and that the policy or group master policy contains governing contractual provisions;

(f) a description of the terms under which the policy or certificate may be returned and premium refunded;

(g) a brief description of the relationship of cost of care and benefits; and

(h) a statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified, long-term care insurance contract under Section 7702B(b), Internal Revenue Code.

(6) A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(a) a description of the principal benefits and coverage provided in the policy;

(b) a statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) a statement that the group master policy determines governing contractual provisions; and

(d) a statement that any long-term care inflation protection option required by rule is not available under the policy.

(7) If an application for a long-term care contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

(8) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request. However, the insurer shall deliver the summary to the applicant no later than at the time of policy delivery regardless of request. In addition to complying with all applicable requirements, the summary shall also include:

(a) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) an illustration for each covered person of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any;

(c) any exclusions, reductions, and limitations on benefits of long-term care; and

(d) if applicable to the policy type, the summary shall also include:

(i) a disclosure of the effects of exercising other rights under the policy;

(ii) a disclosure of guarantees related to long-term care costs of insurance charges; and

(iii) current and projected maximum lifetime benefits.

(9) The provisions of the policy summary required under Subsection (8) may be incorporated into:

(a) a basic illustration; or
(b) the life insurance policy summary required to be delivered in accordance with rule.

Amended by Chapter 297, 2011 General Session

31A-22-1410. Report to policyholder.
A monthly report shall be provided to the policyholder any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status. The report shall include:
(1) any long-term care benefits paid out during the month;
(2) an explanation of any changes in the policy due to long-term care benefits being paid out such as death benefits or cash values; and
(3) the amount of long-term care benefits existing or remaining.

Enacted by Chapter 243, 1991 General Session

31A-22-1411. Incontestability period.
(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate upon a showing of misrepresentation that is material to the acceptance for coverage.
(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate upon a showing of misrepresentation that:
(a) is material to the acceptance for coverage; and
(b) pertains to the condition for which benefits are sought.

Enacted by Chapter 344, 1995 General Session

31A-22-1412. Nonforfeiture benefits.
(1) (a) A long-term care insurance policy or certificate may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit.
(b) The offer of a nonforfeiture benefit under Subsection (1)(a) may be in the form of a rider that is attached to the policy.
(c) If the policyholder or certificate holder declines the nonforfeiture benefit offered under this Subsection (1), the insurer shall provide a contingent benefit upon lapse of the policy or certificate that is available for a specified period of time following a substantial increase in premium rates.
(d) (i) Except as provided in Subsection (1)(d)(ii), if a group long-term care insurance policy is issued, the offer required in this Subsection (1) shall be made to the group policyholder.
(ii) If the policy is issued to a group authorized under Section 31A-22-509, the offer required under this Subsection (1) shall be made to each proposed certificate holder.
(2) The commissioner shall make rules:

(a) specifying the types of nonforfeiture benefits to be offered as part of a long-term care insurance policy or certificate;
(b) specifying the standards for nonforfeiture benefits; and
(c) regarding contingent benefits upon lapse, including a determination of:
(i) the specified period of time during which a contingent benefit upon lapse will be available as provided in Subsection (1); and
(ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as provided in Subsection (1).

Amended by Chapter 116, 2001 General Session

31A-22-1413. Claim information.

If a claim under a long-term care insurance contract is denied, within 60 days of the date a written request by the policyholder or a representative of a policyholder is filed with the insurer, the insurer shall:
(1) provide a written explanation of the reason for the denial; and
(2) make available all information directly related to the denial.

Enacted by Chapter 116, 2001 General Session

31A-22-1414. Marketing.

A policy or rider shall comply with this part if it is advertised, marketed, or offered as:
(1) long-term care insurance; or
(2) nursing home insurance.

Enacted by Chapter 116, 2001 General Session

31A-22-1501. Definitions.

As used in this part:
(1) "Motorboat" has the same meaning as defined under Section 73-18c-102.
(2) "Motorboat business" means a motorboat sales agency, repair shop, service station, storage garage, or public marina.
(3) "Operator" has the same meaning as under Section 73-18c-102.
(4) "Owner" has the same meaning as under Section 73-18c-102.
(5) "Rental company" means any person or organization in the business of providing motorboats to the public.
(6) "Renter" means any person or organization obtaining the use of a motorboat from a rental company under the terms of a rental agreement.

Amended by Chapter 211, 2006 General Session

31A-22-1502. Motorboat liability coverage.

(1) A liability insurance policy purchased to satisfy the owner's or operator's security requirement of Section 73-18c-301 shall:
(a) name the motorboat owner or operator in whose name the policy was

purchased, state that named insured's address, the coverage afforded, the premium charged, the policy period, and the limits of liability;

(b) (i) if it is an owner's policy:

(A) designate by appropriate reference each motorboat on which coverage is granted;

(B) insure the person named in the policy;

(C) insure any other person using any named motorboat with the express or implied permission of the named insured; and

(D) except as provided in Subsection (7), insure any person included in Subsection (1)(c) against loss from the liability imposed by law for damages arising out of the ownership, maintenance, or use of the named motorboat within the United States and Canada, subject to limits exclusive of interest and costs, for each motorboat, in amounts not less than the minimum limits specified under Section 31A-22-1503; or

(ii) if it is an operator's policy, insure the person named as insured against loss from the liability imposed upon him or her by law for damages arising out of the insured's use of any motorboat not owned by the insured, within the same territorial limits and with the same limits of liability as in an owner's policy under Subsection (1)(b)(i); and

(c) except as provided in Subsection (7), insure persons related to the named insured by blood, marriage, adoption, or guardianship who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere, to the same extent as the named insured.

(2) A liability insurance policy covering a motorboat may:

(a) provide for the prorating of the insurance under that policy with other valid and collectible insurance;

(b) grant any lawful coverage in addition to the required motorboat liability coverage;

(c) if the policy is issued to a person other than a motorboat business, limit the coverage afforded to a motorboat business or its officers, agents, or employees to the minimum limits under Section 31A-22-1503, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent; and

(d) if issued to a motorboat business, restrict coverage afforded to anyone other than the motorboat business or its officers, agents, or employees to the minimum limits under Section 31A-22-1503, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent.

(3) Motorboat liability coverage need not insure any liability:

(a) under any workers' compensation law under Title 34A, Utah Labor Code;

(b) resulting from bodily injury to or death of an employee of the named insured, other than a domestic employee, while engaged in the employment of the insured, or while engaged in the operation, maintenance, or repair of a designated motorboat; or

(c) resulting from damage to property owned by, rented to, bailed to, or transported by the insured.

(4) An insurance carrier providing motorboat liability coverage has the right to settle any claim covered by the policy, and if the settlement is made in good faith, the

amount of the settlement is deductible from the limits of liability specified under Section 31A-22-1503.

(5) A policy containing motorboat liability coverage imposes on the insurer the duty to defend, in good faith, any person insured under the policy against any claim or suit seeking damages which would be payable under the policy.

(6) (a) If a policy containing motorboat liability coverage provides an insurer with the defense of lack of cooperation on the part of the insured, that defense is not effective against a third person making a claim against the insurer, unless there was collusion between the third person and the insured.

(b) If the defense of lack of cooperation is not effective against the claimant, after payment, the insurer is subrogated to the injured person's claim against the insured to the extent of the payment and is entitled to reimbursement by the insured after the injured third person has been made whole with respect to the claim against the insured.

(7) A policy of motorboat liability coverage may specifically exclude from coverage a person who is a resident of the named insured's household, including a person who usually makes his or her home in the same household but temporarily lives elsewhere, if each person excluded from coverage satisfies the owner's or operator's security requirement of Section 73-18c-301, independently of the named insured's proof of owner's or operator's security.

Amended by Chapter 211, 2006 General Session

31A-22-1503. Motorboat liability policy minimum limits.

Policies containing motorboat liability coverage may not limit the insurer's liability under that coverage below the following:

(1) (a) $25,000 because of liability for bodily injury to or death of one person, arising out of the use of a motorboat in any one accident;

(b) subject to the limit for one person in Subsection (1)(a), in the amount of $50,000 because of liability for bodily injury to or death of two or more persons arising out of the use of a motorboat in any one accident; and

(c) in the amount of $15,000 because of liability for injury to, or destruction of, property of others arising out of the use of a motorboat in any one accident; or

(2) $65,000 in any one accident whether arising from bodily injury to or the death of others, or from destruction of, or damage to, the property of others.

Amended by Chapter 211, 2006 General Session

31A-22-1504. Mandatory coverage.

(1) A rental company shall provide its renters with primary coverage meeting the requirements of Title 73, Chapter 18c, Financial Responsibility of Motorboat Owners and Operators Act.

(2) All coverage shall include primary defense costs and may not be waived.

Amended by Chapter 211, 2006 General Session

31A-22-1601. Title.

This part is known as the "Genetic Testing Restrictions on Insurers Act."

Enacted by Chapter 120, 2002 General Session

31A-22-1602. Genetic testing restrictions.

Except as provided under Section 31A-22-620, with respect to a matter related to genetic testing and private genetic information, an insurer shall comply with the applicable provisions of Title 26, Chapter 45, Genetic Testing Privacy Act, including Section 26-45-104.

Amended by Chapter 349, 2009 General Session

31A-22-1701. Title -- Scope of part.

(1) This part is known as the "Property and Casualty Certificate of Insurance Act."

(2) (a) Except as provided in Subsection (2)(b), this part applies to a certificate of insurance issued on or after May 10, 2011, as evidence of insurance coverage on property, operations, or risks located in this state.

(b) This part applies on and after July 1, 2012, to a certificate of insurance that is issued as evidence of insurance coverage on property, operations, or risks located in this state if the certificate of insurance is an exhibit to a contract executed before July 1, 2012.

(c) This part applies, regardless of where located, to the following in relation to a certificate of insurance described in Subsection (2)(b):

(i) a certificate holder;

(ii) a policyholder;

(iii) an insurer; or

(iv) an insurance producer.

Enacted by Chapter 253, 2011 General Session

31A-22-1702. Definitions.

Notwithstanding Section 31A-1-301, as used in this part:

(1) "Certificate holder" means a person who:

(a) requests, obtains, or possesses a certificate of insurance; and

(b) is not a policyholder.

(2) "Certificate of insurance" means a document that is prepared for or issued to a person who is not a policyholder as evidence of insurance, regardless of how it is titled or described.

(3) "Insurer" means:

(a) an insurer as defined in Section 31A-1-301; and

(b) any other person engaged in the business of making insurance or a surety contract.

(4) "Person," in addition to the definition in Section 31A-1-301, includes:

(a) to the extent not prohibited by federal law:

(i) the federal government; or
(ii) an administrative unit of the federal government;
(b) the state;
(c) an administrative unit of the state;
(d) a political subdivision of the state; or
(e) an administrative unit of a political subdivision of the state.
(5) "Policyholder" means a person who contracts with a property and casualty insurer for insurance coverage.

Enacted by Chapter 253, 2011 General Session

31A-22-1703. Filing of form.
(1) Notwithstanding Section 31A-21-201, a person may not:
(a) prepare, issue, or request the issuance of a certificate of insurance unless the certificate of insurance form is filed with the commissioner; or
(b) modify a filed certificate of insurance form unless filed with the commissioner.
(2) The commissioner shall object to the use of, or prohibit the use of, a certificate of insurance form filed under this section if the certificate of insurance form:
(a) is unfair, misleading, or deceptive;
(b) violates public policy;
(c) fails to comply with Section 31A-22-1704; or
(d) violates any law, including a rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(3) A standard certificate of insurance form filed for use by a nationally recognized insurance rating organization that is licensed by the commissioner, is considered filed for use for purposes of this section or Section 31A-21-201.

Enacted by Chapter 253, 2011 General Session

31A-22-1704. Scope of certificate of insurance.
(1) A certificate of insurance is not an insurance policy and does not affirmatively or negatively amend, extend, or alter the coverage afforded by an insurance policy to which a certificate of insurance refers.
(2) A certificate of insurance may not confer to a certificate holder a right that is not provided by an insurance policy to which the certificate of insurance refers.
(3) (a) A certificate of insurance may not refer to a contract that is not an insurance policy, including a construction or service contract.
(b) Notwithstanding any requirement, term, or condition of a document with respect to which a certificate of insurance may be issued or may pertain, the insurance coverage afforded by a referenced insurance policy is subject to the terms, exclusions, and conditions of the insurance policy itself.

Enacted by Chapter 253, 2011 General Session

31A-22-1705. False or misleading practices.

(1) A person may not knowingly request or require the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains false or misleading information concerning an insurance policy to which the certificate of insurance refers.

(2) A person may not knowingly prepare or issue a certificate of insurance that:

(a) contains false or misleading information; or

(b) purports to affirmatively or negatively alter, amend, or extend the coverage provided by an insurance policy to which the certificate of insurance refers.

(3) (a) A person may not prepare, issue, or request an opinion letter or other document, either in addition to or in lieu of a certificate of insurance that is inconsistent with this part.

(b) An insurer or insurance producer may prepare or issue an addendum to a certificate of insurance that clarifies or explains the coverage provided by an insurance policy if the addendum complies with this part.

Enacted by Chapter 253, 2011 General Session

31A-22-1706. Notice of cancellation, nonrenewal, or material change.

(1) A certificate holder only has a right to a notice of cancellation, nonrenewal, a material change, or to a similar notice if the certificate holder has rights to the notice under the terms of the insurance policy to which the certificate of insurance refers, or under any rider, or endorsement to the insurance policy.

(2) The terms and conditions of a notice described in Subsection (1), including the required timing of the notice, is governed by the insurance policy. A certificate of insurance may not alter a term or condition of the notice.

Enacted by Chapter 253, 2011 General Session

31A-22-1707. Enforcement -- Rulemaking.

(1) A certificate of insurance or other document that is prepared, issued, or requested in violation of this part is void.

(2) The commissioner may bring action in accordance with Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act, for a violation of this part.

(3) The commissioner may:

(a) examine and investigate the activities of any person who the commissioner believes has been or is engaged in an act prohibited by this part;

(b) enforce this part; and

(c) impose a penalty or enforce a remedy authorized by this title for a violation of this part.

(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that are necessary and proper to carry out this part.

Enacted by Chapter 253, 2011 General Session

31A-22-1801. Title.

This part is known as the "Portable Electronics Insurance Act."

Enacted by Chapter 151, 2012 General Session

31A-22-1802. Definitions.

As used in this part:

(1) "Customer" means a person who purchases portable electronics.

(2) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(3) "Location" means a physical location in the state or a website, call center site, or similar location directed to residents of the state.

(4) "Portable electronics" means:

(a) an electronic device that is portable in nature; and

(b) an accessory or service related to the use of the portable electronic device.

(5) (a) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics that provides coverage for portable electronics against any one or more of the following:

(i) loss;

(ii) theft;

(iii) inoperability due to mechanical failure;

(iv) malfunction;

(v) damage; or

(vi) other similar cause of loss.

(b) "Portable electronics insurance" does not include:

(i) a manufacturer's or vendor's warranty;

(ii) a service contract;

(iii) a policy of insurance covering a vendor's or manufacturer's obligations under a warranty; or

(iv) a homeowner's, renter's, private passenger motor vehicle, commercial multi-peril, or similar policy.

(6) "Portable electronics transaction" means:

(a) the sale or lease of portable electronics by a vendor to a customer; or

(b) the sale by a vendor to a customer of an accessory or a service related to the use of portable electronics.

(7) "Service contract" means a contract or agreement for the repair or maintenance of goods or property, for their operational or structural failure due to a defect in materials, workmanship, or normal wear and tear, with or without additional provisions for incidental payment of indemnity under limited circumstances.

(8) "Supervising entity" mean a business entity that is:

(a) a licensed insurer; or

(b) an insurance producer that is appointed by an insurer to supervise the administration of a portable electronics insurance program.

(9) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(10) "Warranty" means a promise made solely by the manufacturer, importer, seller, or lessor of property or services without consideration, that is not negotiated or

separated from the sale of the product and is incidental to the sale of the product, that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor, or other remedial measures, such as repair or replacement of the property or repetition of services.

Enacted by Chapter 151, 2012 General Session

31A-22-1803. Licensure required.

(1) Subject to Subsection 31A-22-1804(2) and Section 31A-23a-103, a vendor is required to hold a portable electronics limited lines license to sell or offer coverage under a portable electronics insurance policy.

(2) A portable electronics limited lines license issued under this section authorizes an employee or authorized representative of the vendor to sell or offer coverage under a portable electronics insurance policy to a customer at each location at which the vendor who holds the limited lines license engages in portable electronics transactions.

(3) Notwithstanding any other provision of law, a limited lines license issued under this section authorizes the licensee and the licensee's employees or authorized representatives to engage in those activities that are permitted by this section.

(4) A supervising entity shall maintain a registry of vendor locations at which the vendor is authorized to sell or offer portable electronics insurance coverage in this state. Upon request by the commissioner and with three business days notice to the supervising entity, the supervising entity shall make the registry open to inspection and examination by the commissioner during regular business hours of the supervising entity.

Enacted by Chapter 151, 2012 General Session

31A-22-1804. Application for license and fees.

(1) To obtain or renew a portable electronics insurance limited lines license under this part, a person shall:

(a) file with the department an application for a portable electronics limited lines license on forms and in the manner the commissioner prescribes;

(b) subject to Subsection (4), provide the name and other information required by the commissioner for a licensed individual who is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this chapter; and

(c) pay a fee established by the department in accordance with Section 31A-3-103, except for an initial or renewal portable electronics limited lines license in no event may the fee exceed $100 per location in the state at which the vendor engages in portable electronics transactions.

(2) A vendor engaged in portable electronics insurance transactions before July 1, 2012, shall apply for licensure within 90 days of the application being made available by the department. An applicant commencing operations on or after July 1, 2012, shall obtain a portable electronics limited lines license before offering portable electronics insurance.

(3) A portable electronics limited lines license under this part has a term of two years and expires two years after issuance, unless renewed.

(4) If the vendor derives more than 50% of its revenue from the sale of portable electronics insurance, the applicant shall provide the information listed in Subsection (1)(b) for all officers, directors, and shareholders of record having beneficial ownership of 10% or more of any class of securities registered under the federal securities law.

Enacted by Chapter 151, 2012 General Session

31A-22-1805. Employees and authorized representatives of a vendor.

(1) An employee or authorized representative of a vendor may sell or offer portable electronics insurance to a customer and is not subject to licensure as an insurance producer under this title if:

(a) the vendor obtains a portable electronics limited lines license that authorizes the vendor's employee or authorized representative to sell or offer portable electronics insurance pursuant to this section;

(b) the insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the portable electronics insurance program, including development of a training program for each employee or authorized representative of the vendor that complies with the following:

(i) the training shall be delivered to an employee or authorized representative of a vendor who is directly engaged in the activity of selling or offering portable electronics insurance;

(ii) the training may be provided in electronic form if the supervising entity implements a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by a licensed employee of the supervising entity that holds a portable electronics limited lines producer license; and

(iii) each employee and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under Section 31A-22-1807; and

(c) an employee or authorized representative of a vendor of portable electronics may not advertise, represent, or otherwise hold the individual out as an insurance producer of any type.

(2) Notwithstanding any other provision of law, an employee or authorized representative of a vendor of portable electronics may not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage, but may receive compensation for activities under the limited lines license that are incidental to the employee's or authorized representative's overall compensation.

Enacted by Chapter 151, 2012 General Session

31A-22-1806. Penalties.

Notwithstanding Section 31A-2-308, if a vendor or the vendor's employee or authorized representative violate this part, the commissioner may do any of the

following in accordance with Title 63G, Chapter 4, Administrative Procedures Act:

(1) impose a fine not to exceed:

(a) (i) $2,500 per violation by a licensed individual; or

(ii) $5,000 per violation by an entity; or

(b) $40,000 in the aggregate for the conduct; or

(2) impose other penalties that the commissioner considers necessary and reasonable to carry out the purpose of this part, including:

(a) suspending or revoking the privilege of transacting portable electronics insurance pursuant to this part at a specific location where violations have occurred; and

(b) suspending or revoking the ability of individual employees or authorized representatives to act under the vendor's limited lines license.

Enacted by Chapter 151, 2012 General Session

31A-22-1807. Requirements for sale of portable electronics insurance -- Policy provides primary coverage.

(1) At each location where a vendor offers portable electronics insurance to a customer, the vendor shall make available to a prospective customer written materials that:

(a) disclose that portable electronics insurance may provide a duplication of coverage already provided by the customer's homeowner's insurance policy, renter's insurance policy, private passenger motor vehicle policy, or other source of coverage;

(b) state that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics;

(c) summarize the material terms of the portable electronics insurance coverage, including:

(i) the identity of the insurer;

(ii) the identity of the supervising entity;

(iii) the amount of any applicable deductible and how it is to be paid;

(iv) benefits of the coverage; and

(v) key terms and conditions of coverage, such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or non-original manufacturer parts or equipment;

(d) summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(e) state the cancellation rights under Subsection (2).

(2) An enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time, and the person paying the premium shall receive a refund or credit of any applicable unearned premium.

(3) Portable electronics insurance may be offered on a month to month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers. Notwithstanding any other provision of law to the contrary, forms for portable electronics insurance shall be filed with the commissioner in accordance with Section 31A-21-201, and rates for portable

electronics insurance shall be filed in accordance with Section 31A-19a-203.

(4) Eligibility and underwriting standards for customers electing to enroll in coverage shall be filed with the department for each portable electronics insurance program.

(5) A policy of portable electronics insurance shall provide primary coverage in the event of a covered loss under more than one policy.

Enacted by Chapter 151, 2012 General Session

31A-22-1808. Termination of or changes to portable electronics insurance.

Notwithstanding any other provision of law:

(1) (a) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 30 days notice.

(b) Notwithstanding Subsection (1)(a), an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 30 days notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the portable electronics insurance policy.

(c) Notwithstanding Subsection (1)(a), an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) for nonpayment of premium;

(ii) if the enrolled customer ceases to have an active service with the vendor of the portable electronics; or

(iii) subject to Subsection (2), if the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 days after exhaustion of the limit.

(2) If notice is not timely sent under Subsection (1)(c)(iii), enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(3) If an insurer changes the terms and conditions of a portable electronics insurance policy, the insurer shall provide:

(a) the vendor policyholder with a revised policy or endorsement; and

(b) each enrolled customer with:

(i) a revised certificate, endorsement, brochure, or other evidence indicating a change in the terms and conditions has occurred; and

(ii) a summary of material changes.

(4) When a vendor policyholder of a portable electronics insurance policy terminates the portable electronics insurance policy, the vendor policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the portable electronics insurance policy and the effective date of termination. The vendor shall mail or deliver the written notice to the enrolled customer at least 30 days before the termination.

(5) (a) When notice or correspondence with respect to coverage under a policy of portable electronics insurance is required under this section or is otherwise required by law, the notice or correspondence shall be in writing and be mailed or delivered to

the vendor at the vendor's mailing address and to its affected enrolled customers' last known mailing addresses on file with the insurer.

(b) If mailed, the insurer or vendor, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service.

(c) An insurer or vendor policyholder may comply with this Subsection (5) by providing notice or correspondence to a vendor or its affected enrolled customers, as the case may be, by electronic means. If accomplished through electronic means, the insurer or vendor, as the case may be, shall maintain proof that the notice or correspondence was sent. For purposes of this Subsection (5)(c) and Title 46, Chapter 4, Uniform Electronic Transactions Act, the provision of an electronic mail address to an insurer or vendor by an enrolled customer is considered consent to receive notice and correspondence by electronic means as long as a disclosure to the effect is provided to the customer.

(6) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor by the supervising entity appointed by the insurer.

Enacted by Chapter 151, 2012 General Session

31A-22-1809. Billing.

(1) A vendor may bill and collect the premium for portable electronics insurance coverage.

(2) (a) Any charge to an enrolled customer for portable electronics insurance coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill.

(b) If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services.

(3) A vendor who bills and collects the premium for the portable electronics insurance may not be required to maintain the money in a segregated account if the vendor is authorized by the insurer to hold the money in an alternative manner and remits the money to the supervising entity within 60 days of receipt. Money received by a vendor from an enrolled customer for the sale of portable electronics insurance is considered money held in trust by the vendor in a fiduciary capacity for the benefit of the insurer.

(4) A vendor may receive compensation for billing and collection services.

Enacted by Chapter 151, 2012 General Session

31A-22-1810. Applicability.

This part is not applicable to a loan or lease originated by a federally insured depository institution, or a subsidiary or affiliate of a federally insured depository institution, or originated by any other entity as part of a plan to sell or assign an interest

in the loan or lease to a federally insured depository institution, or a subsidiary or affiliate of a federally insured depository institution.

Enacted by Chapter 151, 2012 General Session

31A-23a-101. Purposes.

The purposes of this chapter include:

(1) promoting the professional competence of insurance producers, surplus lines producers, limited line producers, consultants, managing general agents, and reinsurance intermediaries;

(2) providing maximum freedom of marketing methods for insurance, consistent with the interests of the Utah public;

(3) preserving and encouraging competition at the consumer level;

(4) regulating insurance marketing practices in conformity with the general purposes of this title;

(5) governing the qualifications and procedures for the licensing of insurance producers, surplus lines producers, limited line producers, consultants, managing general agents, and reinsurance intermediaries; and

(6) promoting uniform licensing requirements between the several states.

Amended by Chapter 253, 2012 General Session

31A-23a-102. Definitions.

As used in this chapter:

(1) "Bail bond producer" is as defined in Section 31A-35-102.

(2) "Home state" means a state or territory of the United States or the District of Columbia in which an insurance producer:

(a) maintains the insurance producer's principal:

(i) place of residence; or

(ii) place of business; and

(b) is licensed to act as an insurance producer.

(3) "Insurer" is as defined in Section 31A-1-301, except that the following persons or similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:

(a) a risk retention group as defined in:

(i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;

(ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and

(iii) Chapter 15, Part 2, Risk Retention Groups Act;

(b) a residual market pool;

(c) a joint underwriting authority or association; and

(d) a captive insurer.

(4) "License" is defined in Section 31A-1-301.

(5) (a) "Managing general agent" means a person that:

(i) manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office;

(ii) acts as an agent for the insurer whether it is known as a managing general agent, manager, or other similar term;

(iii) produces and underwrites an amount of gross direct written premium equal to, or more than 5% of, the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year:

(A) with or without the authority;

(B) separately or together with an affiliate; and

(C) directly or indirectly; and

(iv) (A) adjusts or pays claims in excess of an amount determined by the commissioner; or

(B) negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding Subsection (5)(a), the following persons may not be considered as managing general agent for the purposes of this chapter:

(i) an employee of the insurer;

(ii) a United States manager of the United States branch of an alien insurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the insurance operations of the insurer;

(B) is under common control with the insurer;

(C) is subject to Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

(6) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning a substantive benefit, term, or condition of the contract if the person engaged in that act:

(a) sells insurance; or

(b) obtains insurance from insurers for purchasers.

(7) "Reinsurance intermediary" means:

(a) a reinsurance intermediary-broker; or

(b) a reinsurance intermediary-manager.

(8) "Reinsurance intermediary-broker" means a person other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

(9) (a) "Reinsurance intermediary-manager" means a person who:

(i) has authority to bind or who manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office; and

(ii) acts as an agent for the reinsurer whether the person is known as a reinsurance intermediary-manager, manager, or other similar term.

(b) Notwithstanding Subsection (9)(a), the following persons may not be considered reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:

(i) an employee of the reinsurer;

(ii) a United States manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager that, pursuant to contract:
(A) manages all the reinsurance operations of the reinsurer;
(B) is under common control with the reinsurer;
(C) is subject to Chapter 16, Insurance Holding Companies; and
(D) is not compensated based on the volume of premiums written; and
(iv) the manager of a group, association, pool, or organization of insurers that:
(A) engage in joint underwriting or joint reinsurance; and
(B) are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.
(10) "Search" means a license subline of authority in conjunction with the title insurance line of authority that allows a person to issue title insurance commitments or policies on behalf of a title insurer.
(11) "Sell" means to exchange a contract of insurance:
(a) by any means;
(b) for money or its equivalent; and
(c) on behalf of an insurance company.
(12) "Solicit" means:
(a) attempting to sell insurance;
(b) asking or urging a person to apply for:
(i) a particular kind of insurance; and
(ii) insurance from a particular insurance company;
(c) advertising insurance, including advertising for the purpose of obtaining leads for the sale of insurance; or
(d) holding oneself out as being in the insurance business.
(13) "Terminate" means:
(a) the cancellation of the relationship between:
(i) an individual licensee or agency licensee and a particular insurer; or
(ii) an individual licensee and a particular agency licensee; or
(b) the termination of:
(i) an individual licensee's or agency licensee's authority to transact insurance on behalf of a particular insurance company; or
(ii) an individual licensee's authority to transact insurance on behalf of a particular agency licensee.
(14) "Title marketing representative" means a person who:
(a) represents a title insurer in soliciting, requesting, or negotiating the placing of:
(i) title insurance; or
(ii) escrow services; and
(b) does not have a search or escrow license as provided in Section 31A-23a-106.
(15) "Uniform application" means the version of the National Association of Insurance Commissioners' uniform application for resident and nonresident producer licensing at the time the application is filed.
(16) "Uniform business entity application" means the version of the National Association of Insurance Commissioners' uniform business entity application for resident and nonresident business entities at the time the application is filed.

Amended by Chapter 319, 2013 General Session

31A-23a-103. Requirement of license.

(1) (a) Unless exempted from the licensing requirement under Section 31A-23a-201 or 31A-23a-207, a person may not perform, offer to perform, or advertise any service as a producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary in Utah, without a valid individual or agency license issued under this chapter.

(b) A valid license includes at least one license type and one line of authority pertaining to that license type.

(c) A person may not utilize the services of another as a producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary if that person knows or should know that the other does not have a license as required by law.

(2) This part may not be construed to require an insurer to obtain an insurance producer license.

(3) An insurance contract is not invalid as a result of a violation of this section.

Amended by Chapter 253, 2012 General Session

31A-23a-104. Application for individual license -- Application for agency license.

(1) This section applies to an initial or renewal license as a:

(a) producer;

(b) surplus lines producer;

(c) limited line producer;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an individual shall:

(i) file an application for an initial or renewal individual license with the commissioner on forms and in a manner the commissioner prescribes; and

(ii) pay a license fee that is not refunded if the application:

(A) is denied; or

(B) is incomplete when filed and is never completed by the applicant.

(b) An application described in this Subsection (2) shall provide:

(i) information about the applicant's identity;

(ii) the applicant's Social Security number;

(iii) the applicant's personal history, experience, education, and business record;

(iv) whether the applicant is 18 years of age or older;

(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111;

(vi) if the application is for a resident individual producer license, certification that the applicant complies with Section 31A-23a-203.5; and

(vii) any other information the commissioner reasonably requires.

(3) The commissioner may require a document reasonably necessary to verify the information contained in an application filed under this section.

(4) An applicant's Social Security number contained in an application filed under this section is a private record under Section 63G-2-302.

(5) (a) Subject to Subsection (5)(b), to obtain or renew an agency license, a person shall:

(i) file an application for an initial or renewal agency license with the commissioner on forms and in a manner the commissioner prescribes; and

(ii) pay a license fee that is not refunded if the application:

(A) is denied; or

(B) is incomplete when filed and is never completed by the applicant.

(b) An application described in Subsection (5)(a) shall provide:

(i) information about the applicant's identity;

(ii) the applicant's federal employer identification number;

(iii) the designated responsible licensed producer;

(iv) the identity of the owners, partners, officers, and directors;

(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and

(vi) any other information the commissioner reasonably requires.

Amended by Chapter 253, 2012 General Session

31A-23a-105. General requirements for individual and agency license issuance and renewal.

(1) (a) The commissioner shall issue or renew a license to a person described in Subsection (1)(b) to act as:

(i) a producer;

(ii) a surplus lines producer;

(iii) a limited line producer;

(iv) a consultant;

(v) a managing general agent; or

(vi) a reinsurance intermediary.

(b) The commissioner shall issue or renew a license under Subsection (1)(a) to a person who, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(i) satisfies the application requirements under Section 31A-23a-104;

(ii) satisfies the character requirements under Section 31A-23a-107;

(iii) satisfies any applicable continuing education requirements under Section 31A-23a-202;

(iv) satisfies any applicable examination requirements under Section 31A-23a-108;

(v) satisfies any applicable training period requirements under Section 31A-23a-203;

(vi) if an applicant for a resident individual producer license, certifies that, to the extent applicable, the applicant:

(A) is in compliance with Section 31A-23a-203.5; and

(B) will maintain compliance with Section 31A-23a-203.5 during the period for which the license is issued or renewed;

(vii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23a-111;

(viii) if a nonresident:

(A) complies with Section 31A-23a-109; and

(B) holds an active similar license in that person's state of residence;

(ix) if an applicant for an individual title insurance producer or agency title insurance producer license, satisfies the requirements of Section 31A-23a-204;

(x) if an applicant for a license to act as a life settlement provider or life settlement producer, satisfies the requirements of Section 31A-23a-117; and

(xi) pays the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for a pending:

(A) individual or agency producer license;

(B) surplus lines producer license;

(C) limited line producer license;

(D) consultant license;

(E) managing general agent license; or

(F) reinsurance intermediary license; or

(ii) a licensed:

(A) individual or agency producer;

(B) surplus lines producer;

(C) limited line producer;

(D) consultant;

(E) managing general agent; or

(F) reinsurance intermediary.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) an administrative action taken against the person, including a denial of a new or renewal license application:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) a criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person files the application for an individual or agency license; and

(B) for an action or prosecution that occurs on or after the day on which the person files the application:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution, within 30 days of the initial appearance before a court; and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

(3) (a) The department may require a person applying for a license or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license or consent.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23a-107 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-23a-107; and

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in the state.

(e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) To become a resident licensee in accordance with Section 31A-23a-104 and this section, a person licensed as one of the following in another state who moves to this state shall apply within 90 days of establishing legal residence in this state:

(a) insurance producer;

(b) surplus lines producer;

(c) limited line producer;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(5) (a) The commissioner may deny a license application for a license listed in Subsection (5)(b) if the person applying for the license, as to the license type and line of

authority classification applied for under Section 31A-23a-106:

(i) fails to satisfy the requirements as set forth in this section; or

(ii) commits an act that is grounds for denial, suspension, or revocation as set forth in Section 31A-23a-111.

(b) This Subsection (5) applies to the following licenses:

(i) producer;

(ii) surplus lines producer;

(iii) limited line producer;

(iv) consultant;

(v) managing general agent; or

(vi) reinsurance intermediary.

(6) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission; and

(b) renew a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission.

Amended by Chapter 319, 2013 General Session

31A-23a-106. License types.

(1) (a) A resident or nonresident license issued under this chapter shall be issued under the license types described under Subsection (2).

(b) A license type and a line of authority pertaining to a license type describe the type of licensee and the lines of business that a licensee may sell, solicit, or negotiate. A license type is intended to describe the matters to be considered under any education, examination, and training required of a license applicant under Sections 31A-23a-108, 31A-23a-202, and 31A-23a-203.

(2) (a) A producer license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the producer has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond;

(vi) title insurance under one or more of the following categories:

(A) search, including authority to act as a title marketing representative;

(B) escrow, including authority to act as a title marketing representative; and

(C) title marketing representative only; and

(vii) personal lines insurance.

(b) A surplus lines producer license type includes the following lines of authority:

(i) property insurance, if the person holds an underlying producer license with the property line of insurance; and

(ii) casualty insurance, if the person holds an underlying producer license with the casualty line of authority.

(c) A limited line producer license type includes the following limited lines of authority:

(i) limited line credit insurance;

(ii) travel insurance;

(iii) motor club insurance;

(iv) car rental related insurance;

(v) legal expense insurance;

(vi) crop insurance;

(vii) self-service storage insurance;

(viii) bail bond producer;

(ix) guaranteed asset protection waiver; and

(x) portable electronics insurance.

(d) A consultant license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the consultant has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(e) A managing general agent license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the managing general agent has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(f) A reinsurance intermediary license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the reinsurance intermediary has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(g) A person who holds a license under Subsection (2)(a) has the qualifications necessary to act as a holder of a license under Subsection (2)(c), except that the

person may not act under Subsection (2)(c)(viii) or (ix).

(3) (a) The commissioner may by rule recognize other producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary lines of authority as to kinds of insurance not listed under Subsections (2)(a) through (f).

(b) Notwithstanding Subsection (3)(a), for purposes of title insurance the Title and Escrow Commission may by rule, with the concurrence of the commissioner and subject to Section 31A-2-404, recognize other categories for an individual title insurance producer or agency title insurance producer line of authority not listed under Subsection (2)(a)(vi).

(4) The variable contracts line of authority requires:

(a) for a producer, licensure by the Financial Industry Regulatory Authority as a:

(i) registered broker-dealer; or

(ii) broker-dealer agent, with a current registration with a broker-dealer; and

(b) for a consultant, registration with the Securities and Exchange Commission or licensure by the Utah Division of Securities as an:

(i) investment adviser; or

(ii) investment adviser representative, with a current association with an investment adviser.

(5) A surplus lines producer is a producer who has a surplus lines license.

Amended by Chapter 319, 2013 General Session

31A-23a-107. Character requirements.

An applicant for a license under this chapter shall show to the commissioner that:

(1) the applicant has the intent in good faith, to engage in the type of business that the license applied for would permit;

(2) (a) if a natural person, the applicant is competent and trustworthy; or

(b) if the applicant is an agency:

(i) the partners, directors, or principal officers or persons having comparable powers are trustworthy; and

(ii) that it will transact business in such a way that the acts that may only be performed by a licensed producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary are performed exclusively by natural persons who are licensed under this chapter to transact that type of business and designated on the agency's license;

(3) the applicant intends to comply with Section 31A-23a-502; and

(4) if a natural person, the applicant is at least 18 years of age.

Amended by Chapter 253, 2012 General Session

31A-23a-108. Examination requirements.

(1) (a) The commissioner may require applicants for any particular license type under Section 31A-23a-106 to pass a line of authority examination as a requirement for a license, except that an examination may not be required of applicants for:

(i) licenses under Subsection 31A-23a-106(2)(c); or

(ii) other limited line license lines of authority recognized by the commissioner or the Title and Escrow Commission by rule as provided in Subsection 31A-23a-106(3).

(b) The examination described in Subsection (1)(a):

(i) shall reasonably relate to the line of authority for which it is prescribed; and

(ii) may be administered by the commissioner or as otherwise specified by rule.

(2) The commissioner shall waive the requirement of an examination for a nonresident applicant who:

(a) applies for an insurance producer license in this state;

(b) has been licensed for the same line of authority in another state; and

(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or

(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:

(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.

(3) A nonresident producer licensee who moves to this state and applies for a resident license within 90 days of establishing legal residence in this state shall be exempt from any line of authority examination that the producer was authorized on the producer's nonresident producer license, except where the commissioner determines otherwise by rule.

(4) This section's requirement may only be applied to applicants who are natural persons.

Amended by Chapter 253, 2012 General Session

31A-23a-109. Nonresident jurisdictional agreement.

(1) (a) If a nonresident license applicant has a valid producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license from the nonresident license applicant's home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive the license requirements for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed as a resident in the nonresident license applicant's home state at the time the nonresident license applicant applies for a nonresident producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted

to the applicant's home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103; and

(ii) the nonresident license applicant's license in the applicant's home state is in good standing.

(2) A nonresident applicant applying under Subsection (1) shall in addition to complying with all license requirements for a license under this chapter execute, in a form acceptable to the commissioner, an agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter related to the applicant's insurance activities in this state, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) service authorized:

(i) in the Utah Rules of Civil Procedure; or

(ii) under Section 78B-3-206.

(3) The commissioner may verify a producer's licensing status through the producer database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state solely on the fact that the person does not reside in this state.

Amended by Chapter 253, 2012 General Session

31A-23a-110. Form and contents of license.

(1) A license issued under this chapter shall be in the form the commissioner prescribes and shall set forth:

(a) the name and address of the licensee;

(b) the license types and lines of authority under Section 31A-23a-106;

(c) the date of license issuance; and

(d) any other information the commissioner considers necessary.

(2) A licensee under this chapter doing business under another name than the licensee's legal name shall notify the commissioner before using the assumed name in this state.

Amended by Chapter 345, 2008 General Session

31A-23a-111. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-23a-113; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) A line of authority issued under this chapter remains in force until:

(a) the qualifications pertaining to a line of authority are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5);

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(iii) lapses under Section 31A-23a-113; or

(iv) is voluntarily surrendered; or

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors.

(5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a line of authority;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a line of authority;

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license or line of authority under Section 31A-23a-104,

31A-23a-105, or 31A-23a-107;

(ii) violates:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance producer's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) violates an insurance law, valid rule, or valid order of another state's insurance department;

(xi) obtains or attempts to obtain a license through misrepresentation or fraud;

(xii) improperly withholds, misappropriates, or converts money or properties received in the course of doing insurance business;

(xiii) intentionally misrepresents the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) life settlement;

(xiv) is convicted of a felony;

(xv) admits or is found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere:

(A) uses fraudulent, coercive, or dishonest practices; or

(B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in another state, province, district, or territory;

(xviii) forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) improperly uses notes or another reference material to complete an

examination for an insurance license;

(xx) knowingly accepts insurance business from an individual who is not licensed;

(xxi) fails to comply with an administrative or court order imposing a child support obligation;

(xxii) fails to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) violates or permits others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is prohibited from engaging in the business of insurance; or

(xxiv) engages in a method or practice in the conduct of business that endangers the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;
(ii) deceit;
(iii) misrepresentation; or
(iv) a violation of an insurance law or rule.
(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.
(b) If no time is specified in an order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval by the commissioner.
(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.
(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Amended by Chapter 253, 2012 General Session

31A-23a-112. Probation -- Grounds for revocation.
(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:
(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-23a-111; or
(b) at the issuance of a new license:
(i) with an admitted violation under 18 U.S.C. Sections 1033 and 1034; or
(ii) with a response to background information questions on a new license application indicating that:
(A) the person has been convicted of a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;
(B) the person is currently charged with a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication is withheld;
(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or
(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.
(2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. Sections 1033 and 1034.
(3) The probation order shall state the conditions for retention of the license, which shall be reasonable.
(4) Any violation of the probation is grounds for revocation pursuant to any

proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 382, 2008 General Session

31A-23a-113. License lapse and voluntary surrender.

(1) (a) A license issued under this chapter shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) complete continuing education requirements under Section 31A-23a-202 before submitting the license renewal application;

(iii) submit a completed renewal application as required by Section 31A-23a-104;

(iv) submit additional documentation required to complete the licensing process as related to a specific license type or line of authority; or

(v) maintain an active license in a resident state if the licensee is a nonresident licensee.

(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) some other extenuating circumstances, such as long-term medical disability.

(ii) A licensee described in Subsection (1)(b)(i) may request:

(A) reinstatement of the license no later than one year after the day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103;

(III) continuing education requirements; or

(IV) other sanction imposed for failure to comply with renewal procedures.

(2) If a license issued under this chapter is voluntarily surrendered, the license or line of authority may be reinstated:

(a) during the license period in which the license is voluntarily surrendered; and

(b) no later than one year after the day on which the license is voluntarily surrendered.

(3) A voluntarily surrendered license that is reinstated during the license period set forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the license complies with any applicable continuing education requirements for the period during which the license was voluntarily surrendered.

Amended by Chapter 253, 2012 General Session

31A-23a-114. Temporary individual or agency license -- Trustee for terminated licensee's business.

(1) (a) The commissioner may issue a temporary individual or agency license:

(i) to a person listed in Subsection (1)(b):

(A) if the commissioner considers that the temporary license is necessary:
(I) for the servicing of an insurance business in the public interest; and
(II) to provide continued service to the insureds who procured insurance in a circumstance described in Subsection (1)(b);
(B) for a period not to exceed 180 days; and
(C) without requiring an examination; or
(ii) in any other circumstance:
(A) if the commissioner considers the public interest will best be served by issuing the temporary license;
(B) for a period not to exceed 180 days; and
(C) without requiring an examination.
(b) The commissioner may issue a temporary individual or agency license in accordance with Subsection (1)(a) to:
(i) the surviving spouse or court-appointed personal representative of a licensee who dies or acquires a mental or physical disability to allow adequate time for:
(A) the sale of the insurance business owned by the licensee;
(B) recovery or return of the licensee to the business; or
(C) the training and licensing of new personnel to operate the licensee's business;
(ii) to a member or employee of a business entity licensed as an agency upon the death or disability of an individual designated in:
(A) the business entity application; or
(B) the license; or
(iii) the designee of a licensed agency entering active service in the armed forces of the United States of America.
(2) If a person's license is terminated under Section 31A-23a-111 or 31A-23a-113, the commissioner may appoint a trustee to provide in the public interest continuing service to the insureds who procured insurance through the person whose license is terminated:
(a) at the request of the person whose license is terminated; or
(b) upon the commissioner's own initiative.
(3) This section does not apply if the deceased licensee or licensee with a disability does not or did not own any ownership interest in the accounts and associated expiration lists that were previously serviced by the licensee.
(4) (a) A person issued a temporary license under Subsection (1) receives the license and shall perform the duties under the license subject to the commissioner's authority to:
(i) require a temporary licensee to have a suitable sponsor who:
(A) is a licensee; and
(B) assumes responsibility for all acts of the temporary licensee; or
(ii) impose other requirements that are:
(A) designed to protect the insureds and the public; and
(B) similar to the condition described in Subsection (4)(a)(i).
(b) A trustee appointed under Subsection (2) shall be appointed and perform the trustee's duties subject to the terms and conditions described in Subsections (4)(b)(i) through (vi).

(i) (A) A trustee appointed under Subsection (2) shall be licensed under this chapter to perform the services required by the trustor's clients.

(B) When possible, the commissioner shall appoint a trustee who is no longer actively engaged on the trustee's own behalf in business as a licensee.

(C) The commissioner shall only select a person to act as trustee who is trustworthy and competent to perform the necessary services.

(ii) (A) If the deceased person, person with a disability, or unlicensed person for whom the trustee is acting was a producer, the insurers through which the former producer's business was written shall cooperate with the trustee in allowing the trustee to service the policies written through the insurer.

(B) The trustee shall abide by the terms of the agency agreement between the former producer and the issuing insurer, except that terms in those agreements terminating the agreement upon the death, disability, or license termination of the former producer do not bar the trustee from continuing to act under the agreement.

(iii) (A) The commissioner shall set the trustee's compensation, which:

(I) may be stated in terms of a percentage of commissions; and

(II) shall be equitable.

(B) The compensation shall be paid exclusively from:

(I) the commissions generated by the former licensee's insurance accounts serviced by the trustee; and

(II) other funds the former licensee or the licensee's successor in interest agree to pay.

(C) The trustee has no special priority to commissions over the former licensee's creditors.

(iv) (A) The commissioner or the state may not be held liable for errors or omissions of:

(I) the former licensee; or

(II) the trustee.

(B) The trustee may not be held liable for errors and omissions that were caused in any material way by the negligence of the former licensee.

(C) The trustee may be held liable for errors and omissions which arise solely from the trustee's negligence.

(D) The trustee's compensation level shall be sufficient to allow the trustee to purchase errors and omissions coverage, if that coverage is not provided the trustee by:

(I) the former licensee; or

(II) the licensee's successor in interest.

(v) (A) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients, either directly or indirectly.

(B) The trustee may not purchase the accounts or expiration lists of the former licensee, unless the commissioner expressly ratifies the terms of the sale.

(C) The commissioner may adopt rules that:

(I) further define the trustee's fiduciary duties; and

(II) explain how the trustee is to carry out the trustee's responsibilities.

(vi) (A) The trust may be terminated by:

(I) the commissioner; or

(II) the person that requested the trust be established.

(B) The trust is terminated by written notice being delivered to:
(I) the trustee; and
(II) the commissioner.
(5) (a) The commissioner may by order:
(i) limit the authority of any temporary licensee or trustee in any way the commissioner considers necessary to protect insureds and the public; and
(ii) revoke a temporary license or trustee's appointment if the commissioner finds that the insureds or the public are endangered.
(b) A temporary license or trustee's appointment may not continue after the owner or personal representative disposes of the business.

Amended by Chapter 366, 2011 General Session

31A-23a-115. Appointment of individual and agency insurance producer, limited line producer, or managing general agent -- Reports and lists.
(1) (a) An insurer shall appoint an individual or agency with whom it has a contract as an insurance producer, limited line producer, or managing general agent to act on the insurer's behalf in order for the licensee to do business for the insurer in this state.
(b) An insurer shall report to the commissioner, at intervals and in the form the commissioner establishes by rule:
(i) a new appointment; and
(ii) a termination of appointment.
(2) (a) (i) An insurer shall report to the commissioner the cause of termination of an appointment if:
(A) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b); or
(B) the insurer has knowledge that the individual or agency licensee is found to have engaged in an activity described in Subsection 31A-23a-111(5)(b) by:
(I) a court;
(II) a government body; or
(III) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(ii) The information provided to the commissioner under this Subsection (2) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.
(b) An insurer is immune from civil action, civil penalty, or damages if the insurer complies in good faith with this Subsection (2) in reporting to the commissioner the cause of termination of an appointment.
(c) Notwithstanding any other provision in this section, an insurer is not immune from any action or resulting penalty imposed on the reporting insurer as a result of proceedings brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection (2).
(3) If an insurer appoints an agency, the insurer need not appoint, report, or pay appointment reporting fees for an individual designated on the agency's license under Section 31A-23a-302.

(4) If an insurer lists a licensee in a report submitted under Subsection (2), there is a rebuttable presumption that in placing a risk with the insurer the appointed licensee or any of the licensee's licensed employees act on behalf of the insurer.

Amended by Chapter 349, 2009 General Session

31A-23a-115.5. Use of customer service representative.

A producer, surplus lines producer, or consultant who employs a customer service representative is responsible for the duties performed by the customer service representative. A customer service representative:

(1) may not maintain an office independent of the customer service representative's licensed producer, surplus lines producer, or consultant employer for the purpose of conducting insurance activities;

(2) except as provided in Subsection (3), may not sell, solicit, negotiate, or bind coverage; and

(3) may provide a customer a quote on behalf of the customer service representative's licensed producer, surplus lines producer, or consultant employer.

Amended by Chapter 253, 2012 General Session

31A-23a-116. Services performed for unauthorized insurers.

(1) A person licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, may not perform an act that assists a person not authorized as an insurer to act as an insurer.

(2) It is a violation of this section to assist a person purporting to be exempt from state insurance regulation under Section 514 of the Employee Retirement Income Security Act of 1974, unless that person submits to the commissioner a certificate from the United States Department of Labor, or other evidence satisfactory to the commissioner, showing that the laws of Utah are preempted under Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law.

(3) It is not a violation of this section:

(a) to assist a person engaged in self insurance as defined under Section 31A-1-301; or

(b) for a surplus lines producer to engage in the placement of insurance under Section 31A-15-103.

Amended by Chapter 345, 2008 General Session

31A-23a-117. Special requirements for life settlement providers and producers.

(1) A life settlement provider or life settlement producer shall be licensed in accordance with this title, with the additional requirements listed in this section.

(2) A life settlement provider shall provide to the commissioner:

(a) a detailed plan of operation with the life settlement provider's:

(i) initial license application; and

(ii) renewal application;

(b) a copy of the life settlement provider's most current audited financial statement;

(c) an antifraud plan that meets the requirements of Section 31A-36-117; and

(d) a bond or other form of assurance of financial responsibility as provided under rules made in accordance with Section 31A-36-119.

(3) A life settlement provider shall provide with the life settlement provider's initial license application information describing the life settlement provider's life settlement experience, training, and education.

(4) A life settlement provider shall provide to the commissioner, within 30 days after a change occurs, new or revised information concerning any of the following:

(a) officers;

(b) holders of more than 10% of its stock;

(c) partners;

(d) directors;

(e) members; and

(f) designated employees.

Amended by Chapter 355, 2009 General Session

31A-23a-118. Car rental related licensing requirements.

(1) Subject to Section 31A-23a-103, a person is required to hold a limited line producer license with a car rental related insurance limited line of authority to sell or offer car rental related insurance coverage under a car rental related insurance policy.

(2) A car rental related insurance limited line license issued pursuant to Sections 31A-23a-103 and 31A-23a-106 authorizes an employee or authorized representative of the licensee to sell or offer coverage under a car rental related insurance policy to a customer at each location at which the licensee engages in car rental related insurance transactions.

(3) An agency holding a car rental related insurance limited line license shall:

(a) be appointed by an insurer underwriting a car rental related insurance policy that the agency sells or offers; and

(b) have a designated responsible licensed individual at each location at which the agency is soliciting, selling, or offering car rental related insurance.

(4) An agency holding a car rental related insurance limited line license may employ a nonlicensed individual employed as a counter sales representative in soliciting, selling, or offering car rental related insurance. The nonlicensed individual shall be:

(a) trained and supervised in the sale of car rental related insurance products; and

(b) responsible to a licensed individual designated by the agency at each location where a car rental related insurance product is sold.

Enacted by Chapter 319, 2013 General Session

31A-23a-201. Exceptions to producer licensing.

(1) The commissioner may not require a license as an insurance producer of:

(a) an officer, director, or employee of an insurer or of an insurance producer if:
(i) the officer, director, or employee does not receive any commission on a policy written or sold to insure risks residing, located, or to be performed in this state; and
(ii) (A) the officer's, director's, or employee's activities are:
(I) executive, administrative, managerial, clerical, or a combination of these activities; and
(II) only indirectly related to the sale, solicitation, or negotiation of insurance;
(B) the officer's, director's, or employee's function relates to:
(I) underwriting;
(II) loss control;
(III) inspection; or
(IV) the processing, adjusting, investigating or settling of a claim on a contract of insurance; or
(C) (I) the officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting an insurance producer;
(II) the officer's, director's, or employee's activities are limited to providing technical advice and assistance to a licensed insurance producer; and
(III) the officer's, director's, or employee's activities do not include the sale, solicitation, or negotiation of insurance;
(b) a person who:
(i) is paid no commission for the services described in Subsection (1)(b)(ii); and
(ii) secures and furnishes information for the purpose of:
(A) group life insurance;
(B) group property and casualty insurance;
(C) group annuities;
(D) group or blanket accident and health insurance;
(E) enrolling individuals under plans;
(F) issuing certificates under plans; or
(G) otherwise assisting in administering plans;
(c) a person who:
(i) is paid no commission for the services described in Subsection (1)(c)(ii); and
(ii) performs administrative services related to mass marketed property and casualty insurance;
(d) (i) any of the following if the conditions of Subsection (1)(d)(ii) are met:
(A) an employer or association; or
(B) an officer, director, employee, or trustee of an employee trust plan;
(ii) a person listed in Subsection (1)(d)(i):
(A) to the extent that the employer, officer, employee, director, or trustee is engaged in the administration or operation of a program of employee benefits for:
(I) the employer's or association's own employees; or
(II) the employees of a subsidiary or affiliate of an employer or association;
(B) the program involves the use of insurance issued by an insurer; and
(C) the employer, association, officer, director, employee, or trustee is not in any manner compensated, directly or indirectly, by the company issuing the contract;
(e) an employee of an insurer or organization employed by an insurer who:

(i) is engaging in:
(A) the inspection, rating, or classification of risks; or
(B) the supervision of the training of insurance producers; and
(ii) is not individually engaged in the sale, solicitation, or negotiation of insurance;
(f) a person whose activities in this state are limited to advertising:
(i) without the intent to solicit insurance in this state;
(ii) through communications in mass media including:
(A) a printed publication; or
(B) a form of electronic mass media;
(iii) that is distributed to residents outside of the state; and
(iv) if the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;
(g) a person who:
(i) is not a resident of this state;
(ii) sells, solicits, or negotiates a contract of insurance:
(A) for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; and
(B) insures risks located in a state in which the person is licensed as provided in Subsection (1)(g)(iii); and
(iii) is licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business; or
(h) if the employee does not sell, solicit, or receive a commission for a contract of insurance, a salaried full-time employee who counsels or advises the employee's employer relating to the insurance interests of:
(i) the employer; or
(ii) a subsidiary or business affiliate of the employer.
(2) The commissioner may by rule exempt a class of persons from the license requirement of Subsection 31A-23a-103(1) if:
(a) the functions performed by the class of persons does not require:
(i) special competence;
(ii) special trustworthiness; or
(iii) regulatory surveillance made possible by licensing; or
(b) other existing safeguards make regulation unnecessary.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-202. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe the continuing education requirements for a producer and a consultant.
(2) (a) The commissioner may not state a continuing education requirement in terms of formal education.
(b) The commissioner may state a continuing education requirement in terms of hours of insurance-related instruction received.
(c) Insurance-related formal education may be a substitute, in whole or in part, for the hours required under Subsection (2)(b).

(3) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (3).

(b) (i) Except as provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

(ii) An hour of continuing education in accordance with Subsection (3)(b)(i) may be obtained through:

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) another method provided by rule.

(iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), an individual title insurance producer is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses unless the individual title insurance producer is licensed in this state as an individual title insurance producer for 20 or more consecutive years.

(B) If an individual title insurance producer is licensed in this state as an individual title insurance producer for 20 or more consecutive years, the individual title insurance producer is required to complete 6 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), an individual title insurance producer is considered to have met the continuing education requirements imposed under Subsection (3)(b)(iii)(A) or (B) if the individual title insurance producer:

(I) is an active member in good standing with the Utah State Bar;

(II) is in compliance with the continuing education requirements of the Utah State Bar; and

(III) if requested by the department, provides the department evidence that the individual title insurance producer complied with the continuing education requirements of the Utah State Bar.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d) (i) A licensee is exempt from continuing education requirements under this section if:

(A) the licensee was first licensed before April 1, 1978;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

(C) the licensee requests an exemption from the department; and

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b);

(ii) authorize a continuing education provider or a state or national professional producer or consultant association to:

(A) offer a qualified program for a license type or line of authority on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner; and

(iii) provide that membership by a producer or consultant in a state or national professional producer or consultant association is considered a substitute for the equivalent of two hours for each year during which the producer or consultant is a member of the professional association, except that the commissioner may not give more than two hours of continuing education credit in a year regardless of the number of professional associations of which the producer or consultant is a member.

(f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a professional producer or consultant association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(4) The commissioner shall approve a continuing education provider or continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule set the processes and procedures for continuing education provider registration and course approval.

(6) The requirements of this section apply only to a producer or consultant who is an individual.

(7) A nonresident producer or consultant is considered to have satisfied this state's continuing education requirements if the nonresident producer or consultant satisfies the nonresident producer's or consultant's home state's continuing education requirements for a licensed insurance producer or consultant.

(8) A producer or consultant subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Amended by Chapter 319, 2013 General Session

31A-23a-203. Training period requirements.

(1) A producer is eligible to become a surplus lines producer only if the producer:

(a) has passed the applicable surplus lines producer examination;

(b) has been a producer with property and casualty lines of authority for at least three years during the four years immediately preceding the date of application; and

(c) has paid the applicable fee under Section 31A-3-103.

(2) A person is eligible to become a consultant only if the person has acted in a capacity that would provide the person with preparation to act as an insurance consultant for a period aggregating not less than three years during the four years immediately preceding the date of application.

(3) (a) A resident producer with an accident and health line of authority may only sell long-term care insurance if the producer:

(i) initially completes a minimum of three hours of long-term care training before selling long-term care coverage; and

(ii) after completing the training required by Subsection (3)(a)(i), completes a minimum of three hours of long-term care training during each subsequent two-year licensing period.

(b) A course taken to satisfy a long-term care training requirement may be used toward satisfying a producer continuing education requirement.

(c) Long-term care training is not a continuing education requirement to renew a producer license.

(d) An insurer that issues long-term care insurance shall demonstrate to the commissioner, upon request, that a producer who is appointed by the insurer and who sells long-term care insurance coverage is in compliance with this Subsection (3).

(4) The training periods required under this section apply only to an individual applying for a license under this chapter.

Amended by Chapter 253, 2012 General Session

31A-23a-203.5. Errors and omissions coverage requirements.

(1) In accordance with this section, a resident individual producer shall ensure that the resident individual producer is covered:

(a) for the legal liability of the resident individual producer as the result of an erroneous act or failure to act in the resident individual producer's capacity as a producer; and

(b) at all times during the term of the resident individual producer's license.

(2) The coverage required by Subsection (1) shall consist of:

(a) a policy naming the resident individual producer;

(b) a policy naming the agency that designates the resident individual producer in accordance with this chapter; or

(c) a written agreement by an insurer or group of affiliated insurers, on behalf of a resident individual producer who is or will become an exclusive agent of the insurer or group of affiliated insurers, under which the insurer or group of affiliated insurers agrees to assume responsibility, to the benefit of an aggrieved person, for legal liability of the resident individual producer as the result of an erroneous act or failure to act in the resident individual producer's capacity as a producer for the insurer or group of affiliated insurers.

(3) The commissioner may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide for:

(a) the terms and conditions of the coverage required under Subsection (1); and

(b) if the coverage required by Subsection (1) is terminated during a resident

individual producer's license term, requirements to:

(i) provide notice; and

(ii) replace the coverage.

(4) An individual title insurance producer is considered to be in compliance with this section when:

(a) the individual title insurance producer is not designated by an agency title producer and maintains the individual title insurance producer's own bond, policy, or other financial protection in accordance with Subsection 31A-23a-204(2); or

(b) the individual title insurance producer is designated by an agency title insurance producer that maintains a bond, policy, or other financial protection in accordance with Subsection 31A-23a-204(2).

(5) Notwithstanding the other provisions of this section, a resident individual producer is exempt from the requirement to maintain coverage as provided in this section during a period in which the resident individual producer is not either:

(a) appointed by an insurer under this title; or

(b) designated by an agency under this title.

(6) A limited lines producer is exempt from this section.

Amended by Chapter 319, 2013 General Session

31A-23a-204. Special requirements for title insurance producers and agencies.

An individual title insurance producer or agency title insurance producer shall be licensed in accordance with this chapter, with the additional requirements listed in this section.

(1) (a) A person that receives a new license under this title as an agency title insurance producer shall at the time of licensure be owned or managed by at least one individual who is licensed for at least three of the five years immediately preceding the date on which the agency title insurance producer applies for a license with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

(b) An agency title insurance producer subject to Subsection (1)(a) may comply with Subsection (1)(a) by having the agency title insurance producer owned or managed by:

(i) one or more individuals who are licensed with the search line of authority for the time period provided in Subsection (1)(a); and

(ii) one or more individuals who are licensed with the escrow line of authority for the time period provided in Subsection (1)(a).

(c) A person licensed as an agency title insurance producer shall at all times during the term of licensure be owned or managed by at least one individual who is licensed for at least three years within the preceding five-year period with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

(d) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt an attorney with real estate experience from the experience requirements in Subsection (1)(a).

(e) An individual who satisfies the requirements of this Subsection (1) is known as a "qualifying licensee." At any given time, an individual may be a qualifying licensee for not more than two agency title insurance producers.

(2) (a) An individual title insurance producer or agency title insurance producer appointed by an insurer shall maintain:

(i) a fidelity bond;

(ii) a professional liability insurance policy; or

(iii) a financial protection:

(A) equivalent to that described in Subsection (2)(a)(i) or (ii); and

(B) that the commissioner considers adequate.

(b) The bond, insurance, or financial protection required by this Subsection (2):

(i) shall be supplied under a contract approved by the commissioner to provide protection against the improper performance of any service in conjunction with the issuance of a contract or policy of title insurance; and

(ii) be in a face amount no less than $50,000.

(c) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt individual title insurance producer or agency title insurance producers from the requirements of this Subsection (2) upon a finding that, and only so long as, the required policy or bond is generally unavailable at reasonable rates.

(3) An individual title insurance producer or agency title insurance producer appointed by an insurer may maintain a reserve fund to the extent money was deposited before July 1, 2008, and not withdrawn to the income of the individual title insurance producer or agency title insurance producer.

(4) An examination for licensure shall include questions regarding the search and examination of title to real property.

(5) An individual title insurance producer may not perform the functions of escrow unless the individual title insurance producer has been examined on the fiduciary duties and procedures involved in those functions.

(6) The Title and Escrow Commission may adopt rules, subject to Section 31A-2-404, after consulting with the commissioner and the commissioner's test administrator, establishing an examination for a license that will satisfy this section.

(7) A license may be issued to an individual title insurance producer or agency title insurance producer who has qualified:

(a) to perform only searches and examinations of title as specified in Subsection (4);

(b) to handle only escrow arrangements as specified in Subsection (5); or

(c) to act as a title marketing representative.

(8) (a) A person licensed to practice law in Utah is exempt from the requirements of Subsections (2) and (3) if that person issues 12 or less policies in any 12-month period.

(b) In determining the number of policies issued by a person licensed to practice law in Utah for purposes of Subsection (8)(a), if the person licensed to practice law in Utah issues a policy to more than one party to the same closing, the person is considered to have issued only one policy.

(9) A person licensed to practice law in Utah, whether exempt under Subsection (8) or not, shall maintain a trust account separate from a law firm trust account for all

title and real estate escrow transactions.

Amended by Chapter 319, 2013 General Session

31A-23a-205. Special requirements for bail bond producers and bail bond enforcement agents.

(1) As used in this section, "bail bond producer" and "bail enforcement agent" have the same definitions as in Section 31A-35-102.

(2) A bail bond producer may not operate in this state without an appointment from one or more authorized bail bond surety insurers or licensed bail bond surety companies.

(3) A bail bond enforcement agent may not operate in this state without an appointment from one or more licensed bail bond producers.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-206. Special requirements for variable contracts line of authority.

(1) Before applying for a variable contracts line of authority:

(a) a producer shall be licensed under Section 61-1-3 as a:

(i) broker-dealer; or

(ii) broker-dealer agent; and

(b) a consultant shall be licensed under Section 61-1-3 as an:

(i) investment adviser; or

(ii) investment adviser representative.

(2) A producer's or consultant's variable contracts line of authority is revoked on the day the producer's or consultant's securities related license under Section 61-1-3 is no longer valid.

Amended by Chapter 253, 2012 General Session

31A-23a-207. Registration of motor club agents.

(1) Subsection 31A-23a-103(1) does not apply to persons who sell no insurance products other than motor club service contracts, if those contracts provide only for those services described in Subsections 31A-11-102(1)(b) through (1)(f), and personal accident insurance provided automatically with the purchase of the motor club contract.

(2) Section 31A-11-110 applies to those persons in Subsection (1).

(3) Subsection 31A-23a-103(1) applies to persons selling motor club contracts providing services in addition to those described under Subsections 31A-11-102(1)(b) through (1)(f).

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-208. Producer and agency authority in health insurance exchange.

A producer or agency licensed under this chapter, with a line of authority that permits the producer or agency to sell, negotiate, or solicit accident and health

insurance, is authorized to sell, negotiate, or solicit qualified health plans offered on an exchange that is:

(1) operated in the state; or

(2) operated in the state and certified by the United States Department of Health and Human Services as a:

(a) state-based exchange under PPACA;

(b) a federally facilitated exchange under PPACA; or

(c) a partnership exchange under PPACA.

Enacted by Chapter 341, 2013 General Session

31A-23a-301. Agency license.

An insurance organization shall be licensed as an agency if the insurance organization acts as:

(1) a producer;

(2) a surplus lines producer;

(3) a limited line producer;

(4) a consultant;

(5) a managing general agent; or

(6) a reinsurance intermediary.

Amended by Chapter 253, 2012 General Session

31A-23a-302. Agency designations.

(1) An agency shall designate an individual that has an individual producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license to act on the agency's behalf in order for the licensee to do business for the agency in this state.

(2) An agency shall report to the commissioner, at intervals and in the form the commissioner establishes by rule:

(a) a new designation; and

(b) a terminated designation.

(3) (a) An agency licensed under this chapter shall report to the commissioner the cause of termination of a designation if:

(i) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b); or

(ii) the agency has knowledge that the individual licensee is found to have engaged in an activity described in Subsection 31A-23a-111(5)(b) by:

(A) a court;

(B) a government body; or

(C) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The information provided the commissioner under Subsection (3)(a) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(c) An agency is immune from civil action, civil penalty, or damages if the

agency complies in good faith with this Subsection (3) in reporting to the commissioner the cause of termination of a designation.

(d) Notwithstanding any other provision in this section, an agency is not immune from an action or resulting penalty imposed on the reporting agency as a result of proceedings brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection (3).

(4) An agency licensed under this chapter may act in a capacity for which it is licensed only through an individual who is licensed under this chapter to act in the same capacity.

(5) An agency licensed under this chapter shall designate and report to the commissioner in accordance with any rule made by the commissioner the name of the designated responsible licensed individual who has authority to act on behalf of the agency in the matters pertaining to compliance with this title and orders of the commissioner.

(6) If an agency designates a licensee in reports submitted under Subsection (2) or (5), there is a rebuttable presumption that the designated licensee acts on behalf of the agency.

(7) (a) When a license is held by an agency, both the agency itself and any individual designated under the agency license shall be considered to be the holder of the agency license for purposes of this section.

(b) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the agency license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (7)(b)(ii).

Amended by Chapter 253, 2012 General Session

31A-23a-401. Disclosure of conflicting interests.

(1) (a) Except as provided under Subsection (1)(b):

(i) a licensee under this chapter may not act in the same or any directly related transaction as:

(A) a producer for the insured or consultant; and

(B) producer for the insurer; and

(ii) a producer for the insured or consultant may not recommend or encourage the purchase of insurance from or through an insurer or other producer:

(A) of which the producer for the insured or consultant or producer for the insured's or consultant's spouse is an owner, executive, or employee; or

(B) to which the producer for the insured or consultant has the type of relation that a material benefit would accrue to the producer for the insured or consultant or spouse as a result of the purchase.

(b) Subsection (1)(a) does not apply if the following three conditions are met:

(i) Prior to performing the consulting services, the producer for the insured or consultant shall disclose to the client, prominently, in writing:

(A) the producer for the insured's or consultant's interest as a producer for the insurer, or the relationship to an insurer or other producer; and

(B) that as a result of those interests, the producer for the insured's or the consultant's recommendations should be given appropriate scrutiny.

(ii) The producer for the insured's or consultant's fee shall be agreed upon, in writing, after the disclosure required under Subsection (1)(b)(i), but before performing the requested services.

(iii) Any report resulting from requested services shall contain a copy of the disclosure made under Subsection (1)(b)(i).

(2) A licensee under this chapter may not act as to the same client as both a producer for the insurer and a producer for the insured without the client's prior written consent based on full disclosure.

(3) Whenever a person applies for insurance coverage through a producer for the insured, the producer for the insured shall disclose to the applicant, in writing, that the producer for the insured is not the producer for the insurer or the potential insurer. This disclosure shall also inform the applicant that the applicant likely does not have the benefit of an insurer being financially responsible for the conduct of the producer for the insured.

(4) If a licensee is subject to both this section and Subsection 31A-23a-501(4), the licensee shall provide the disclosure required under each statute.

Amended by Chapter 12, 2009 General Session

31A-23a-402. Unfair marketing practices -- Communication -- Unfair discrimination -- Coercion or intimidation -- Restriction on choice.

(1) (a) (i) Any of the following may not make or cause to be made any communication that contains false or misleading information, relating to an insurance product or contract, any insurer, or any licensee under this title, including information that is false or misleading because it is incomplete:

(A) a person who is or should be licensed under this title;

(B) an employee or producer of a person described in Subsection (1)(a)(i)(A);

(C) a person whose primary interest is as a competitor of a person licensed under this title; and

(D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

(ii) As used in this Subsection (1), "false or misleading information" includes:

(A) assuring the nonobligatory payment of future dividends or refunds of unused premiums in any specific or approximate amounts, but reporting fully and accurately past experience is not false or misleading information; and

(B) with intent to deceive a person examining it:

(I) filing a report;

(II) making a false entry in a record; or

(III) wilfully refraining from making a proper entry in a record.

(iii) A licensee under this title may not:

(A) use any business name, slogan, emblem, or related device that is misleading or likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee already in business; or

(B) use any advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency, including the Health Insurance Exchange, also called the "Utah Health Exchange," created in Section 63M-1-2504, the Comprehensive Health Insurance Pool created in Chapter 29, Comprehensive Health Insurance Pool Act, and the Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's Health Insurance Act:

(I) is responsible for the insurance sales activities of the person;

(II) stands behind the credit of the person;

(III) guarantees any returns on insurance products of or sold by the person; or

(IV) is a source of payment of any insurance obligation of or sold by the person.

(iv) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that person is an insurer.

(v) A person other than persons licensed as health maintenance organizations under Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to itself.

(b) A licensee's violation creates a rebuttable presumption that the violation was also committed by the insurer if:

(i) the licensee under this title distributes cards or documents, exhibits a sign, or publishes an advertisement that violates Subsection (1)(a), with reference to a particular insurer:

(A) that the licensee represents; or

(B) for whom the licensee processes claims; and

(ii) the cards, documents, signs, or advertisements are supplied or approved by that insurer.

(2) (a) A title insurer, individual title insurance producer, or agency title insurance producer or any officer or employee of the title insurer, individual title insurance producer, or agency title insurance producer may not pay, allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title insurance business:

(i) any rebate, reduction, or abatement of any rate or charge made incident to the issuance of the title insurance;

(ii) any special favor or advantage not generally available to others;

(iii) any money or other consideration, except if approved under Section 31A-2-405; or

(iv) material inducement.

(b) "Charge made incident to the issuance of the title insurance" includes escrow charges, and any other services that are prescribed in rule by the Title and Escrow Commission after consultation with the commissioner and subject to Section 31A-2-404.

(c) An insured or any other person connected, directly or indirectly, with the transaction may not knowingly receive or accept, directly or indirectly, any benefit referred to in Subsection (2)(a), including:

(i) a person licensed under Title 61, Chapter 2c, Utah Residential Mortgage Practices and Licensing Act;

(ii) a person licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act;

(iii) a builder;

(iv) an attorney; or

(v) an officer, employee, or agent of a person listed in this Subsection (2)(c)(iii).

(3) (a) An insurer may not unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage, except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved.

(b) Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly discriminatory merely because they are more favorable than in similar individual policies.

(4) (a) This Subsection (4) applies to:

(i) a person who is or should be licensed under this title;

(ii) an employee of that licensee or person who should be licensed;

(iii) a person whose primary interest is as a competitor of a person licensed under this title; and

(iv) one acting on behalf of any person described in Subsections (4)(a)(i) through (iii).

(b) A person described in Subsection (4)(a) may not commit or enter into any agreement to participate in any act of boycott, coercion, or intimidation that:

(i) tends to produce:

(A) an unreasonable restraint of the business of insurance; or

(B) a monopoly in that business; or

(ii) results in an applicant purchasing or replacing an insurance contract.

(5) (a) (i) Subject to Subsection (5)(a)(ii), a person may not restrict in the choice of an insurer or licensee under this chapter, another person who is required to pay for insurance as a condition for the conclusion of a contract or other transaction or for the exercise of any right under a contract.

(ii) A person requiring coverage may reserve the right to disapprove the insurer or the coverage selected on reasonable grounds.

(b) The form of corporate organization of an insurer authorized to do business in this state is not a reasonable ground for disapproval, and the commissioner may by rule specify additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an application for insurance.

(6) A person may not make any charge other than insurance premiums and premium financing charges for the protection of property or of a security interest in property, as a condition for obtaining, renewing, or continuing the financing of a purchase of the property or the lending of money on the security of an interest in the property.

(7) (a) A licensee under this title may not refuse or fail to return promptly all indicia of agency to the principal on demand.

(b) A licensee whose license is suspended, limited, or revoked under Section

31A-2-308, 31A-23a-111, or 31A-23a-112 may not refuse or fail to return the license to the commissioner on demand.

(8) (a) A person may not engage in an unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that the method of competition, the act, or the practice:

(i) is misleading;

(ii) is deceptive;

(iii) is unfairly discriminatory;

(iv) provides an unfair inducement; or

(v) unreasonably restrains competition.

(b) Notwithstanding Subsection (8)(a), for purpose of the title insurance industry, the Title and Escrow Commission shall make rules, subject to Section 31A-2-404, that define an unfair method of competition or unfair or deceptive act or practice after a finding that the method of competition, the act, or the practice:

(i) is misleading;

(ii) is deceptive;

(iii) is unfairly discriminatory;

(iv) provides an unfair inducement; or

(v) unreasonably restrains competition.

Amended by Chapter 319, 2013 General Session

31A-23a-402.5. Inducements.

(1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee under this title, or an officer or employee of a licensee, may not induce a person to enter into, continue, or terminate an insurance contract by offering a benefit that is not:

(i) specified in the insurance contract; or

(ii) directly related to the insurance contract.

(b) An insurer may not make or knowingly allow an agreement of insurance that is not clearly expressed in the insurance contract to be issued or renewed.

(c) A licensee under this title may not absorb the tax under Section 31A-3-301.

(2) This section does not apply to a title insurer, an individual title insurance producer, or agency title insurance producer, or an officer or employee of a title insurer, an individual title insurance producer, or an agency title insurance producer.

(3) Items not prohibited by Subsection (1) include an insurer:

(a) reducing premiums because of expense savings;

(b) providing to a policyholder or insured one or more incentives, as defined by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to participate in a program or activity designed to reduce claims or claim expenses, including:

(i) a premium discount offered to a small or large employer group based on a wellness program if:

(A) the premium discount for the employer group does not exceed 20% of the group premium; and

(B) the premium discount based on the wellness program is offered uniformly by the insurer to all employer groups in the large or small group market;

(ii) a premium discount offered to employees of a small or large employer group in an amount that does not exceed federal limits on wellness program incentives; or

(iii) a combination of premium discounts offered to the employer group and the employees of an employer group, based on a wellness program, if:

(A) the premium discounts for the employer group comply with Subsection (3)(b)(i); and

(B) the premium discounts for the employees of an employer group comply with Subsection (3)(b)(ii); or

(c) receiving premiums under an installment payment plan.

(4) Items not prohibited by Subsection (1) include a producer, consultant, or other licensee, or an officer or employee of a licensee, either directly or through a third party:

(a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not conditioned on a quote or the purchase of a particular insurance product;

(b) extending credit on a premium to the insured:

(i) without interest, for no more than 90 days from the effective date of the insurance contract;

(ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid balance after the time period described in Subsection (4)(b)(i); and

(iii) except that an installment or payroll deduction payment of premiums on an insurance contract issued under an insurer's mass marketing program is not considered an extension of credit for purposes of this Subsection (4)(b);

(c) preparing or conducting a survey that:

(i) is directly related to an accident and health insurance policy purchased from the licensee; or

(ii) is used by the licensee to assess the benefit needs and preferences of insureds, employers, or employees directly related to an insurance product sold by the licensee;

(d) providing limited human resource services that are directly related to an insurance product sold by the licensee, including:

(i) answering questions directly related to:

(A) an employee benefit offering or administration, if the insurance product purchased from the licensee is accident and health insurance or health insurance; and

(B) employment practices liability, if the insurance product offered by or purchased from the licensee is property or casualty insurance; and

(ii) providing limited human resource compliance training and education directly pertaining to an insurance product purchased from the licensee;

(e) providing the following types of information or guidance:

(i) providing guidance directly related to compliance with federal and state laws for an insurance product purchased from the licensee;

(ii) providing a workshop or seminar addressing an insurance issue that is directly related to an insurance product purchased from the licensee; or

(iii) providing information regarding:

(A) employee benefit issues;

(B) directly related insurance regulatory and legislative updates; or

(C) similar education about an insurance product sold by the licensee and how the insurance product interacts with tax law;

(f) preparing or providing a form that is directly related to an insurance product purchased from, or offered by, the licensee;

(g) preparing or providing documents directly related to a premium only cafeteria plan within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but not providing ongoing administration of a flexible spending account;

(h) providing enrollment and billing assistance, including:

(i) providing benefit statements or new hire insurance benefits packages; and

(ii) providing technology services such as an electronic enrollment platform or application system;

(i) communicating coverages in writing and in consultation with the insured and employees;

(j) providing employee communication materials and notifications directly related to an insurance product purchased from a licensee;

(k) providing claims management and resolution to the extent permitted under the licensee's license;

(l) providing underwriting or actuarial analysis or services;

(m) negotiating with an insurer regarding the placement and pricing of an insurance product;

(n) recommending placement and coverage options;

(o) providing a health fair or providing assistance or advice on establishing or operating a wellness program, but not providing any payment for or direct operation of the wellness program;

(p) providing COBRA and Utah mini-COBRA administration, consultations, and other services directly related to an insurance product purchased from the licensee;

(q) assisting with a summary plan description;

(r) providing information necessary for the preparation of documents directly related to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as amended;

(s) providing information or services directly related to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services directly related to health care access, portability, and renewability when offered in connection with accident and health insurance sold by a licensee;

(t) sending proof of coverage to a third party with a legitimate interest in coverage;

(u) providing information in a form approved by the commissioner and directly related to determining whether an insurance product sold by the licensee meets the requirements of a third party contract that requires or references insurance coverage;

(v) facilitating risk management services directly related to property and casualty insurance products sold or offered for sale by the licensee, including:

(i) risk management;

(ii) claims and loss control services;

(iii) risk assessment consulting, including analysis of:

(A) employer's job descriptions; or
(B) employer's safety procedures or manuals; and
(iv) providing information and training on best practices;
(w) otherwise providing services that are legitimately part of servicing an insurance product purchased from a licensee; and
(x) providing other directly related services approved by the department.
(5) An inducement prohibited under Subsection (1) includes a producer, consultant, or other licensee, or an officer or employee of a licensee:
(a) (i) providing a premium or commission rebate;
(ii) paying the salary of an employee of a person who purchases an insurance product from the licensee; or
(iii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, paying the salary for an onsite staff member to perform an act prohibited under Subsection (5)(b)(xii); or
(b) engaging in one or more of the following unless a fee is paid in accordance with Subsection (8):
(i) performing background checks of prospective employees;
(ii) providing legal services by a person licensed to practice law;
(iii) performing drug testing that is directly related to an insurance product purchased from the licensee;
(iv) preparing employer or employee handbooks, except that a licensee may:
(A) provide information for a medical benefit section of an employee handbook;
(B) provide information for the section of an employee handbook directly related to an employment practices liability insurance product purchased from the licensee; or
(C) prepare or print an employee benefit enrollment guide;
(v) providing job descriptions, postings, and applications for a person;
(vi) providing payroll services;
(vii) providing performance reviews or performance review training;
(viii) providing union advice;
(ix) providing accounting services;
(x) providing data analysis information technology programs, except as provided in Subsection (4)(h)(ii);
(xi) providing administration of health reimbursement accounts or health savings accounts; or
(xii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of the following prohibited benefits:
(A) performing background checks of prospective employees;
(B) providing legal services by a person licensed to practice law;
(C) performing drug testing that is directly related to an insurance product purchased from the insurer;
(D) preparing employer or employee handbooks;
(E) providing job descriptions postings, and applications;
(F) providing payroll services;
(G) providing performance reviews or performance review training;
(H) providing union advice;

(I) providing accounting services;
(J) providing discrimination testing; or
(K) providing data analysis information technology programs.
(6) A producer, consultant, or other licensee or an officer or employee of a licensee shall itemize and bill separately from any other insurance product or service offered or provided under Subsection (5)(b).
(7) (a) A de minimis gift or meal not to exceed $25 for each individual receiving the gift or meal is presumed to be a social courtesy not conditioned on a quote or purchase of a particular insurance product for purposes of Subsection (4)(a).
(b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed $10 may be conditioned on receipt of a quote of a particular insurance product if the de minimis gift or meal is provided by the insurer and not by a producer or consultant.
(8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with Subsection 31A-23a-501(2) in charging the fee, except that the fee paid for the item shall equal or exceed the fair market value of the item.

Amended by Chapter 319, 2013 General Session

31A-23a-403. Inherent unsuitability.
(1) If the commissioner finds after a hearing that a certain type of accident and health insurance, life insurance, or annuity product is inherently unsuitable for persons of certain ages or in certain conditions of health, the commissioner shall make a rule declaring the accident and health insurance, life insurance, or annuity product as inherently unsuitable for persons of certain ages or in certain conditions of health.
(2) An accident and health insurance, life insurance, or annuity product that is subject to the rule may not be sold to a person for whom the product has been determined as inherently unsuitable unless that person purchasing the product signs a receipt acknowledging having received a statement that expresses that the product has been determined by the commissioner to be inherently unsuitable for persons of certain ages or in certain conditions of health.
(3) Unless the insurer or its appointed licensee establishes that its sale of coverage is inconsistent with the rule made under Subsection (1) is due to excusable neglect, the purchaser may treat the sale as voidable, if acted upon by the insured within a two-year period from the date of sale.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-405. Insurer liability.
(1) As used in this section, "insurer" includes bail bond surety companies as defined in Section 31A-35-102.
(2) There is a rebuttable presumption that every insurer is bound by any act of its appointed licensee performed in this state that is within the scope of the appointed licensee's actual (express or implied) or apparent authority, until the insurer has canceled the appointed licensee's appointment and has made reasonable efforts to recover from the appointed licensee its policy forms and other indicia of agency.

Reasonable efforts include a formal demand in writing for return of the indicia, and notice to the commissioner if the appointed licensee does not promptly comply with the demand. This Subsection (2) neither waives any common law defense available to insurers, nor precludes the insured from seeking redress against the appointed licensee individually or jointly against the insurer and licensee.

(3) When a licensee under this chapter with authority to bind more than one insurer on a particular risk agrees to bind coverage on a particular risk, but fails to outwardly indicate the insurer with which the risk is placed, and before the risk is placed with a particular insurer a loss occurs, if there is no conclusive admissible evidence indicating the insurer with which the licensee exercised his binding authority, a court may equitably apportion the loss among all insurers with which the licensee had binding authority as to the particular type of risk.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-406. Title insurance producer's business.

(1) An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist:

(a) the individual title insurance producer or agency title insurance producer is licensed with:

(i) the title line of authority; and

(ii) the escrow subline of authority;

(b) the individual title insurance producer or agency title insurance producer is appointed by a title insurer authorized to do business in the state;

(c) the individual title insurance producer or agency title insurance producer issues one or more of the following as part of the transaction:

(i) an owner's policy of title insurance; or

(ii) a lender's policy of title insurance;

(d) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow:

(i) is deposited:

(A) in a federally insured financial institution; and

(B) in a trust account that is separate from all other trust account money that is not related to real estate transactions;

(ii) is the property of the one or more persons entitled to the money under the provisions of the escrow; and

(iii) is segregated escrow by escrow in the records of the individual title insurance producer or agency title insurance producer;

(e) earnings on money held in escrow may be paid out of the escrow account to any person in accordance with the conditions of the escrow;

(f) the escrow does not require the individual title insurance producer or agency title insurance producer to hold:

(i) construction money; or

(ii) money held for exchange under Section 1031, Internal Revenue Code; and

(g) the individual title insurance producer or agency title insurance producer shall maintain a physical office in Utah staffed by a person with an escrow subline of

authority who processes the escrow.

(2) Notwithstanding Subsection (1), an individual title insurance producer or agency title insurance producer may engage in the escrow business if:

(a) the escrow involves:

(i) a mobile home;

(ii) a grazing right;

(iii) a water right; or

(iv) other personal property authorized by the commissioner; and

(b) the individual title insurance producer or agency title insurance producer complies with this section except for Subsection (1)(c).

(3) Money held in escrow:

(a) is not subject to any debts of the individual title insurance producer or agency title insurance producer;

(b) may only be used to fulfill the terms of the individual escrow under which the money is accepted; and

(c) may not be used until the conditions of the escrow are met.

(4) Assets or property other than escrow money received by an individual title insurance producer or agency title insurance producer in accordance with an escrow shall be maintained in a manner that will:

(a) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(b) otherwise comply with the general duties and responsibilities of a fiduciary or bailee.

(5) (a) A check from the trust account described in Subsection (1)(d) may not be drawn, executed, or dated, or money otherwise disbursed unless the segregated escrow account from which money is to be disbursed contains a sufficient credit balance consisting of collected and cleared money at the time the check is drawn, executed, or dated, or money is otherwise disbursed.

(b) As used in this Subsection (5), money is considered to be "collected and cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day the cash is deposited;

(ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

(iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:

(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution;

(B) a check drawn on the trust account of a principal broker or associate broker licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual title insurance producer or agency title insurance producer has reasonable and prudent grounds to believe sufficient money will be available from the trust account on which the check is drawn at the time of disbursement of proceeds from the individual title insurance producer or agency title insurance producer's escrow account;

(C) a personal check not to exceed $500 per closing; or

(D) a check drawn on the escrow account of another individual title insurance producer or agency title insurance producer, if the individual title insurance producer or agency title insurance producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the escrow account of the individual title insurance producer or agency title insurance producer in the escrow transaction.

(c) A check or deposit not described in Subsection (5)(b) may be disbursed:

(i) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(ii) upon notification from the financial institution to which the money has been deposited that final settlement has occurred on the deposited financial instrument.

(6) An individual title insurance producer or agency title insurance producer shall maintain a record of a receipt or disbursement of escrow money.

(7) An individual title insurance producer or agency title insurance producer shall comply with:

(a) Section 31A-23a-409;

(b) Title 46, Chapter 1, Notaries Public Reform Act; and

(c) any rules adopted by the Title and Escrow Commission, subject to Section 31A-2-404, that govern escrows.

(8) If an individual title insurance producer or agency title insurance producer conducts a search for real estate located in the state, the individual title insurance producer or agency title insurance producer shall conduct a reasonable search of the public records.

Amended by Chapter 319, 2013 General Session

31A-23a-406.5. Conduct of escrow.

(1) Only an escrow agent or a title insurer in compliance with Subsection 31A-4-107(1)(a) and Section 31A-14-211 shall conduct escrow.

(2) Subsection (1) does not limit or expand the authority granted to:

(a) a person defined as an escrow agent in Section 7-22-101;

(b) a person licensed to practice law in Utah, if that person meets the requirements of Section 31A-23a-204;

(c) a person licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act; or

(d) a person licensed under Title 58, Chapter 55, Utah Construction Trades Licensing Act.

Enacted by Chapter 319, 2013 General Session

31A-23a-407. Liability of title insurers for acts of title insurance producers.

Any title company, represented by one or more individual title insurance producers appointed by an insurer or agency title insurance producers, is directly and primarily liable to others dealing with the individual title insurance producers or agency

title insurance producers for the receipt and disbursement of funds deposited in escrows with the individual title insurance producers appointed by an insurer or agency title insurance producers in all those transactions where a commitment or binder for or policy or contract of title insurance of that title insurer has been ordered, or a preliminary report of the title insurer has been issued or distributed. This liability does not modify, mitigate, impair, or affect the contractual obligations between the individual title insurance producers or agency title insurance producers and the title insurer.

Amended by Chapter 319, 2013 General Session

31A-23a-408. Representations of agency.

A person may not represent that the person is acting in behalf of an insurer unless a written agency contract is in effect giving the person authority from the insurer and the insurer appoints that person to act in behalf of the insurer.

Amended by Chapter 284, 2011 General Session

31A-23a-409. Trust obligation for money collected.

(1) (a) Subject to Subsection (7), a licensee is a trustee for money that is paid to, received by, or collected by a licensee for forwarding to insurers or to insureds.

(b) (i) Except as provided in Subsection (1)(b)(ii), a licensee may not commingle trust funds with:

(A) the licensee's own money; or

(B) money held in any other capacity.

(ii) This Subsection (1)(b) does not apply to:

(A) amounts necessary to pay bank charges; and

(B) money paid by insureds and belonging in part to the licensee as a fee or commission.

(c) Except as provided under Subsection (4), a licensee owes to insureds and insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or insureds through the licensee.

(d) (i) Unless money is sent to the appropriate payee by the close of the next business day after their receipt, the licensee shall deposit them in an account authorized under Subsection (2).

(ii) Money deposited under this Subsection (1)(d) shall remain in an account authorized under Subsection (2) until sent to the appropriate payee.

(2) Money required to be deposited under Subsection (1) shall be deposited:

(a) in a federally insured trust account in a depository institution, as defined in Section 7-1-103, which:

(i) has an office in this state, if the licensee depositing the money is a resident licensee;

(ii) has federal deposit insurance; and

(iii) is authorized by its primary regulator to engage in the trust business, as defined by Section 7-5-1, in this state; or

(b) in some other account, approved by the commissioner by rule or order, providing safety comparable to federally insured trust accounts.

(3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the amount of the federal insurance on the accounts.

(4) A trust account into which money is deposited may be interest bearing. The interest accrued on the account may be paid to the licensee, so long as the licensee otherwise complies with this section and with the contract with the insurer.

(5) A depository institution or other organization holding trust funds under this section may not offset or impound trust account funds against debts and obligations incurred by the licensee.

(6) A licensee who, not being lawfully entitled to do so, diverts or appropriates any portion of the money held under Subsection (1) to the licensee's own use, is guilty of theft under Title 76, Chapter 6, Part 4, Theft. Section 76-6-412 applies in determining the classification of the offense. Sanctions under Section 31A-2-308 also apply.

(7) A nonresident licensee:

(a) shall comply with Subsection (1)(a) by complying with the trust account requirements of the nonresident licensee's home state; and

(b) is not required to comply with the other provisions of this section.

Amended by Chapter 253, 2012 General Session

31A-23a-410. Insurer's liability if insured pays premium to a licensee or group policyholder.

(1) Subject to Subsections (2) and (5), as between the insurer and the insured, the insurer is considered to have received the premium and is liable to the insured for losses covered by the insurance and for any unearned premiums upon cancellation of the insurance if an insurer, including a surplus lines insurer:

(a) assumes a risk; and

(b) the premium for that insurance is received by:

(i) a licensee who placed the insurance;

(ii) a group policyholder;

(iii) an employer who deducts part or all of the premium from an employee's wages or salary; or

(iv) an employer who pays all or part of the premium for an employee.

(2) Subsection (1) does not apply if:

(a) the insured pays a licensee, knowing the licensee does not intend to submit the premium to the insurer; or

(b) the insured has premium withheld from the insured's wages or salary knowing the employer does not intend to submit it to the insurer.

(3) (a) In the case of an employer who has received the premium by deducting all or part of it from the wages or salaries of the certificate holders, the insurer may terminate its liability by giving notice of coverage termination to:

(i) the certificate holders;

(ii) the policyholder; and

(iii) the producer, if any, for the policy.

(b) The insurer may not send the notice required by Subsection (3)(a) to a certificate holder before 20 days after the day on which premium is due and unpaid.

(c) The liability of the insurer for the losses covered by the insurance terminates at the later of:

(i) the last day of the coverage period for which premium has been withheld by the employer;

(ii) 10 days after the date the insurer mails notice to the certificate holder that coverage has terminated; or

(iii) if the insurer fails to provide notice as required by this Subsection (3), 45 days from the last date for which premium is received.

(4) Despite an employer's collection of premium under Subsection (1), the responsibility of an insurer to continue to cover the losses covered by the insurance to group policy certificate holders terminates upon the effective date of notice from the policyholder that:

(a) coverage of a similar kind and quality has been obtained from another insurer; or

(b) the policyholder is electing to voluntarily terminate the certificate holder's coverage and has given the employees notice of the termination.

(5) If the insurer is obligated to pay a claim pursuant to this section, the licensee or employer who received the premium and failed to forward it is obligated to the insurer for the entire unpaid premium due under the policy together with reasonable expenses of suit and reasonable attorney fees.

(6) If, under an employee health insurance plan, an employee builds up credit for future coverage because the employee has not used the policy protection, or in some other way, the insurer is obligated to the employee for that future coverage earned while the policy was in full effect.

(7) (a) Notwithstanding that an insurer is liable for losses as provided in this section, this section applies only to apportion the liability for the losses described in this section.

(b) This section does not:

(i) extend a policy or coverage beyond its date of termination; or

(ii) alter or amend a provision of a policy.

Amended by Chapter 349, 2009 General Session

31A-23a-411.1. Person's liability if premium received is not forwarded to the insurer.

A person commits insurance fraud as described in Subsection 31A-31-103(1)(f) if that person knowingly fails to forward to the insurer a premium:

(1) received from one of the following in partial or total payment of the premium due from:

(a) an applicant;

(b) a policyholder; or

(c) a certificate holder; or

(2) collected from or on behalf of an insured employee under an insured employee benefit plan.

Enacted by Chapter 252, 2003 General Session

31A-23a-412. Place of business and residence address -- Records.

(1) (a) A licensee under this chapter shall register and maintain with the commissioner:

(i) the address and telephone numbers of the licensee's principal place of business; and

(ii) a valid business email address at which the commissioner may contact the licensee.

(b) If a licensee is an individual, in addition to complying with Subsection (1)(a) the individual shall register and maintain with the commissioner the individual's residence address and telephone number.

(c) A licensee shall notify the commissioner within 30 days of a change of any of the following required to be registered with the commissioner under this section:

(i) an address;

(ii) a telephone number; or

(iii) a business email address.

(2) (a) Except as provided under Subsection (3), a licensee under this chapter shall keep at the principal place of business address registered under Subsection (1), separate and distinct books and records of the transactions consummated under the Utah license.

(b) The books and records described in Subsection (2)(a) shall:

(i) be in an organized form;

(ii) be available to the commissioner for inspection upon reasonable notice; and

(iii) include all of the following:

(A) if the licensee is a producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary:

(I) a record of each insurance contract procured by or issued through the licensee, with the names of insurers and insureds, the amount of premium and commissions or other compensation, and the subject of the insurance;

(II) the names of any other producers, surplus lines producers, limited line producers, consultants, managing general agents, or reinsurance intermediaries from whom business is accepted, and of persons to whom commissions or allowances of any kind are promised or paid; and

(III) a record of the consumer complaints forwarded to the licensee by an insurance regulator;

(B) if the licensee is a consultant, a record of each agreement outlining the work performed and the fee for the work; and

(C) any additional information which:

(I) is customary for a similar business; or

(II) may reasonably be required by the commissioner by rule.

(3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can be obtained immediately from a central storage place or elsewhere by on-line computer terminals located at the registered address.

(4) A licensee who represents only a single insurer satisfies Subsection (2) if the insurer maintains the books and records pursuant to Subsection (2) at a place satisfying Subsections (1) and (5).

(5) (a) The books and records maintained under Subsection (2) or Section

31A-23a-413 shall be available for the inspection of the commissioner during the business hours for a period of time after the date of the transaction as specified by the commissioner by rule, but in no case for less than the current calendar year plus three years.

(b) Discarding books and records after the applicable record retention period has expired does not place the licensee in violation of a later-adopted longer record retention period.

Amended by Chapter 253, 2012 General Session

31A-23a-413. Title insurance producer's annual report.

An agency title insurance producer and an individual title insurance producer who has not been designated by an agency title insurance producer shall annually file with the commissioner, by a date and in a form the commissioner specifies by rule, a verified statement of the agency title insurance producer's or individual title insurance producer's financial condition, transactions, and affairs as of the end of the preceding calendar year.

Amended by Chapter 319, 2013 General Session

31A-23a-414. Consultant's duty to report illegal insurance.

Section 31A-15-110 applies to a consultant's duty to report illegal insurance.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-415. Assessment on agency title insurance producers or title insurers -- Account created.

(1) For purposes of this section:

(a) "Premium" is as defined in Subsection 59-9-101(3).

(b) "Title insurer" means a person:

(i) making any contract or policy of title insurance as:

(A) insurer;

(B) guarantor; or

(C) surety;

(ii) proposing to make any contract or policy of title insurance as:

(A) insurer;

(B) guarantor; or

(C) surety; or

(iii) transacting or proposing to transact any phase of title insurance, including:

(A) soliciting;

(B) negotiating preliminary to execution;

(C) executing of a contract of title insurance;

(D) insuring; and

(E) transacting matters subsequent to the execution of the contract and arising out of the contract.

(c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to

real or personal property located in Utah, an owner of real or personal property, the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of:

(i) liens or encumbrances upon, defects in, or the unmarketability of the title to the property; or

(ii) invalidity or unenforceability of any liens or encumbrances on the property.

(2) (a) The commissioner may assess each title insurer, each individual title insurance producer who is not designated by an agency title insurance producer, and each agency title insurance producer an annual assessment:

(i) determined by the Title and Escrow Commission:

(A) after consultation with the commissioner; and

(B) in accordance with this Subsection (2); and

(ii) to be used for the purposes described in Subsection (3).

(b) An agency title insurance producer and individual title insurance producer who is not designated by an agency title insurance producer shall be assessed up to:

(i) $250 for the first office in each county in which the agency title insurance producer or individual title insurance producer maintains an office; and

(ii) $150 for each additional office the agency title insurance producer or individual title insurance producer maintains in the county described in Subsection (2)(b)(i).

(c) A title insurer shall be assessed up to:

(i) $250 for the first office in each county in which the title insurer maintains an office;

(ii) $150 for each additional office the title insurer maintains in the county described in Subsection (2)(c)(i); and

(iii) an amount calculated by:

(A) aggregating the assessments imposed on:

(I) agency title insurance producers and individual title insurance producers under Subsection (2)(b); and

(II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii);

(B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total costs and expenses determined under Subsection (2)(d); and

(C) multiplying:

(I) the amount calculated under Subsection (2)(c)(iii)(B); and

(II) the percentage of total premiums for title insurance on Utah risk that are premiums of the title insurer.

(d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title and Escrow Commission by rule shall establish the amount of costs and expenses described under Subsection (3) that will be covered by the assessment, except the costs or expenses to be covered by the assessment may not exceed $80,000 annually.

(3) (a) Money received by the state under this section shall be deposited into the Title Licensee Enforcement Restricted Account.

(b) There is created in the General Fund a restricted account known as the "Title Licensee Enforcement Restricted Account."

(c) The Title Licensee Enforcement Restricted Account shall consist of the money received by the state under this section.

(d) The commissioner shall administer the Title Licensee Enforcement Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or expense incurred by the department in the administration, investigation, and enforcement of this part and Part 5, Compensation of Producers and Consultants, related to:

(i) the marketing of title insurance; and

(ii) audits of agency title insurance producers.

(e) An appropriation from the Title Licensee Enforcement Restricted Account is nonlapsing.

(4) The assessment imposed by this section shall be in addition to any premium assessment imposed under Subsection 59-9-101(3).

Amended by Chapter 319, 2013 General Session

31A-23a-416. Solicitations to loan applicants.

(1) (a) A person authorized to engage in insurance activities in this state shall prominently disclose in writing the information described in Subsection (1)(b) to a person seeking an extension of credit if:

(i) the person authorized to engage in insurance activities also extends credit directly or through a subsidiary or an affiliate;

(ii) the person requires a customer to obtain insurance in connection with an extension of credit; and

(iii) the person offers to the person seeking an extension of credit the line of credit insurance required in connection with the extension of credit.

(b) The disclosure required by Subsection (1)(a) shall be in a form substantially similar to the following. "You may obtain insurance required in connection with your extension of credit from any insurance producer or approved insurer that sells such insurance. Your choice of insurance provider will not affect our credit decision or your credit terms."

(c) The person shall make the required disclosure under Subsection (1)(a):

(i) at the time of written application for an extension of credit; or

(ii) if there is no written application, before the closing of the extension of credit.

(2) The disclosure required by Subsection (1)(c)(ii) may be in a verbal, electronic, or other unwritten form if a printed disclosure is included with the first printed statement of terms and conditions of the extension of credit sent to the person seeking the extension of credit.

(3) This section does not apply when:

(a) a person is contacting a person in the course of direct or mass marketing to a group of persons in a manner that bears no relation to the person's application for an extension of credit or credit decision; and

(b) an agreement for the extension of credit is changed or extended, if the person who originally sought the extension of credit is not required to purchase new or additional insurance.

(4) (a) For purposes of this section, "approved insurer" means an insurer that is approved to issue insurance related to the extension of credit by the person that

extends the credit.

(b) The commissioner shall make rules establishing standards that govern the approval under Subsection (4)(a) of an insurer by a person that extends credit.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-417. Financial services insurance activities regulation.

(1) It is the intent of the Legislature that the regulation of insurance activities of any person in this state be based on functional regulation principles established in the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102.

(2) The insurance activities of any person in this state shall be functionally regulated by the commissioner subject to Sections 104, 301-308, 501-507, and 509 of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102.

(3) Under Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may adopt rules consistent with Section 104(d) of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102, and the functional regulation of insurance activities of any person otherwise subject to the jurisdiction of the commissioner in this state described in Subsection (2).

(4) The commissioner shall consult and coordinate with the commissioner of the Department of Financial Institutions and the director of the Division of Securities for the purpose of assuring, to the extent possible, that the rules prescribed by the department are consistent and comparable with federal regulations governing the insurance, banking, and securities industries.

Amended by Chapter 382, 2008 General Session

31A-23a-501. Licensee compensation.

(1) As used in this section:

(a) "Commission compensation" includes funds paid to or credited for the benefit of a licensee from:

(i) commission amounts deducted from insurance premiums on insurance sold by or placed through the licensee; or

(ii) commission amounts received from an insurer or another licensee as a result of the sale or placement of insurance.

(b) (i) "Compensation from an insurer or third party administrator" means commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration:

(A) whether or not payable pursuant to a written agreement; and

(B) received from:

(I) an insurer; or

(II) a third party to the transaction for the sale or placement of insurance.

(ii) "Compensation from an insurer or third party administrator" does not mean compensation from a customer that is:

(A) a fee or pass-through costs as provided in Subsection (1)(e); or

(B) a fee or amount collected by or paid to the producer that does not exceed an amount established by the commissioner by administrative rule.

(c) (i) "Customer" means:

(A) the person signing the application or submission for insurance; or

(B) the authorized representative of the insured actually negotiating the placement of insurance with the producer.

(ii) "Customer" does not mean a person who is a participant or beneficiary of:

(A) an employee benefit plan; or

(B) a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the producer or affiliate.

(d) (i) "Noncommission compensation" includes all funds paid to or credited for the benefit of a licensee other than commission compensation.

(ii) "Noncommission compensation" does not include charges for pass-through costs incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

(e) "Pass-through costs" include:

(i) costs for copying documents to be submitted to the insurer; and

(ii) bank costs for processing cash or credit card payments.

(2) A licensee may receive from an insured or from a person purchasing an insurance policy, noncommission compensation if the noncommission compensation is stated on a separate, written disclosure.

(a) The disclosure required by this Subsection (2) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(b) Noncommission compensation shall be:

(i) limited to actual or reasonable expenses incurred for services; and

(ii) uniformly applied to all insureds or prospective insureds in a class or classes of business or for a specific service or services.

(c) A copy of the signed disclosure required by this Subsection (2) shall be maintained by any licensee who collects or receives the noncommission compensation or any portion of the noncommission compensation.

(d) All accounting records relating to noncommission compensation shall be maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

(3) (a) A licensee may receive noncommission compensation when acting as a producer for the insured in connection with the actual sale or placement of insurance if:

(i) the producer and the insured have agreed on the producer's noncommission compensation; and

(ii) the producer has disclosed to the insured the existence and source of any other compensation that accrues to the producer as a result of the transaction.

(b) The disclosure required by this Subsection (3) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation

and the existence and source of any other compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(c) The following additional noncommission compensation is authorized:

(i) compensation received by a producer of a compensated corporate surety who under procedures approved by a rule or order of the commissioner is paid by surety bond principal debtors for extra services;

(ii) compensation received by an insurance producer who is also licensed as a public adjuster under Section 31A-26-203, for services performed for an insured in connection with a claim adjustment, so long as the producer does not receive or is not promised compensation for aiding in the claim adjustment prior to the occurrence of the claim;

(iii) compensation received by a consultant as a consulting fee, provided the consultant complies with the requirements of Section 31A-23a-401; or

(iv) other compensation arrangements approved by the commissioner after a finding that they do not violate Section 31A-23a-401 and are not harmful to the public.

(d) Subject to Section 31A-23a-402.5, a producer for the insured may receive compensation from an insured through an insurer, for the negotiation and sale of a health benefit plan, if there is a separate written agreement between the insured and the licensee for the compensation. An insurer who passes through the compensation from the insured to the licensee under this Subsection (3)(d) is not providing direct or indirect compensation or commission compensation to the licensee.

(4) (a) For purposes of this Subsection (4), "producer" includes:

(i) a producer;

(ii) an affiliate of a producer; or

(iii) a consultant.

(b) A producer may not accept or receive any compensation from an insurer or third party administrator for the initial placement of a health benefit plan, other than a hospital confinement indemnity policy, unless prior to the customer's initial purchase of the health benefit plan the producer discloses in writing to the customer that the producer will receive compensation from the insurer or third party administrator for the placement of insurance, including the amount or type of compensation known to the producer at the time of the disclosure.

(c) A producer shall:

(i) obtain the customer's signed acknowledgment that the disclosure under Subsection (4)(b) was made to the customer; or

(ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to the customer; and

(B) keep the signed statement on file in the producer's office while the health benefit plan placed with the customer is in force.

(d) (i) A licensee who collects or receives any part of the compensation from an insurer or third party administrator in a manner that facilitates an audit shall, while the health benefit plan placed with the customer is in force, maintain a copy of:

(A) the signed acknowledgment described in Subsection (4)(c)(i); or

(B) the signed statement described in Subsection (4)(c)(ii).

(ii) The standard application developed in accordance with Section 31A-22-635

shall include a place for a producer to provide the disclosure required by this Subsection (4), and if completed, shall satisfy the requirement of Subsection (4)(d)(i).

(e) Subsection (4)(c) does not apply to:

(i) a person licensed as a producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent; or

(ii) the placement of insurance in a secondary or residual market.

(5) This section does not alter the right of any licensee to recover from an insured the amount of any premium due for insurance effected by or through that licensee or to charge a reasonable rate of interest upon past-due accounts.

(6) This section does not apply to bail bond producers or bail enforcement agents as defined in Section 31A-35-102.

(7) A licensee may not receive noncommission compensation from an insured or enrollee for providing a service or engaging in an act that is required to be provided or performed in order to receive commission compensation, except for the surplus lines transactions that do not receive commissions.

Amended by Chapter 341, 2013 General Session

31A-23a-502. Controlled business, except as to title insurance.

(1) As used in this section, "controlled business" means insurance procured by:

(a) an insurance producer who is a natural person upon the life, person, or property of himself, his relative within the second degree by blood or marriage, his employer, employees, or organization; or

(b) an insurance producer that is an organization upon its own property or upon the life, person, or property of its partners, shareholders, directors, or employees, or their relatives within the second degree by blood or marriage.

(2) No producer may receive any compensation from an insurer for effecting insurance upon controlled business unless during the preceding 12 months the producer had effected other insurance with aggregate premiums exceeding the premiums on the controlled business.

(3) This section does not apply to title insurance.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-503. Controlled business in title insurance.

(1) As used in this section:

(a) "Associate" means any:

(i) business organized for profit in which a person who refers title business is a director, officer, partner, or employee;

(ii) spouse or relative within the second degree by blood or marriage of a person who refers title business, who is a natural person;

(iii) employee of a person who refers title business; or

(iv) person with whom a person who refers title business or any associate of that title insurer, individual title insurance producer, or agency title insurance producer has any agreement, arrangement, or understanding, or pursues any course of conduct, designed to avoid the provisions of this chapter.

(b) "Controlled business" means that portion of the title insurance business of a title insurer, individual title insurance producer, or agency title insurance producer in this state that is referred to it by all those producers of title business who have a financial interest in the title insurer, individual title insurance producer, or agency title insurance producer and by all associates of those producers. Business is referred if there is influence over the selection of the person with whom the business is placed.

(c) "A person who refers title business" includes any person engaged in this state in a business of:

(i) buying or selling interests in real property;

(ii) making loans secured by interests in real property; or

(iii) acting as a representative or employee of a person who buys or sells any interest in real property or who lends or borrows money with interest as security, other than acting as a licensed title insurer, individual title insurance producer, or agency title insurance producer doing the business of title insurance.

(d) "Financial interest" means any legal or beneficial interest that together with other interests entitles the holder to more than 1% of the net profits or net worth of the business in which the interest is held.

(2) A title insurer, individual title insurance producer, or agency title insurance producer or person having a financial interest in a title insurer, individual title insurance producer, or agency title insurance producer may not knowingly be a party to or knowingly permit to continue in any arrangement in which the title insurer, individual title insurance producer, or agency title insurance producer, or person knows or has reason to believe that any person who refers title business has or will have, directly or indirectly, a financial interest in the title insurer, individual title insurance producer, or agency title insurance producer, if it reasonably appears that a substantial factor in the person who refers title business owning or acquiring the financial interest is the expected realization of financial profit or gain derived in whole or in part from controlled business.

(3) A title insurer may not appoint or knowingly continue its authorization of any individual title insurance producer or agency title insurance producer in which the company knows or has reason to believe that any person who refers title business has or will have, directly or indirectly, a financial interest, if it reasonably appears that a substantial factor in the person who refers title business owning or acquiring the financial interest is the person's expected realization of financial profit or gain derived in whole or part from controlled business.

(4) (a) If for any calendar quarter, the gross operating revenues of a title insurer, individual title insurance producer, or agency title insurance producer derived from all sources of controlled business in this state amount to more than 1/3 of its gross operating revenues from all other sources of its business of title insurance in this state, it is presumed that the expected realization of financial profit or gain derived in whole or in part from controlled business was a substantial factor in the ownership of financial interest in the title insurer, individual title insurance producer, or agency title insurance producer.

(b) The title insurer, individual title insurance producer, or agency title insurance producer has the burden of overcoming the presumption described in Subsection (4)(a).

(c) This Subsection (4) does not authorize any controlled business if a violation

of the standards set forth in Subsection (2) or (3) exists.

(5) A title insurer, individual title insurance producer, or agency title insurance producer may not accept any order for the business of title insurance that it knows or has reason to believe constitutes controlled business, unless it records and maintains in its permanent records on forms prescribed by the commissioner the facts relating to the transactions.

(6) An applicant for qualification as a title insurer, individual title insurance producer, or agency title insurance producer may not be granted a license if it reasonably appears that the expected realization of financial profit or gain to be derived in whole or in part from controlled business is or will be a substantial factor in the applicant's plan of operation or in the ownership or acquisition of financial interests in the applicant by any person who refers title business.

(7) Each title insurer, individual title insurance producer, and agency title insurance producer shall maintain permanent records relating to its controlled business on forms prescribed by the commissioner.

(8) (a) Each title insurer and agency title insurance producer shall file annually with the commissioner, on forms prescribed by the commissioner, reports setting forth:

(i) the names and addresses of any persons owning a financial interest in the title insurer or agency title insurance producer as of the last day of the calendar year, who are known or reasonably believed by the title insurer or agency title insurance producer to be a person who refers title business; and

(ii) a summary compiled from the title insurer's or agency title insurance producer's records of the controlled business, sufficient to inform the commissioner and the Title and Escrow Commission as to the proportion of the title insurer's or agency title insurance producer's gross operating revenues attributable to controlled business during the preceding calendar year.

(b) The reports shall be filed with the reports required under Section 31A-23a-413 and shall contain the certification of an officer of the title insurer or agency title insurance producer that the information contained in them is true to the best of the officer's knowledge, information, and belief. Upon filing, the reports are public records.

(c) A report filed pursuant to Subsection (8)(a) is subject to review by the Title and Escrow Commission.

(9) An attorney who is also a licensed individual title insurance producer and who issues as producer a policy of title insurance to a client on behalf of whom the attorney is also acting as an attorney and who, in so doing, acts consistently with the applicable ethical standards of the Utah State Bar pertaining to the billing and receipt of legal fees and the receipt of a commission on a policy of title insurance is not, without more, considered to be engaged in controlled business.

Amended by Chapter 319, 2013 General Session

31A-23a-504. Sharing commissions.

(1) (a) Except as provided in Subsection 31A-15-103(3), a licensee under this chapter or an insurer may only pay consideration or reimburse out-of-pocket expenses to a person if the licensee knows that the person is licensed under this chapter as to the particular type of insurance to act in Utah as:

(i) a producer;
(ii) a limited line producer;
(iii) a consultant;
(iv) a managing general agent; or
(v) a reinsurance intermediary.
(b) A person may only accept commission compensation or other compensation as a person described in Subsections (1)(a)(i) through (v) that is directly or indirectly the result of an insurance transaction if that person is licensed under this chapter to act as described in Subsection (1)(a).
(2) (a) Except as provided in Section 31A-23a-501, a consultant may not pay or receive a commission or other compensation that is directly or indirectly the result of an insurance transaction.
(b) A consultant may share a consultant fee or other compensation received for consulting services performed within Utah only:
(i) with another consultant licensed under this chapter; and
(ii) to the extent that the other consultant contributed to the services performed.
(3) This section does not prohibit:
(a) the payment of renewal commissions to former licensees under this chapter, former Title 31, Chapter 17, or their successors in interest under a deferred compensation or agency sales agreement;
(b) compensation paid to or received by a person for referral of a potential customer that seeks to purchase or obtain an opinion or advice on an insurance product if:
(i) the person is not licensed to sell insurance;
(ii) the person does not sell or provide opinions or advice on the product; and
(iii) the compensation does not depend on whether the referral results in a purchase or sale; or
(c) the payment or assignment of a commission, service fee, brokerage, or other valuable consideration to an agency or a person who does not sell, solicit, or negotiate insurance in this state, unless the payment would constitute an inducement or commission rebate under Section 31A-23a-402 or 31A-23a-402.5.
(4) (a) In selling a policy of title insurance, sharing of commissions under Subsection (1) may not occur if it will result in:
(i) an unlawful rebate;
(ii) compensation in connection with controlled business; or
(iii) payment of a forwarding fee or finder's fee.
(b) A person may share compensation for the issuance of a title insurance policy only to the extent that the person contributed to the search and examination of the title or other services connected with the title insurance policy.
(5) This section does not apply to a bail bond producer or bail enforcement agent as defined in Section 31A-35-102 and as described in Subsection 31A-23a-106(2)(c) or a nonlicensed individual employee or authorized representative of a licensed limited line producer who holds one or more of the following limited lines of authority as described in Subsection 31A-23a-106(2)(c):
(a) car rental related insurance;
(b) self-service storage insurance; or

(c) portable electronics insurance.

Amended by Chapter 319, 2013 General Session

31A-23a-505. Benefit plans for producers.

An authorized insurer may establish retirement, insurance, and other benefit plans for producers on a basis approved by the commissioner.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-601. Licensure.

(1) A person, firm, association, or corporation may not act in the capacity of managing general agent with respect to risks located in this state for an insurer licensed in this state unless the person is a licensed producer in this state.

(2) A person, firm, association, or corporation may not act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless the person is licensed as a producer in this state pursuant to this chapter. The license may be a nonresident license.

(3) The commissioner may require a bond in an amount he finds acceptable for the protection of each insurer represented.

(4) The commissioner may require the managing general agent to maintain an errors and omissions policy or other security acceptable to the commissioner.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-602. Required contract provisions.

A person, firm, association, or corporation acting in the capacity of a managing general agent may not place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party, and where both parties share responsibility for a particular function, the contract specifies the division of shared responsibilities. The written contract shall contain the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.

(2) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer at least monthly.

(3) All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a bank which is insured by the FDIC. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the managing general agent shall be maintained. The insurer shall have access and the right to copy all accounts and records related to its business and shall have access to all books, bank accounts, and

records of the managing general agent. The records shall be retained according to Section 31A-23a-412 and shall be kept in a form usable by the insurer and the commissioner.

(5) The contract may not be assigned in whole or part by the managing general agent.

(6) The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and rules. The contract shall contain appropriate underwriting guidelines including:

(a) the maximum annual premium volume;

(b) the basis of the rates to be charged;

(c) the types of risks which may be written;

(d) maximum limits of liability;

(e) applicable exclusions;

(f) territorial limitations;

(g) policy cancellation provisions; and

(h) the maximum policy period.

(7) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(a) All claims shall be reported to the company in a timely manner.

(b) A copy of the claim file shall be sent to the insurer at its request, or as soon as it becomes known that the claim:

(i) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the company;

(ii) involves a coverage dispute;

(iii) may exceed the managing general agent's claims settlement authority;

(iv) is open for more than six months; or

(v) is closed by payment the lesser of an amount set by the commissioner or an amount set by the company.

(c) All claim files will be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, the files become the sole property of the insurer or its estate. The managing general agent shall have reasonable access to and the right to copy the files on a timely basis.

(d) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(8) Where electronic claims files are in existence, the contract shall address the timely transmission of the data.

(9) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves, controlling claim payments, or in any other manner, interim profits may not be paid to the managing general agent until one year after they are earned for property insurance business, and five years after they are earned on casualty business, but not until the profits have been verified by a review conducted pursuant to Section 31A-23a-603.

(10) The managing general agent may not:

(a) bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(b) commit the insurer to participate in insurance or reinsurance syndicates;

(c) appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which the producer is appointed;

(d) without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which may not exceed 1% of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(e) collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer; if prior approval is given, a report shall be promptly forwarded to the insurer;

(f) permit its subproducer to serve on the insurer's board of directors;

(g) jointly employ an individual who is employed with the insurer; or

(h) appoint a submanaging general agent.

Amended by Chapter 297, 2011 General Session

31A-23a-603. Duties of insurers.

(1) The insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each managing general agent with which the insurer has done business.

(2) (a) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent.

(b) The requirement of Subsection (2)(a) is in addition to any other required loss reserve certification.

(3) The insurer shall at least semiannually conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the managing general agent.

(5) (a) Within 30 days after entering into or terminating a contract with a managing general agent, the insurer shall provide written notification of the appointment or termination to the commissioner.

(b) A notice of appointment of a managing general agent shall include:

(i) a statement of duties that the applicant is expected to perform on behalf of the insurer;

(ii) the lines of insurance for which the applicant is to be authorized to act; and

(iii) any other information the commissioner may request.

(6) (a) An insurer shall review the insurer's books and records each quarter to determine if any producer, as defined in Section 31A-1-301, has become a managing

general agent as defined in Section 31A-23a-102.

(b) If the insurer determines that a producer has become a managing general agent:

(i) the insurer shall promptly notify the producer and the commissioner of the determination; and

(ii) the insurer and producer shall fully comply with the provisions of this chapter within 30 days.

(7) (a) An insurer may not appoint officers, directors, employees, subproducers, or controlling shareholders of the insurer's managing general agents to the insurer's board of directors.

(b) This Subsection (7) does not apply to relationships governed by:

(i) Chapter 16, Insurance Holding Companies; or

(ii) Chapter 23a, Part 7, Producer Controlled Insurers, if it applies.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-604. Examination authority.

The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-605. Penalties and liabilities.

(1) If the commissioner finds after a hearing that any person has violated any provision of this part, the commissioner may order:

(a) for each separate violation, a penalty in an amount of $5,000;

(b) revocation or suspension of the producer's license; and

(c) the managing general agent to reimburse the insurer, the rehabilitator, or liquidator of the insurer for any losses incurred by the insurer caused by the managing general agent's violation.

(2) Nothing contained in this section affects the right of the commissioner to impose any other penalties provided for in this title.

(3) Nothing contained in this part is intended to, or in any manner limits or restricts the rights of policyholders, claimants, and auditors.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-701. Applicability.

(1) This part applies to licensed insurers, as defined in Section 31A-23a-102, that are domiciled:

(a) in this state; or

(b) in a state that does not have a substantially similar law.

(2) All provisions of Chapter 16, Insurance Holding Companies, to the extent they are not superseded by this part, continue to apply to all parties within holding company systems subject to this part.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-702. Minimum standards.

(1) This section applies if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than 5% of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year.

(2) Notwithstanding Subsection (1), this section does not apply if:

(a) the controlling producer places insurance only with the controlled insurer, or only with the controlled insurer and members of the controlled insurer's holding company system, or with the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with the insurance placed;

(b) the controlling producer accepts insurance placements only from nonaffiliated producers who are not controlling producers, and not directly from insureds; and

(c) the controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

(3) A controlled insurer may not accept business from a controlling producer and a controlling producer may not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer that specifies the responsibilities of each party and that has been approved by the board of directors of the insurer. The contract shall contain the following minimum provisions:

(a) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(b) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the controlling producer.

(c) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer at least monthly. The due date shall be fixed so that premiums or premium installments collected shall be remitted no later than 90 days after the effective date of any policy placed with the controlled insurer under the contract.

(d) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System FDIC, in accordance with applicable provisions of this title. However, funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction.

(e) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer.

(f) The contract may not be assigned in whole or in part by the controlling producer.

(g) The controlled insurer shall provide the controlling producer with its underwriting standards, rules, procedures, and manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer.

(h) The contract shall state the rates and terms of the controlling producer's commissions, charges, or other fees and the purposes for those charges or fees. The rates of the commissions, charges, and other fees may not be greater than those applicable to comparable business and services placed with the controlled insurer by producers other than controlling producers. For purposes of Subsections (3)(g) and (h), examples of "comparable business and services" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(i) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then the compensation may not be determined and paid until at least five years after the premiums on liability insurance are earned, and at least one year after the premiums are earned on any other insurance. In no event may the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to Subsection (5).

(j) The contract shall include a limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit to each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and may not accept business from the controlling producer if the limit is reached. The controlling producer may not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

(k) The controlling producer may negotiate but may not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer. However, the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(4) Each controlled insurer shall have an audit committee of the board of directors. The audit committee shall annually meet to review the adequacy of the insurer's loss reserves. The committee shall meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or any other independent loss reserve specialists acceptable to the commissioner.

(5) (a) In addition to any other required loss reserve certification, the controlled insurer shall file with the commissioner on April 1 of each year an opinion of an independent casualty actuary, or any other independent loss reserve specialist acceptable to the commissioner. The opinion shall report loss ratios for each line of business written and shall attest to the adequacy of loss reserves established for losses incurred and outstanding as of year-end on business placed by the producer including losses incurred but not reported.

(b) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the producer, the percentage that amount represents of the net premiums written, and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

Amended by Chapter 297, 2011 General Session

31A-23a-703. Disclosure.

The producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer. However, if the business is placed through a producer who is not a controlling producer, the controlling producer shall retain in his records a signed commitment from the noncontrolling producer that the noncontrolling producer is aware of the relationship between the insurer and the producer and that the noncontrolling producer has, or will, notify the insured.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-704. Penalties.

(1) (a) If, after notice and opportunity to be heard, the commissioner finds that the controlling producer or any other person has not materially complied with this part, or any rule made or order issued under the part, the commissioner may order the controlling producer to cease placing business with the controlled insurer.

(b) If the commissioner finds that because of the material noncompliance that the controlled insurer or any policyholder of the controlled insurer has suffered any loss or damage, the commissioner may maintain a civil action or may intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or the commissioner may seek other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to Chapter 27a, Insurer Receivership Act, and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this part, or any rule made or order issued under this part, and the insurer suffered any loss or damage as a result of the noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(3) Nothing in this section affects the right of the commissioner to impose any other penalties provided for in this title.

(4) Nothing contained in this section is intended to or shall in any manner alter

or affect the rights of policyholders, claimants, creditors, or other third parties.

Amended by Chapter 309, 2007 General Session

31A-23a-801. Licensure.

(1) A person, firm, association, or corporation may not act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation unless:

(a) in this state, the reinsurance intermediary-broker is a licensed producer in this state; or

(b) in another state, the reinsurance intermediary-broker is a licensed producer in this state or another state having a licensing law substantially similar to this part, or the reinsurance intermediary-broker is licensed in this state as a nonresident reinsurance intermediary.

(2) A person, firm, association, or corporation may not act as a reinsurance intermediary-manager:

(a) for a reinsurer domiciled in this state, unless the reinsurance intermediary-manager is a licensed producer in this state;

(b) in this state, if the reinsurance intermediary-manager maintains an office either directly or as a member or employee of a firm or association, or as an officer, director, or employee of a corporation in this state, unless the reinsurance intermediary-manager is a licensed producer in this state; or

(c) in another state for a nondomestic insurer, unless the reinsurance intermediary-manager is a licensed producer in this state or another state having a licensing law substantially similar to this chapter, or the person is licensed in this state as a nonresident reinsurance intermediary.

(3) The commissioner may require a bond in an amount he finds acceptable for the protection of each reinsurer represented.

(4) (a) The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation which has complied with the requirements of this chapter.

(i) Any license issued to a firm or association will authorize all the members of the firm or association, and any designated employees, to act as reinsurance intermediaries under the license. Each member, employee, or similar person shall be named in the application and any supplements to the application.

(ii) Any license issued to a corporation shall authorize all of the officers, directors, and any designated employees to act as reinsurance intermediaries on behalf of the corporation, and all authorized persons shall be named in the application and any supplements to the application.

(b) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this title for designation of service of process upon unauthorized insurers. The applicant also shall furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process

affecting the nonresident reinsurance intermediary may be served. The licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and the change does not become effective until acknowledged by the commissioner.

(5) The commissioner may refuse to issue a reinsurance intermediary license if he determines that the applicant, any one named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy, or that any controlling person of the applicant is not trustworthy to act as a reinsurance intermediary, or that any of the persons named has given cause for revocation or suspension of the license, or has failed to comply with any prerequisite for the issuance of the license. Upon written request the commissioner will furnish a summary of the basis for his refusal to issue a license. The summary document shall be confidential.

(6) Licensed attorneys-at-law of this state when acting in their professional capacity as attorneys are exempt from this section.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-802. Required contract provisions -- Reinsurance intermediary-broker.

Transactions between a reinsurance intermediary-broker and the insurer it represents in that capacity may only be entered into pursuant to a written authorization, which specifies the responsibilities of each party. The authorization shall, at a minimum, provide that the reinsurance intermediary-broker:

(1) may have his authority terminated by the insurer at any time;

(2) will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the reinsurance intermediary-broker, and that he will remit all funds due to the insurer within 30 days of receipt;

(3) shall hold, in a fiduciary capacity, all funds collected for the insurer's account in a financial institution, which is a qualified United States financial institution;

(4) will comply with Section 31A-23a-803;

(5) will comply with the written standards established by the insurer for the cession or retrocession of all risks; and

(6) will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-803. Books and records -- Reinsurance intermediary-broker.

(1) For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, he will keep a complete record for each transaction showing:

(a) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(b) the period of coverage, including the effective and expiration dates, cancellation provisions, and notice required of cancellation;

(c) reporting and settlement requirements of balances;
(d) the rate used to compute the reinsurance premium;
(e) the names and addresses of assuming reinsurers;
(f) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker;
(g) related correspondence and memoranda;
(h) proof of placement;
(i) details regarding retrocessions handled by the reinsurance intermediary-broker, including the identity of retrocessionaires and percentage of each contract assumed or ceded;
(j) financial records including premium and loss accounts; and
(k) when the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:
(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or
(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.
(2) The insurer will have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-804. Duties of insurers utilizing the services of a reinsurance intermediary-broker.
(1) An insurer may not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-broker on its behalf unless the person is licensed as required by Subsection 31A-23a-801(1).
(2) An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business, unless the reinsurance intermediary-broker is under common control with the insurer and subject to Title 31A, Chapter 16, Insurance Holding Companies.
(3) The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-805. Required contract provisions -- Reinsurance intermediary-manager.
Transactions between a reinsurance intermediary-manager and the reinsurer it represents in that capacity may only be entered into pursuant to a written contract, which specifies the responsibilities of each party, and which shall be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through the producer, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, provide or require the

following:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The reinsurance intermediary-manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to the reinsurance intermediary-manager, and he shall remit all funds due under the contract to the reinsurer at least monthly.

(3) All funds collected for the reinsurer's account will be held by the reinsurance intermediary-manager in a fiduciary capacity in a financial institution which is a qualified United States financial institution. The reinsurance intermediary-manager may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate account for each reinsurer that it represents.

(4) For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, he shall keep a complete record for each transactions showing:

(a) the type of contract, limits, underwriting restrictions, classes of risks, and territory;

(b) period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(c) reporting and settlement requirements of balances;

(d) rates used to compute the reinsurance premium;

(e) names and addresses of reinsurers;

(f) rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;

(g) related correspondence and memoranda;

(h) proof of placement;

(i) details regarding retrocessions handled by the reinsurance intermediary-manager, as permitted by Subsection 31A-23a-807(4), including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(j) financial records, including premium and loss accounts; and

(k) when the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the reinsurance intermediary-manager which are related to its business, in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the reinsurance

intermediary-manager.

(7) The reinsurance intermediary-manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(8) The contract shall set forth the rates, terms, and purposes of commissions, charges, and other fees which the reinsurance intermediary-manager may levy against the reinsurer.

(9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

(a) All claims will be reported to the reinsurer in a timely manner.

(b) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(ii) involves a coverage dispute;

(iii) may exceed the reinsurance intermediary-manager claims settlement authority;

(iv) is open for more than six months; or

(v) is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer.

(c) All claim files will be the joint property of the reinsurer and reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer the files shall become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager shall have reasonable access to and the right to copy the files on a timely basis.

(d) Any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager, or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, that the contract shall provide interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later time period set by the commissioner for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to Subsection 31A-23a-807(3).

(11) The reinsurance intermediary-manager will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified public accountant.

(12) The reinsurer shall at least semi-annually conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager.

(13) The reinsurance intermediary-manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to this contract.

(14) Within the scope of its actual or apparent authority the acts of the reinsurance intermediary-manager shall be considered to be the acts of the reinsurer on whose behalf it is acting.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-806. Prohibited acts.

(1) The reinsurance intermediary-manager may not cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for facultative retrocessions. The guidelines shall include a list of reinsurers with which automatic agreements are in effect, and for each listed reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(2) The reinsurance intermediary-manager may not commit the reinsurer to participate in reinsurance syndicates.

(3) The reinsurance intermediary-manager may not appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which the producer is appointed.

(4) The reinsurance intermediary-manager may not, without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or 1% of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year.

(5) The reinsurance intermediary-manager may not collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report shall be promptly forwarded to the reinsurer.

(6) The reinsurance intermediary-manager may not jointly employ an individual who is employed by the reinsurer unless the reinsurance intermediary-manager is under common control with the reinsurer subject to Title 31A, Chapter 16, Insurance Holding Companies.

(7) The reinsurance intermediary-manager may not appoint a subreinsurance intermediary-manager.

Amended by Chapter 297, 2011 General Session

31A-23a-807. Duties of reinsurers utilizing the services of reinsurance.

(1) A reinsurer may not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-manager on its behalf unless the person is licensed as required by Subsection 31A-23a-801(2).

(2) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager which the reinsurer has engaged, which shall be prepared by an independent certified public accountant in a form acceptable to the commissioner.

(3) If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of

loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. The actuary's opinion shall be in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer, who may not be affiliated with the reinsurance intermediary-manager.

(5) Within 30 days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of the termination to the commissioner.

(6) A reinsurer may not appoint to its board of directors, any officer, director, employee, controlling shareholder, or subproducer of its reinsurance intermediary-manager. This subsection does not apply to relationships governed by Title 31A, Chapter 16, Insurance Holding Companies, or Chapter 23a, Part 7, Producer Controlled Insurers, if it applies.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-808. Examination authority.

(1) A reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary, which shall be kept in a form usable to the commissioner.

(2) A reinsurance intermediary-manager may be examined as if it were the reinsurer.

Renumbered and Amended by Chapter 298, 2003 General Session

31A-23a-809. Penalties and liabilities.

(1) A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing conducted in accordance with Title 63G, Chapter 4, Administrative Procedures Act, to be in violation of any provisions of this title, shall:

(a) for each separate violation, pay a civil penalty in an amount not exceeding $5,000;

(b) be subject to revocation or suspension of its license; and

(c) if a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

(2) Nothing contained in this section affects the right of the commissioner to impose any other penalties provided in this title.

(3) Nothing contained in this part is intended to, or in any manner limits or restricts the rights of policyholders, claimants, creditors, or other third parties; nor does it confer any rights to such persons.

Amended by Chapter 382, 2008 General Session

31A-23b-101. Title.

This chapter is known as the "Navigator License Act."

Enacted by Chapter 341, 2013 General Session

31A-23b-102. Definitions.

As used in this chapter:

(1) "Compensation" is as defined in:

(a) Subsections 31A-23a-501(1)(a), (b), and (d); and

(b) PPACA.

(2) "Enroll" and "enrollment" mean to:

(a) (i) obtain personally identifiable information about an individual; and

(ii) inform an individual about accident and health insurance plans or public programs offered on an exchange;

(b) solicit insurance; or

(c) submit to the exchange:

(i) personally identifiable information about an individual; and

(ii) an individual's selection of a particular accident and health insurance plan or public program offered on the exchange.

(3) (a) "Exchange" means an online marketplace:

(i) for an individual to purchase a qualified health plan; and

(ii) that is certified by the United States Department of Health and Human Services as either a state-based exchange or a federally facilitated exchange under PPACA.

(b) (i) "Exchange" does not include:

(A) an online marketplace for the purchase of health insurance if the online marketplace is not a certified exchange under PPACA; or

(B) except as provided in Subsection (3)(b)(ii), an online marketplace for small employers that is certified as a PPACA compliant SHOP exchange.

(ii) For purposes of this chapter, exchange does include a small employer SHOP exchange described under Subsection (3)(b)(i)(B) if:

(A) federal regulations under PPACA require a small employer exchange to allow navigators to assist small employers and their employees with selection of qualified health plans on a small employer exchange; and

(B) the state has not entered into an agreement with the United States Department of Health and Human Services that permits the state to limit the scope of practice of navigators to only the individual PPACA exchange.

(4) "Navigator":

(a) means a person who facilitates enrollment in an exchange by offering to assist, or who advertises any services to assist, with:

(i) the selection of and enrollment in a qualified health plan or a public program offered on an exchange; or

(ii) applying for premium subsidies through an exchange; and

(b) includes a person who is an in-person assister or an application assister as described in:

(i) federal regulations or guidance issued under PPACA; and

(ii) the state exchange blueprint published by the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services.

(5) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

(6) "Public programs" means the state Medicaid program in Title 26, Chapter 18, Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

(7) "Solicit" is as defined in Section 31A-23a-102.

Enacted by Chapter 341, 2013 General Session

31A-23b-201. Requirement of license.

(1) (a) Except as provided in Section 31A-23b-211, a person may not perform, offer to perform, or advertise any service as a navigator in the state, without:

(i) a valid navigator license issued under this chapter; or

(ii) a valid producer license under Subsection 31A-23a-106(2)(a) with a line of authority that permits the person to sell, negotiate, or solicit accident and health insurance.

(b) A person may not utilize the services of another as a navigator if that person knows or should know that the other person does not have a license as required by law.

(2) An insurance contract is not invalid as a result of a violation of this section.

Enacted by Chapter 341, 2013 General Session

31A-23b-202. Qualifications for a license.

(1) (a) The commissioner shall issue or renew a license to a person to act as a navigator if the person:

(i) satisfies the:

(A) application requirements under Section 31A-23b-203;

(B) character requirements under Section 31A-23b-204;

(C) examination and training requirements under Section 31A-23b-205; and

(D) continuing education requirements under Section 31A-23b-206;

(ii) certifies that, to the extent applicable, the applicant:

(A) is in compliance with the surety bond requirements of Section 31A-23b-207; and

(B) will maintain compliance with Section 31A-23b-207 during the period for which the license is issued or renewed; and

(iii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23b-401.

(b) A license issued under this chapter is valid for two years.

(2) (a) A person shall report to the commissioner:

(i) an administrative action taken against the person, including a denial of a new or renewal license application:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) a criminal prosecution taken against the person in any jurisdiction.

(b) The report required by Subsection (2)(a) shall be filed:

(i) at the time the person files the application for an individual or agency license; and

(ii) for an action or prosecution that occurs on or after the day on which the person files the application:

(A) for an administrative action, within 30 days of the final disposition of the administrative action; or

(B) for a criminal prosecution, within 30 days of the initial appearance before a court.

(c) The report required by Subsection (2)(a) shall include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(a).

(3) (a) The department may:

(i) require a person applying for a license to submit to a criminal background check as a condition of receiving a license; or

(ii) accept a background check conducted by another organization.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23b-204 for issuance or renewal of a license;

(ii) determining if a person failed to maintain the character requirements under Section 31A-23b-204; and

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or in-person assistor in the state.

(e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license a fee equal to the aggregate of

Subsections (3)(e)(i) and (ii).

(4) The commissioner may deny an application for a license under this chapter if the person applying for the license:

(a) fails to satisfy the requirements of this section; or

(b) commits an act that is grounds for denial, suspension, or revocation as set forth in Section 31A-23b-401.

Enacted by Chapter 341, 2013 General Session

31A-23b-203. Application for individual license -- Application for agency license.

(1) This section applies to an initial or renewal license as a navigator.

(2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an individual shall:

(i) file an application for an initial or renewal individual license with the commissioner on forms and in a manner the commissioner prescribes; and

(ii) pay a license fee that is not refunded if the application:

(A) is denied; or

(B) is incomplete when filed and is never completed by the applicant.

(b) An application described in this Subsection (2) shall provide:

(i) information about the applicant's identity;

(ii) the applicant's Social Security number;

(iii) the applicant's personal history, experience, education, and business record;

(iv) whether the applicant is 18 years of age or older;

(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23b-401 or 31A-23b-402;

(vi) that the applicant complies with the surety bond requirements of Section 31A-23b-207;

(vii) that the applicant completed the training requirements in Section 31A-23b-205; and

(viii) any other information the commissioner reasonably requires.

(3) The commissioner may require a document reasonably necessary to verify the information contained in an application filed under this section.

(4) An applicant's Social Security number contained in an application filed under this section is a private record under Section 63G-2-302.

(5) (a) Subject to Subsection (5)(b), to obtain or renew a navigator agency license, a person shall:

(i) file an application for an initial or renewal navigator agency license with the commissioner on forms and in a manner the commissioner prescribes; and

(ii) pay a license fee that is not refunded if the application:

(A) is denied; or

(B) is incomplete when filed and is never completed by the applicant.

(b) An application described in Subsection (5)(a) shall provide:

(i) information about the applicant's identity;

(ii) the applicant's federal employer identification number;

(iii) the designated responsible licensed individual;

(iv) the identity of the owners, partners, officers, and directors;
(v) whether the applicant, or individual identified in Subsections (5)(b)(iii) and (iv), has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23b-401; and
(vi) any other information the commissioner reasonably requires.

Enacted by Chapter 341, 2013 General Session

31A-23b-204. Character requirements.
An applicant for a license under this chapter shall demonstrate to the commissioner that:
(1) the applicant has the intent, in good faith, to engage in the practice of a navigator as the license would permit;
(2) (a) if a natural person, the applicant is competent and trustworthy; or
(b) if the applicant is an agency:
(i) the partners, directors, or principal officers or persons having comparable powers are trustworthy; and
(ii) that it will transact business in a way that the acts that may only be performed by a licensed navigator are performed only by a natural person who is licensed under this chapter, or Chapter 23a, Insurance Marketing-Licensing Producers, Consultants, and Reinsurance Intermediaries;
(3) the applicant intends to comply with the surety bond requirements of Section 31A-23b-207;
(4) if a natural person, the applicant is at least 18 years of age; and
(5) the applicant does not have a conflict of interest as defined by regulations issued under PPACA.

Enacted by Chapter 341, 2013 General Session

31A-23b-205. Examination and training requirements.
(1) The commissioner may require applicants for a license to pass an examination and complete a training program as a requirement for a license.
(2) The examination described in Subsection (1) shall reasonably relate to:
(a) the duties and functions of a navigator;
(b) requirements for navigators as established by federal regulation under PPACA; and
(c) other requirements that may be established by the commissioner by administrative rule.
(3) The examination may be administered by the commissioner or as otherwise specified by administrative rule.
(4) The training required by Subsection (1) shall be approved by the commissioner and shall include:
(a) accident and health insurance plans;
(b) qualifications for and enrollment in public programs;
(c) qualifications for and enrollment in premium subsidies;
(d) cultural and linguistic competence;

(e) conflict of interest standards;
(f) exchange functions; and
(g) other requirements that may be adopted by the commissioner by administrative rule.
(5) This section applies only to applicants who are natural persons.

Enacted by Chapter 341, 2013 General Session

31A-23b-206. Continuing education requirements.
(1) The commissioner shall, by rule, prescribe continuing education requirements for a navigator.
(2) (a) The commissioner may not require a degree from an institution of higher education as part of continuing education.
(b) The commissioner may state a continuing education requirement in terms of hours of instruction received in:
(i) accident and health insurance;
(ii) qualification for and enrollment in public programs;
(iii) qualification for and enrollment in premium subsidies;
(iv) cultural competency;
(v) conflict of interest standards; and
(vi) other exchange functions.
(3) (a) Continuing education requirements shall require:
(i) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;
(ii) that 3 of the 24 credit hours described in Subsection (3)(a)(i) be ethics courses; and
(iii) that the licensee complete at least half of the required hours through classroom hours of insurance and exchange related instruction.
(b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be obtained through:
(i) classroom attendance;
(ii) home study;
(iii) watching a video recording;
(iv) experience credit; or
(v) another method approved by rule.
(c) A licensee may obtain continuing education hours at any time during the two-year license period.
(d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule:
(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b); and
(ii) authorize one or more continuing education providers, including a state or national professional producer or consultant associations, to:
(A) offer a qualified program on a geographically accessible basis; and
(B) collect a reasonable fee for funding and administration of a continuing

education program, subject to the review and approval of the commissioner.

(4) The commissioner shall approve a continuing education provider or a continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule establish the procedures for continuing education provider registration and course approval.

(6) This section applies only to a navigator who is a natural person.

(7) A navigator shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Enacted by Chapter 341, 2013 General Session

31A-23b-207. Requirement to obtain surety bond.

(1) (a) Except as provided in Subsections (1)(b)(ii) and (2), a navigator shall obtain a surety bond in an amount designated by the commissioner by administrative rule to cover the legal liability of the navigator as the result of an erroneous act or failure to act in the navigator's capacity as a navigator.

(b) The navigator shall:

(i) maintain a surety bond at all times during the term of the navigator's license; or

(ii) demonstrate to the commissioner that the navigator is capable of covering a legal liability for erroneous acts or failure to act in a manner approved by the commissioner.

(2) A navigator is not required to obtain and maintain a surety bond during a period in which the navigator's scope of practice is limited to assisting individuals with:

(a) enrollment in public programs; and

(b) qualification for premium and cost sharing subsidies.

Enacted by Chapter 341, 2013 General Session

31A-23b-208. Form and contents of license.

(1) A license issued under this chapter shall be in the form the commissioner prescribes and shall set forth:

(a) the name and address of the licensee;

(b) the date of license issuance; and

(c) any other information the commissioner considers necessary.

(2) A licensee under this chapter doing business under a name other than the licensee's legal name shall notify the commissioner before using the assumed name in this state.

Enacted by Chapter 341, 2013 General Session

31A-23b-209. Agency designations.

(1) An organization shall be licensed as a navigator agency if the organization acts as a navigator.

(2) A navigator agency that does business in the state shall designate an individual who is licensed under this chapter to act on the agency's behalf.

(3) A navigator agency shall report to the commissioner, at intervals and in the form the commissioner establishes by rule:

(a) a new designation under Subsection (2); and

(b) a terminated designation under Subsection (2).

(4) (a) A navigator agency licensed under this chapter shall report to the commissioner the cause of termination of a designation if:

(i) the reason for termination is a reason described in Subsection 31A-23b-401(4)(b); or

(ii) the navigator agency has knowledge that the individual licensee engaged in an activity described in Subsection 31A-23b-401(4)(b) by:

(A) a court;

(B) a government body; or

(C) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The information provided to the commissioner under Subsection (4)(a) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(c) A navigator agency is immune from civil action, civil penalty, or damages if the agency complies in good faith with this Subsection (4) by reporting to the commissioner the cause of termination of a designation.

(d) A navigator agency is not immune from an action or resulting penalty imposed on the reporting agency as a result of proceedings brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection (4).

(5) A navigator agency licensed under this chapter may act in a capacity for which it is licensed only through an individual who is licensed under this chapter to act in the same capacity.

(6) A navigator agency licensed under this chapter shall designate and report to the commissioner, in accordance with any rule made by the commissioner, the name of the designated responsible licensed individual who has authority to act on behalf of the navigator agency in the matters pertaining to compliance with this title and orders of the commissioner.

(7) If a navigator agency designates a licensee in reports submitted under Subsection (3) or (6), there is a rebuttable presumption that the designated licensee acts on behalf of the navigator agency.

(8) (a) When a license is held by a navigator agency, both the navigator agency itself and any individual designated under the navigator agency license are considered the holders of the navigator agency license for purposes of this section.

(b) If an individual designated under the navigator agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the navigator agency license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the navigator agency, if the navigator agency:

(A) is reckless or negligent in its supervision of the individual; or
(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or
(iii) (A) the individual; and
(B) the navigator agency, if the agency meets the requirements of Subsection (8)(b)(ii).

Enacted by Chapter 341, 2013 General Session

31A-23b-210. Place of business and residence address -- Records.

(1) (a) A licensee under this chapter shall register and maintain with the commissioner:
(i) the address and telephone numbers of the licensee's principal place of business; and
(ii) a valid business email address at which the commissioner may contact the licensee.
(b) If a licensee is an individual, in addition to complying with Subsection (1)(a), the individual shall register and maintain with the commissioner the individual's residence address and telephone number.
(c) A licensee shall notify the commissioner within 30 days of a change of any of the following required to be registered with the commissioner under this section:
(i) an address;
(ii) a telephone number; or
(iii) a business email address.
(2) Except as provided under Subsection (3), a licensee under this chapter shall keep at the principal place of business address registered under Subsection (1), separate and distinct books and records of the transactions consummated under the Utah license.
(3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can be obtained immediately from a central storage place or elsewhere by online computer terminals located at the registered address.
(4) (a) The books and records maintained under Subsection (2) shall be available for the inspection by the commissioner during the business hours for a period of time after the date of the transaction as specified by the commissioner by rule, but in no case for less than the current calendar year plus three years.
(b) Discarding books and records after the applicable record retention period has expired does not place the licensee in violation of a later-adopted longer record retention period.

Enacted by Chapter 341, 2013 General Session

31A-23b-211. Exceptions to navigator licensing.

(1) For purposes of this section:
(a) "Negotiate" is as defined in Section 31A-23a-102.
(b) "Sell" is as defined in Section 31A-23a-102.
(c) "Solicit" is as defined in Section 31A-23a-102.

(2) The commissioner may not require a license as a navigator of:

(a) a person who is employed by or contracts with:

(i) a health care facility that is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, to assist an individual with enrollment in a public program or an application for premium subsidy; or

(ii) the state, a political subdivision of the state, an entity of a political subdivision of the state, or a public school district to assist an individual with enrollment in a public program or an application for premium subsidy;

(b) a federally qualified health center as defined by Section 1905(1)(2)(B) of the Social Security Act which assists an individual with enrollment in a public program or an application for premium subsidy;

(c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants, and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to sell, solicit, or negotiate accident and health insurance plans;

(d) an officer, director, or employee of a navigator:

(i) who does not receive compensation or commission from an insurer issuing an insurance contract, an agency administering a public program, an individual who enrolled in a public program or insurance product, or an exchange; and

(ii) whose activities:

(A) are executive, administrative, managerial, clerical, or a combination thereof;

(B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the enrollment in a public program offered through the exchange;

(C) are in the capacity of a special agent or agency supervisor assisting an insurance producer or navigator;

(D) are limited to providing technical advice and assistance to a licensed insurance producer or navigator; or

(E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment in a public program; and

(e) a person who does not sell, solicit, or negotiate insurance and is not directly or indirectly compensated by an insurer issuing an insurance contract, an agency administering a public program, an individual who enrolled in a public program or insurance product, or an exchange, including:

(i) an employer, association, officer, director, employee, or trustee of an employee trust plan who is engaged in the administration or operation of a program:

(A) of employee benefits for the employer's or association's own employees or the employees of a subsidiary or affiliate of an employer or association; and

(B) that involves the use of insurance issued by an insurer or enrollment in a public health plan on an exchange;

(ii) an employee of an insurer or organization employed by an insurer who is engaging in the inspection, rating, or classification of risk, or the supervision of training of insurance producers; or

(iii) an employee who counsels or advises the employee's employer with regard to the insurance interests of the employer, or a subsidiary or business affiliate of the employer.

(3) The exemption from licensure under Subsections (2)(a) and (b) does not

apply if a person described in Subsections (2)(a) and (b) enrolls a person in a private insurance plan.

(4) The commissioner may by rule exempt a class of persons from the license requirement of Subsection 31A-23b-201(1) if:

(a) the functions performed by the class of persons do not require:

(i) special competence;

(ii) special trustworthiness; or

(iii) regulatory surveillance made possible by licensing; or

(b) other existing safeguards make regulation unnecessary.

Enacted by Chapter 341, 2013 General Session

31A-23b-301. Unfair practices -- Compensation -- Limit of scope of practice.

(1) As used in this section, "false or misleading information" includes, with intent to deceive a person examining it:

(a) filing a report;

(b) making a false entry in a record; or

(c) willfully refraining from making a proper entry in a record.

(2) (a) Communication that contains false or misleading information relating to enrollment in an insurance plan or a public program, including information that is false or misleading because it is incomplete, may not be made by:

(i) a person who is or should be licensed under this title;

(ii) an employee of a person described in Subsection (2)(a)(i);

(iii) a person whose primary interest is as a competitor of a person licensed under this title; and

(iv) a person on behalf of any of the persons listed in this Subsection (2)(a).

(b) A licensee under this chapter may not:

(i) use any business name, slogan, emblem, or related device that is misleading or likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental agency, a PPACA exchange, insurer, or other licensee already in business; or

(ii) use any advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency, public program, or insurer:

(A) is responsible for the insurance or public program enrollment assistance activities of the person;

(B) stands behind the credit of the person; or

(C) is a source of payment of any insurance obligation of or sold by the person.

(c) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that person is an insurer.

(3) A person may not engage in an unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that the method of competition, the act, or the practice:

(a) is misleading;

(b) is deceptive;
(c) is unfairly discriminatory;
(d) provides an unfair inducement; or
(e) unreasonably restrains competition.
(4) A navigator licensed under this chapter is subject to the inducement provisions of Section 31A-23a-402.5.
(5) A navigator licensed under this chapter or who should be licensed under this chapter:
(a) may not receive direct or indirect compensation from an accident or health insurer or from an individual who receives services from a navigator in accordance with:
(i) federal conflict of interest regulations established pursuant to PPACA; and
(ii) administrative rule adopted by the department;
(b) may be compensated by the exchange for performing the duties of a navigator;
(c) (i) may perform, offer to perform, or advertise a service as a navigator only for a person selecting a qualified health plan or public program offered on an exchange; and
(ii) may not perform, offer to perform, or advertise any services as a navigator for individuals or small employer groups selecting accident and health insurance plans, qualified health plans, public programs, business, or services that are not offered on an exchange; and
(d) may not recommend a particular accident and health insurance plan or qualified health plan.

Enacted by Chapter 341, 2013 General Session

31A-23b-401. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.
(1) A license as a navigator under this chapter remains in force until:
(a) revoked or suspended under Subsection (4);
(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;
(c) the licensee dies or is adjudicated incompetent as defined under:
(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;
(d) lapsed under this section; or
(e) voluntarily surrendered.
(2) The following may be reinstated within one year after the day on which the license is no longer in force:
(a) a lapsed license; or
(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.
(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not

prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke a license;

(ii) suspend a license for a specified period of 12 months or less;

(iii) limit a license in whole or in part; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (4)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or 31A-23b-206;

(ii) violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) failed to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) refused:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(vi) had an officer who refused to:

(A) give information with respect to the navigator's affairs; or

(B) perform any other legal obligation as to an examination;

(vii) provided information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(viii) violated an insurance law, valid rule, or valid order of another state's insurance department;

(ix) obtained or attempted to obtain a license through misrepresentation or fraud;

(x) improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xi) intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) application for public program;

(xii) is convicted of a felony;

(xiii) admitted or is found to have committed an insurance unfair trade practice or fraud;

(xiv) in the conduct of business in this state or elsewhere:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xv) had an insurance license, navigator license, or its equivalent, denied, suspended, or revoked in another state, province, district, or territory;

(xvi) forged another's name to:

(A) an application for insurance;

(B) a document related to an insurance transaction;

(C) a document related to an application for a public program; or

(D) a document related to an application for premium subsidies;

(xvii) improperly used notes or another reference material to complete an examination for a license;

(xviii) knowingly accepted insurance business from an individual who is not licensed;

(xix) failed to comply with an administrative or court order imposing a child support obligation;

(xx) failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxi) violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is prohibited from engaging in the business of insurance; or

(xxii) engaged in a method or practice in the conduct of business that endangered the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

(5) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) surrendered in lieu of administrative action;

(iv) lapsed; or
(v) voluntarily surrendered; and
(b) the licensee:
(i) continues to act as a licensee; or
(ii) violates the terms of the license limitation.
(6) A licensee under this chapter shall immediately report to the commissioner:
(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;
(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or
(c) a judgment or injunction entered against that person on the basis of conduct involving:
(i) fraud;
(ii) deceit;
(iii) misrepresentation; or
(iv) a violation of an insurance law or rule.
(7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.
(b) If no time is specified in an order or agreement described in Subsection (7)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval of the commissioner.
(8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this chapter if so ordered by a court.
(9) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Enacted by Chapter 341, 2013 General Session

31A-23b-402. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:
(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under this section; or
(b) at the issuance of a new license:
(i) with an admitted violation under 18 U.S.C. Secs. 1033 and 1034; or
(ii) with a response to background information questions on a new license application indicating that:
(A) the person has been convicted of a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for probation;
(B) the person is currently charged with a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime

that is a ground for probation regardless of whether adjudication is withheld;

(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. Secs. 1033 and 1034.

(3) The probation order shall state the conditions for revocation or retention of the license, which shall be reasonable.

(4) Any violation of the probation is a ground for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Enacted by Chapter 341, 2013 General Session

31A-23b-403. License lapse and voluntary surrender.

(1) (a) A license issued under this chapter shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) complete continuing education requirements under Section 31A-23b-206 before submitting the license renewal application;

(iii) submit a completed renewal application as required by Section 31A-23b-203;

(iv) submit additional documentation required to complete the licensing process; or

(v) maintain an active license in a resident state if the licensee is a nonresident licensee.

(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) other extenuating circumstances, including long-term medical disability.

(ii) A licensee described in Subsection (1)(b)(i) may request:

(A) reinstatement of the license no later than one year after the day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103;

(III) continuing education requirements; or

(IV) other sanctions imposed for failure to comply with renewal procedures.

(2) If a license issued under this chapter is voluntarily surrendered, the license may be reinstated:

(a) during the license period in which the license is voluntarily surrendered; and

(b) no later than one year after the day on which the license is voluntarily

surrendered.

(3) A voluntarily surrendered license that is reinstated during the license period set forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the license complies with any applicable continuing education requirements for the period during which the license was voluntarily surrendered.

Enacted by Chapter 341, 2013 General Session

31A-23b-404. Penalties.

(1) (a) If, after notice and opportunity to be heard, the commissioner finds that the navigator or any other person has not materially complied with this part, or any rule made or order issued under this chapter, the commissioner may order the navigator or other person to cease doing business in the state.

(b) If the commissioner finds that because of the material noncompliance an insurer, any policyholder of an insurer, or a recipient of a public program who used the services of the navigator or other person has suffered any loss or damage due to the material noncompliance, the commissioner may:

(i) maintain a civil action or may intervene in an action brought by or on behalf of the insurer, policyholder, or the recipient of the public program, for recovery of compensatory damages for the benefit of the insurer, policyholder, or recipient of a public program; or

(ii) seek other appropriate relief.

(2) Nothing in this section affects the right of the commissioner to impose any other penalties provided for in this title.

(3) Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

Enacted by Chapter 341, 2013 General Session

31A-25-102. Scope and purposes.

(1) This chapter applies to all third party administrators.

(2) The purposes of this chapter include:

(a) encouraging disclosure of contracts between insurers and third party administrators, both to potential insureds and to the commissioner;

(b) promoting the financial responsibility of third party administrators;

(c) subjecting persons administering insurance in Utah to the jurisdiction of the Utah commissioner and courts;

(d) regulating third party administrators' practices in conformity with the general purposes of this title; and

(e) governing the qualifications and procedures for the licensing of third party administrators.

Amended by Chapter 116, 2001 General Session

31A-25-201. License and authority from insurers required.

(1) A person may not perform, offer to perform, or advertise any service as a

third party administrator in Utah, without a valid license under Section 31A-25-203 and express authority from all insurers it represents. A person may not utilize the services of another as a third party administrator if he knows or should know that the other does not have a license or the insurer authority as required by law. The commissioner shall be notified of the commencement or termination of insurer authority in a form established by rules.

(2) The commissioner may by rule exempt certain persons or classes of persons from the license requirement of Subsection (1) if the functions they perform do not require the special competence, trustworthiness, or regulatory surveillance made possible by licensing.

(3) A contract is not invalid as a result of a violation of this section.

Amended by Chapter 261, 1989 General Session

31A-25-202. Application for license.

(1) (a) An application for a license as a third party administrator shall be:

(i) made to the commissioner on forms and in a manner the commissioner prescribes; and

(ii) accompanied by the applicable fee, which is not refundable if the application is denied.

(b) The application for a license as a third party administrator shall:

(i) state the applicant's:

(A) Social Security number; or

(B) federal employer identification number;

(ii) provide information about:

(A) the applicant's identity;

(B) the applicant's personal history, experience, education, and business record;

(C) if the applicant is a natural person, whether the applicant is 18 years of age or older; and

(D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

(iii) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

(3) An applicant's Social Security number contained in an application filed under this section is a private record under Section 63G-2-302.

Amended by Chapter 382, 2008 General Session

31A-25-203. General requirements for license issuance.

(1) The commissioner shall issue a license to act as a third party administrator to a person who:

(a) satisfies the character requirements under Section 31A-25-204;

(b) satisfies the financial responsibility requirement under Section 31A-25-205;

(c) has not committed an act that is a ground for denial, suspension, or revocation provided in Section 31A-25-208;

(d) if a nonresident, complies with Section 31A-25-206; and
(e) pays the applicable fees under Section 31A-3-103.
(2) (a) This Subsection (2) applies to the following persons:
(i) an applicant for a third party administrator's license; or
(ii) a licensed third party administrator.
(b) A person described in Subsection (2)(a) shall report to the commissioner:
(i) an administrative action taken against the person, including a denial of a new or renewal license application:
(A) in another jurisdiction; or
(B) by another regulatory agency in this state; and
(ii) a criminal prosecution taken against the person in any jurisdiction.
(c) The report required by Subsection (2)(b) shall:
(i) be filed:
(A) at the time the person applies for a third party administrator's license; and
(B) if an action or prosecution occurs on or after the day on which the person applies for a third party administrator license:
(I) for an administrative action, within 30 days of the final disposition of the administrative action; or
(II) for a criminal prosecution, within 30 days of the initial appearance before a court; and
(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).
(3) (a) The department may require a person applying for a license or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license or consent.
(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:
(i) submit a fingerprint card in a form acceptable to the department; and
(ii) consent to a fingerprint background check by:
(A) the Utah Bureau of Criminal Identification; and
(B) the Federal Bureau of Investigation.
(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request concerning a person applying for a third party administrator's license:
(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.
(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:
(i) determining if a person satisfies the character requirements under Section 31A-25-204 for issuance or renewal of a license;
(ii) determining if a person has failed to maintain the character requirements under Section 31A-25-204; and
(iii) preventing a person who violates the federal Violent Crime Control and Law

Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in the state.

(e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) The commissioner may deny a license application to act as a third party administrator to a person who:

(a) fails to satisfy the requirements of this section; or

(b) commits an act that is a ground for denial, suspension, or revocation provided in Section 31A-25-208.

Amended by Chapter 253, 2012 General Session

31A-25-204. Character requirements.

Each applicant for a license under this chapter shall show to the commissioner all of the following:

(1) he or it has the good faith intent to engage in the type of business the license applied for would permit;

(2) if a natural person, he is competent and trustworthy, or, if a partnership or corporation, all the partners, directors, principal officers, or persons having comparable powers are trustworthy; and

(3) if a natural person, he is at least 18 years of age.

Enacted by Chapter 242, 1985 General Session

31A-25-205. Financial responsibility.

(1) Every person licensed under this chapter shall maintain an insurance policy or surety bond:

(a) (i) while licensed; and

(ii) for one year after the person is licensed; and

(b) issued:

(i) by an authorized insurer;

(ii) in an amount specified under Subsection (2); and

(iii) on a policy or contract form that is acceptable under Subsection (3).

(2) (a) Insurance policies or surety bonds satisfying the requirement of Subsection (1) shall be in a face amount equal to:

(i) at least the greater of:

(A) 10% of the total funds handled by the administrator; or

(B) $5,000; and

(ii) may not exceed $500,000.

(b) In fixing the policy or bond face amount under Subsection (2)(a), the total funds handled is:

(i) the greater of:

(A) the premiums received during the previous calendar year; or

(B) claims paid through the administrator during the previous calendar year; or

(ii) if no funds were handled during the preceding year, the total funds reasonably anticipated to be handled by the administrator during the current calendar year.

(c) This section does not prohibit any person dealing with the administrator from requiring, by contract, insurance coverage in amounts greater than the insurance coverage required under this section.

(3) (a) Insurance policies or surety bonds issued to satisfy Subsection (1) shall:

(i) be on forms approved by the commissioner; and

(ii) require the insurer to pay, up to the policy or bond face amount, any judgment:

(A) obtained by participants in or beneficiaries of plans administered by the insured licensee; and

(B) that arises from the negligence or culpable acts of the licensee or any employee or agent of the licensee in connection with the activities of a third party administrator as defined in Section 31A-1-301.

(b) The commissioner may require that policies or bonds issued to satisfy the requirements of this section require the insurer to give the commissioner 20 day prior notice of policy cancellation.

(4) The commissioner shall establish annual reporting requirements and forms to monitor compliance with this section.

(5) This section may not be construed as limiting any cause of action an insured would otherwise have against the insurer.

Amended by Chapter 71, 2002 General Session
Amended by Chapter 308, 2002 General Session

31A-25-206. Nonresident jurisdictional agreement.

(1) (a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident third party administrator license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed as a resident in the nonresident license applicant's home state at the time the nonresident license applicant applies for a nonresident third party administrator license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103;

(ii) the nonresident license applicant's license in the applicant's home state is in good standing; and

(iii) the nonresident license applicant's home state awards nonresident third party administrator licenses to residents of this state on the same basis as this state awards licenses to residents of that home state.

(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter related to the applicant's insurance activities in Utah, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) other service authorized in the Utah Rules of Civil Procedure.

(3) The commissioner may verify the third party administrator's licensing status through the database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Amended by Chapter 116, 2001 General Session

31A-25-207. Form and contents of license.

(1) Licenses issued under this chapter shall be in the form the commissioner prescribes and shall set forth:

(a) the name, address, and telephone number of the licensee;

(b) the date of license issuance; and

(c) any other information the commissioner considers advisable.

(2) A third party administrator doing business under any other name than the administrator's legal name shall notify the commissioner prior to using the assumed name in this state.

(3) (a) An organization shall be licensed as an agency if the organization acts as a third party administrator.

(b) An agency license issued under Subsection (3)(a) shall set forth the names of all natural persons licensed under this chapter who are authorized to act in those capacities for the organization in this state.

Amended by Chapter 116, 2001 General Session

31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal and reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (4);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-25-210; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke a license;

(ii) suspend a license for a specified period of 12 months or less;

(iii) limit a license in whole or in part; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (4)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license under Section 31A-25-202, 31A-25-203, or 31A-25-204;

(ii) has violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another third party administrator that transacts business in this state without a license;

(vii) refuses:
(A) to be examined; or
(B) to produce its accounts, records, and files for examination;
(viii) has an officer who refuses to:
(A) give information with respect to the third party administrator's affairs; or
(B) perform any other legal obligation as to an examination;
(ix) provides information in the license application that is:
(A) incorrect;
(B) misleading;
(C) incomplete; or
(D) materially untrue;
(x) has violated an insurance law, valid rule, or valid order of another state's insurance department;
(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;
(xiii) has intentionally misrepresented the terms of an actual or proposed:
(A) insurance contract; or
(B) application for insurance;
(xiv) has been convicted of a felony;
(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;
(xvi) in the conduct of business in this state or elsewhere has:
(A) used fraudulent, coercive, or dishonest practices; or
(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
(xvii) has had an insurance license or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;
(xviii) has forged another's name to:
(A) an application for insurance; or
(B) a document related to an insurance transaction;
(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;
(xx) has knowingly accepted insurance business from an individual who is not licensed;
(xxi) has failed to comply with an administrative or court order imposing a child support obligation;
(xxii) has failed to:
(A) pay state income tax; or
(B) comply with an administrative or court order directing payment of state income tax;
(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and 1034; or
(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.
(c) For purposes of this section, if a license is held by an agency, both the

agency itself and any individual designated under the license are considered to be the holders of the agency license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participated in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

(5) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(6) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in any other state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against the person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in the order or agreement described in Subsection (7)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval of the commissioner.

(8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by the court.

(9) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative

Rulemaking Act.

Amended by Chapter 284, 2011 General Session

31A-25-209. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-25-208; or

(b) at the issuance of a new license:

(i) with an admitted violation under 18 U.S.C. Sections 1033 and 1034; or

(ii) with a response to a background information question on a new license application indicating that:

(A) the person has been convicted of a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;

(B) the person is currently charged with a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication is withheld;

(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. Sections 1033 and 1034.

(3) A probation order under this section shall state the conditions for retention of the license, which shall be reasonable.

(4) A violation of the probation is grounds for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 382, 2008 General Session

31A-25-210. License lapse and voluntary surrender.

(1) (a) A license issued under this chapter shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) submit a completed renewal application as required by Section 31A-25-202;

(iii) produce, when due, evidence of compliance with the financial responsibility requirement under Section 31A-25-205; or

(iv) maintain an active license in a resident state if the licensee is a nonresident licensee.

(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) some other extenuating circumstances, such as long-term medical disability.

(ii) A licensee described in Subsection (1)(b)(i) may request:

(A) reinstatement of the license no later than one year from the day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103; or

(III) other sanction imposed for failure to comply with renewal procedures.

(2) If a license issued under this chapter is voluntarily surrendered, the license may be reinstated:

(a) during the license period in which the license is voluntarily surrendered; and

(b) no later than one year after the day on which the license is voluntarily surrendered.

Amended by Chapter 349, 2009 General Session

31A-25-301. Written agreements required.

(1) Every third party administrator shall have a written agreement with each insurer and with each group policyholder represented.

(2) The agreements required by Subsection (1) shall contain provisions which include the requirements of this part, except where those requirements are not applicable to the particular functions carried out by the third party administrator.

(3) If a policy is issued to a trustee, a copy of the trust agreement and its amendments shall be furnished to the third party administrator and kept on file in the offices of the third party administrator.

Amended by Chapter 204, 1986 General Session

31A-25-302. Books and records required -- Access.

(1) Any insurer contracting with an administrator for administrator services has the right of continuing access to those records maintained by the third party administrator which permit the insurer to fulfill all of its contractual obligations to insured persons. The proprietary rights of the parties in the records are governed by the written agreement between the insurer and third party administrator.

(2) Every administrator shall maintain at a location accessible to the commissioner, for at least three years, the administrator's written agreements, and complete books and records of all transactions among the administrator, insurers, and insured persons. The books and records shall be maintained in accordance with prudent standards of insurance recordkeeping. The administrator shall provide copies of the books and records to any successor administrator upon request.

(3) The commissioner shall have access to the books and records maintained by the administrator for the purpose of audit and inspection. Any trade secrets contained in the books and records, including the identity and addresses of

policyholders and certificate holders, are confidential, except the commissioner may use that information in any proceeding instituted against the administrator.

Enacted by Chapter 242, 1985 General Session

31A-25-303. Standards pertaining to advertising and underwriting.

(1) A third party administrator may use advertising pertaining to the business underwritten by the insurer only to the extent it has been approved in writing by the insurer in advance.

(2) The agreement required under Subsection 31A-25-301(1) shall include a provision on underwriting or other standards pertaining to the business underwritten by the insurer.

Enacted by Chapter 242, 1985 General Session

31A-25-304. Liability of the insurer if administrator receives premium.

If an insurer utilizes the services of a third party administrator under the terms of a written agreement, as required under this chapter, the payment to the third party administrator of any premiums for insurance by or on behalf of the insured is considered as having been received by the insurer. However, the payment of return premiums or claims by the insurer to the third party administrator is not payment to the insured or claimant. This chapter does not limit any right of the insurer against a third party administrator resulting from the third party administrator's failure to make payments to the insurer, insureds, or claimants.

Enacted by Chapter 242, 1985 General Session

31A-25-305. Fiduciary requirements for third party administrators.

(1) All money received by a third party administrator in that capacity shall be held by the third party administrator as a fiduciary. The money shall be paid in a timely manner to the persons entitled to it. While any money is being held by the third party administrator, it shall be deposited promptly in one or more fiduciary bank accounts maintained by the third party administrator pursuant to any rules the commissioner adopts to protect the integrity of the funds.

(2) If premiums deposited in a fiduciary account have been collected on behalf of more than one insurer or more than one class of insureds, the third party administrator shall keep records clearly recording the deposits and withdrawals from the account by or for the benefit of persons beneficially entitled to them, if there are not separate accounts for that purpose. The third party administrator shall furnish the insurer or policyholder with copies of the records pertaining to deposits and withdrawals on behalf of the insurer or policyholder.

(3) The third party administrator may not pay any claim by withdrawals from a fiduciary account. Withdrawals from the account may be made as provided in the written agreement between the third party administrator and the insurer, or between the third party administrator and the policyholders, as required under this chapter, for the following:

(a) remittance to an insurer entitled to the remittance;
(b) deposit in an account maintained in the name of the insurer;
(c) transfer to and deposit in a claims-paying account, with claims to be paid as provided by Section 31A-25-306;
(d) payment to a group policyholder for remittance to the insurer entitled to the remittance;
(e) payment to the third party administrator of its commission, fees, or charges; or
(f) remittance of return premiums to the persons entitled to them.

Enacted by Chapter 242, 1985 General Session

31A-25-306. Payments by administrator.
An administrator shall pay a claim from money collected on behalf of the insurer on drafts or checks as authorized by the insurer.

Amended by Chapter 253, 2012 General Session

31A-25-307. Delivery by administrator of policies and communications from insurer.
Any policies, certificates, booklets, termination notices, or other written communications delivered by the insurer to the administrator for delivery to its policyholders shall be delivered by the administrator promptly after receipt of instructions from the insurer to do so.

Enacted by Chapter 242, 1985 General Session

31A-25-401. Compensation not to be contingent on claims expense.
The compensation paid to a third party administrator for any policies under which the third party administrator adjusts or settles claims may be contingent on claims experience only if the third party administrator discloses to the person whose plan is being administered any conflicts of interest which are present on account of the compensation arrangement.

Enacted by Chapter 242, 1985 General Session

31A-25-402. Notice to insureds regarding administration of policies.
(1) If the services of a third party administrator are utilized, the third party administrator shall provide a written notice to the insureds, advising them of the identity of and relationship among the third party administrator, the policyholder, and any insurer issuing the policy. This notice shall be approved by the policyholder and by the insurer, if any.
(2) If a third party administrator collects funds, the third party administrator shall identify and state separately in writing to the person paying the administrator the amount of the third party administrator's charge and the premium specified by the insurer for the insurance coverage.

Amended by Chapter 204, 1986 General Session

31A-26-101. Purposes.

The purposes of this chapter are:

(1) to promote the professional competence of those engaged in claims adjusting;

(2) to encourage fair and rapid settlement of claims;

(3) to protect claimants under insurance policies from unfair claims adjustment practices;

(4) to prevent compensation arrangements for insurance adjusters that endanger the fairness of claim settlements; and

(5) to govern the qualifications and procedures for the licensing of insurance adjusters.

Amended by Chapter 116, 2001 General Session

31A-26-102. Definitions.

As used in this chapter, unless expressly provided otherwise:

(1) "Company adjuster" means a person employed by an insurer whose regular duties include insurance adjusting.

(2) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insurers.

(3) "Insurance adjusting" or "adjusting" means directing the investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

(4) "Organization" means a person other than a natural person, and includes a sole proprietorship by which a natural person does business under an assumed name.

(5) "Portable electronics insurance" is as defined in Section 31A-22-1802.

(6) "Public adjuster" means a person required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants under insurance policies.

Amended by Chapter 151, 2012 General Session

31A-26-103. Workers' compensation claims.

In addition to being subject to this and other chapters of this title, insurers writing workers' compensation insurance in this state, including the Workers' Compensation Fund created under Chapter 33, are subject to the Labor Commission with respect to claims for and payment of compensation and benefits.

Amended by Chapter 222, 2000 General Session

31A-26-201. Requirement of license.

(1) Except as provided in Subsection (2):

(a) a person may not perform, offer to perform, or solicit the opportunity to perform an act of insurance adjusting without a valid license under Section 31A-26-203; and

(b) a person may not use the insurance adjusting services of another if the person knows or should know that the one providing these services does not have a license as required by law.

(2) The following are exempt from the license requirement of Subsection (1), when acting in the indicated capacity:

(a) an individual engaged in insurance adjusting as a regular salaried employee of, and not an independent contractor for, an insurer;

(b) an arbitrator or an umpire selected by the claimant and insurer to decide, alone or with others, whether a claim should be paid and how much should be paid;

(c) an attorney at law acting in an attorney-client relationship;

(d) an insurance producer, but only as to:

(i) a class of insurance for which the insurance producer is licensed under Section 31A-23a-106; and

(ii) a claim adjusted on the request of an insurer for which the insurance producer is a producer;

(e) a regular salaried employee of, and not an independent contractor for, a policyholder or claimant under an insurance policy;

(f) an employee of a licensed insurance adjuster who provides only administrative or clerical assistance;

(g) an individual who does not do insurance adjusting under Section 31A-26-102, but who is specially employed to obtain facts about a loss for or furnish technical assistance to a licensed adjuster or a company adjuster, including:

(i) a photographer;

(ii) an estimator;

(iii) an appraiser;

(iv) a marine surveyor;

(v) a private detective;

(vi) an engineer; and

(vii) a handwriting expert;

(h) a holder of a group insurance policy, with respect to administrative activities in connection with that insurance policy, who receives no compensation for the policyholder's services beyond the actual expenses estimated on a reasonable basis;

(i) an individual engaged in insurance adjusting as a regular salaried employee of, and not an independent contractor for, an administrator licensed under Chapter 25, Third Party Administrators; or

(j) a person who gives advice or assistance without compensation or expectation of compensation, direct or indirect.

(3) A claim settlement between an insurer and an insured or a claimant under an insurance policy may not be considered invalid as a result of a violation of this section.

Amended by Chapter 10, 2010 General Session

31A-26-202. Application for license.

(1) (a) The application for a license as an independent adjuster or public adjuster shall be:

(i) made to the commissioner on forms and in a manner the commissioner prescribes; and

(ii) accompanied by the applicable fee, which is not refunded if the application is denied.

(b) The application shall provide:

(i) information about the applicant's identity, including:

(A) the applicant's:

(I) Social Security number; or

(II) federal employer identification number;

(B) the applicant's personal history, experience, education, and business record;

(C) if the applicant is a natural person, whether the applicant is 18 years of age or older; and

(D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

(ii) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

(3) An applicant's Social Security number contained in an application filed under this section is a private record under Section 63G-2-302.

Amended by Chapter 382, 2008 General Session

31A-26-203. Adjuster's license required.

(1) The commissioner shall issue a license to act as an independent adjuster or public adjuster to a person who, as to the license classification applied for under Section 31A-26-204:

(a) satisfies the character requirements under Section 31A-26-205;

(b) satisfies the applicable continuing education requirements under Section 31A-26-206;

(c) satisfies the applicable examination requirements under Section 31A-26-207;

(d) has not committed an act that is a ground for denial, suspension, or revocation provided for in Section 31A-26-213;

(e) if a nonresident, complies with Section 31A-26-208; and

(f) pays the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for:

(A) an independent adjuster's license; or

(B) a public adjuster's license;

(ii) a licensed independent adjuster; or

(iii) a licensed public adjuster.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) an administrative action taken against the person, including a denial of a new or renewal license application:

(A) in another jurisdiction; or
(B) by another regulatory agency in this state; and
(ii) a criminal prosecution taken against the person in any jurisdiction.
(c) The report required by Subsection (2)(b) shall:
(i) be filed:
(A) at the time the person applies for an adjustor's license; and
(B) if an action or prosecution occurs on or after the day on which the person applies for an adjustor's license:
(I) for an administrative action, within 30 days of the final disposition of the administrative action; or
(II) for a criminal prosecution, within 30 days of the initial appearance before a court; and
(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).
(3) (a) The department may require a person applying for a license or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license or consent.
(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:
(i) submit a fingerprint card in a form acceptable to the department; and
(ii) consent to a fingerprint background check by:
(A) the Utah Bureau of Criminal Identification; and
(B) the Federal Bureau of Investigation.
(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request concerning a person applying for an independent or public adjuster's license:
(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.
(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:
(i) determining if a person satisfies the character requirements under Section 31A-26-205 for issuance or renewal of a license;
(ii) determining if a person has failed to maintain the character requirements under Section 31A-26-205; and
(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in the state.
(e) If the department requests the criminal background information, the department shall:
(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(c)(i);
(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal

Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) The commissioner may deny a license application to act as an independent adjuster or public adjuster to a person who, as to the license classification applied for under Section 31A-26-204:

(a) fails to satisfy the requirements in this section; or

(b) commits an act that is a ground for denial, suspension, or revocation provided for in Section 31A-26-213.

(5) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance classification only with the concurrence of the Title and Escrow Commission; or

(b) renew a license for a title insurance classification only with the concurrence of the Title and Escrow Commission.

Amended by Chapter 253, 2012 General Session

31A-26-204. License classifications.

A resident or nonresident license issued under this chapter shall be issued under the classifications described under Subsections (1), (2), and (3). A classification describes the matters to be considered under a prerequisite education or examination required of license applicants under Sections 31A-26-206 and 31A-26-207.

(1) Independent adjuster license classifications include:

(a) accident and health insurance, including related service insurance under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(b) property and casualty insurance, including a surety or other bond;

(c) crop insurance; and

(d) workers' compensation insurance.

(2) Public adjuster license classifications include:

(a) accident and health insurance, including related service insurance under Chapter 7 or 8;

(b) property and casualty insurance, including a surety or other bond;

(c) crop insurance; and

(d) workers' compensation insurance.

(3) (a) The commissioner may by rule:

(i) recognize other independent adjuster or public adjuster license classifications as to other kinds of insurance not listed under Subsection (1); and

(ii) create license classifications that grant only part of the authority arising under another license class.

(b) Notwithstanding Subsection (3)(a), for purpose of title insurance, the Title and Escrow Commission may make the rules provided for in Subsection (3)(a), subject to Section 31A-2-404.

Amended by Chapter 349, 2009 General Session

31A-26-205. Character requirements.

Each applicant for a license under this chapter shall show to the commissioner that:

(1) he has the good faith intent to engage in the type of business the license or licenses applied for would permit;

(2) if a natural person, he is competent and trustworthy, or that, if an organization, all the partners, directors, principal officers, or persons in fact having comparable powers are trustworthy, and that it will transact business in such a way that all acts that may only be performed by a licensed adjuster are performed exclusively by natural persons who are licensed under this chapter to transact that business and listed on the organization's license under Section 31A-26-209; and

(3) if a natural person, he is at least 18 years of age.

Amended by Chapter 204, 1986 General Session

31A-26-206. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe continuing education requirements for each class of license under Section 31A-26-204.

(2) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (2).

(b) (i) Except as otherwise provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

(ii) A continuing education hour completed in accordance with Subsection (2)(b)(i) may be obtained through:

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) other methods provided by rule.

(iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d) (i) A licensee is exempt from the continuing education requirements of this section if:

(A) the licensee was first licensed before April 1, 1978;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before

May 11, 2011;

(C) the licensee requests an exemption from the department; and

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (2)(b); and

(ii) authorize a professional adjuster association to:

(A) offer a qualified program for a classification of license on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a qualified program, subject to the review and approval of the commissioner.

(f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and administer a qualified program shall reasonably relate to the cost of administering the qualified program.

(ii) Nothing in this section shall prohibit a provider of a continuing education program or course from charging a fee for attendance at a course offered for continuing education credit.

(iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(3) The continuing education requirements of this section apply only to a licensee who is an individual.

(4) The continuing education requirements of this section do not apply to a member of the Utah State Bar.

(5) The commissioner shall designate a course that satisfies the requirements of this section, including a course presented by an insurer.

(6) A nonresident adjuster is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident adjuster satisfies the nonresident producer's home state's continuing education requirements for a licensed insurance adjuster; and

(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's continuing education requirements for a producer as satisfying the continuing education requirements of the home state.

(7) A licensee subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education requirement applies.

Amended by Chapter 284, 2011 General Session

31A-26-207. Examination requirements.

(1) The commissioner may require applicants for any particular class of license

under Section 31A-26-204 to pass an examination as a requirement to receiving a license. The examination shall reasonably relate to the specific license class for which it is prescribed. The examinations may be administered by the commissioner or as specified by rule.

(2) The commissioner shall waive the requirement of an examination for a nonresident applicant who:

(a) applies for an insurance adjuster license in this state;

(b) has been licensed for the same line of authority in another state; and

(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or

(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:

(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.

(3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and 31A-26-203, a person licensed as an insurance producer in another state who moves to this state shall make application within 90 days of establishing legal residence in this state.

(b) A person who becomes a resident licensee under Subsection (3)(a) may not be required to meet prelicensing education or examination requirements to obtain any line of authority previously held in the prior state unless:

(i) the prior state would require a prior resident of this state to meet the prior state's prelicensing education or examination requirements to become a resident licensee; or

(ii) the commissioner imposes the requirements by rule.

(4) The requirements of this section only apply to applicants who are natural persons.

(5) The requirements of this section do not apply to members of the Utah State Bar.

Amended by Chapter 116, 2001 General Session

31A-26-208. Nonresident jurisdictional agreement.

(1) (a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident adjuster's license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed as a resident in the nonresident license applicant's home state at the time the nonresident license applicant applies for a nonresident adjuster license;

(B) has submitted the proper request for licensure;
(C) has submitted to the commissioner:
(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state; or
(II) a completed uniform application; and
(D) has paid the applicable fees under Section 31A-3-103;
(ii) the nonresident license applicant's license in the applicant's home state is in good standing; and
(iii) the nonresident license applicant's home state awards nonresident adjuster licenses to residents of this state on the same basis as this state awards licenses to residents of that home state.
(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the commissioner and courts of this state on any matter related to the adjuster's insurance activities in this state, on the basis of:
(a) service of process under Sections 31A-2-309 and 31A-2-310; or
(b) other service authorized under the Utah Rules of Civil Procedure or Section 78B-3-206.
(3) The commissioner may verify an adjuster's licensing status through the database maintained by:
(a) the National Association of Insurance Commissioners; or
(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Amended by Chapter 284, 2011 General Session

31A-26-209. Form and contents of license.
(1) Licenses issued under this chapter shall be in the form the commissioner prescribes and shall set forth:
(a) the name, address, and telephone number of the licensee;
(b) the license classifications under Section 31A-26-204;
(c) the date of license issuance; and
(d) any other information the commissioner considers advisable.
(2) An adjuster doing business under any other name than the adjuster's legal name shall notify the commissioner prior to using the assumed name in this state.
(3) (a) An organization shall be licensed as an agency if the organization acts as:
(i) an independent adjuster; or
(ii) a public adjuster.
(b) The agency license issued under Subsection (3)(a) shall set forth the names of all natural persons licensed under this chapter who are authorized to act in those capacities for the organization in this state.

Amended by Chapter 173, 2004 General Session

31A-26-210. Reports from organizations licensed as adjusters.

(1) An organization licensed as an adjuster under Section 31A-26-203 shall designate an individual who has an individual adjuster license to act on the organization's behalf in order for the licensee to do business for the organization in this state.

(2) An organization licensed under this chapter shall report to the commissioner, at intervals and in the form the commissioner establishes by rule:

(a) a new designation; and

(b) a terminated designation.

(3) (a) An organization licensed under this chapter shall report to the commissioner the cause of termination of a designation if:

(i) the reason for termination is a reason described in Subsection 31A-26-213(5)(b); or

(ii) the organization has knowledge that the individual licensee is found to have engaged in an activity described in Subsection 31A-26-213(5)(b) by:

(A) a court;

(B) a government body; or

(C) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The information provided the commissioner under Subsection (3)(a) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(c) An organization is immune from civil action, civil penalty, or damages if the organization complies in good faith with this Subsection (3) in reporting to the commissioner the cause of termination of a designation.

(d) Notwithstanding any other provision in this section, an organization is not immune from an action or resulting penalty imposed on the reporting organization as a result of a proceeding brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection (3).

(4) An organization licensed under this chapter may act in a capacity for which it is licensed only through an individual who is licensed under this chapter to act in the same capacity.

(5) An organization licensed under this chapter shall designate and report promptly to the commissioner the name of the designated responsible licensed individual who has authority to act on behalf of the organization in all matters pertaining to compliance with this title and orders of the commissioner.

(6) If an agency designates a licensee in a report submitted under Subsection (2) or (5), there is a rebuttable presumption that the designated licensee acts on behalf of the agency.

(7) (a) When a license is held by an organization, both the organization itself and an individual designated under the license shall, for purposes of this section, be considered to be the holders of the organization license.

(b) If an individual designated under the organization license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the

organization license, the commissioner may suspend, revoke, or limit the license of:

(i) that individual;

(ii) the organization, if the organization:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the organization, if the organization meets the requirements of Subsection (7)(b)(ii).

Amended by Chapter 349, 2009 General Session

31A-26-211. Claims liaison.

Authorized insurers with employees engaged in insurance adjusting may be required by the commissioner to designate one or more natural persons to whom the commissioner or his staff may direct inquiries concerning the insurer's claims adjustments. Insurers shall report to the commissioner the name, title, business address, telephone number of, and any changes in its designees under this section.

Amended by Chapter 204, 1986 General Session

31A-26-212. Emergency license.

In the event of a catastrophe or emergency which arises out of a disaster, act of God, riot, civil commotion, conflagration, or other similar occurrence, the commissioner shall, upon application, issue emergency licenses to persons who are not licensed adjusters. An emergency license shall be applied for within a week of beginning claims adjustment. It may remain in force for not more than 90 days, unless extended by the commissioner before it expires for an additional period of not more than 90 additional days. The insurer who contracts with an independent adjuster who is so licensed is responsible for all his claims practices while so engaged, as if he were a regular salaried employee. The fee for an emergency license is the same as the fee required of other licensed adjusters, unless the commissioner waives the fee.

Enacted by Chapter 242, 1985 General Session

31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-26-214.5; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which it is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) A license classification issued under this chapter remains in force until:

(a) the qualifications pertaining to a license classification are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5); or

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action.

(5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a license classification;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a license classification;

(iii) limit in whole or in part:

(A) a license; or

(B) a license classification; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license or license classification under Section 31A-26-202, 31A-26-203, 31A-26-204, or 31A-26-205;

(ii) has violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance adjuster that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance adjuster's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) has violated an insurance law, valid rule, or valid order of another state's insurance department;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xiii) has intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of a felony;

(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere has:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

(xx) has knowingly accepted insurance business from an individual who is not licensed;

(xxi) has failed to comply with an administrative or court order imposing a child support obligation;

(xxii) has failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and 1034; or

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participated in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for conducting an insurance business without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in any other state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time not to exceed five years within which the former licensee may not apply for a new license.

(b) If no time is specified in the order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years without the express approval of the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Amended by Chapter 284, 2011 General Session

31A-26-214. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-26-213; or

(b) at the issuance of a new license:

(i) with an admitted violation under 18 U.S.C. Sections 1033 and 1034; or

(ii) with a response to a background information question on any new license application indicating that:

(A) the person has been convicted of a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;

(B) the person is currently charged with a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication was withheld;

(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may put a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to violations under 18 U.S.C. Sections 1033 and 1034.

(3) A probation order under this section shall state the conditions for retention of the license, which shall be reasonable.

(4) A violation of the probation is grounds for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 382, 2008 General Session

31A-26-214.5. License lapse and voluntary surrender.

(1) (a) A license issued under this chapter shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) complete continuing education requirements under Section 31A-26-206 before submitting the license renewal application;

(iii) submit a completed renewal application as required by Section 31A-26-202;

(iv) submit additional documentation required to complete the licensing process

as related to a specific license type or license classification; or

(v) maintain an active license in a resident state if the licensee is a nonresident licensee.

(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) some other extenuating circumstances, such as long-term medical disability.

(ii) A licensee described in Subsection (1)(b)(i) may request:

(A) reinstatement of the license no later than one year after the day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103;

(III) continuing education requirements; or

(IV) other sanction imposed for failure to comply with renewal procedures.

(2) If a license issued under this chapter is voluntarily surrendered, the license may be reinstated:

(a) during the license period in which it is voluntarily surrendered; and

(b) no later than one year after the day on which the license is voluntarily surrendered.

Amended by Chapter 349, 2009 General Session

31A-26-215. Temporary license -- Appointment of trustee for terminated licensee's business.

(1) (a) The commissioner may issue a temporary insurance adjuster license:

(i) to a person listed in Subsection (1)(b):

(A) if the commissioner considers that the temporary license is necessary:

(I) for the servicing of an insurance business in the public interest; and

(II) to provide continued service to the insureds who are being serviced in a circumstance described in Subsection (1)(b);

(B) for a period not to exceed 180 days; and

(C) without requiring an examination; or

(ii) in any other circumstance:

(A) if the commissioner considers the public interest will best be served by issuing the temporary license;

(B) for a period not to exceed 180 days; and

(C) without requiring an examination.

(b) The commissioner may issue a temporary insurance producer license in accordance with Subsection (1)(a) to:

(i) the surviving spouse or court-appointed personal representative of a licensed insurance adjuster who dies or acquires a mental or physical disability to allow adequate time for:

(A) the sale of the insurance business owned by the adjuster;
(B) recovery or return of the adjuster to the business; or
(C) the training and licensing of new personnel to operate the adjuster's business;
(ii) to a member or employee of a business entity licensed as an insurance adjuster upon the death or disability of an individual designated in:
(A) the business entity application; or
(B) the license; or
(iii) the designee of a licensed insurance adjuster entering active service in the armed forces of the United States of America.
(2) If a person's license is terminated under Section 31A-26-213, the commissioner may appoint a trustee to provide in the public interest continuing service to the insureds who procured insurance through the person whose license is terminated:
(a) at the request of the person whose license is terminated; or
(b) upon the commissioner's own initiative.
(3) This section does not apply if the deceased or disabled adjuster has not owned or does not own an ownership interest in the accounts and associated expiration lists that were previously serviced by the adjuster.
(4) (a) A person issued a temporary license under Subsection (1) receives the license and shall perform the duties under the license subject to the commissioner's authority to:
(i) require a temporary licensee to have a suitable sponsor who:
(A) is a licensed producer; and
(B) assumes responsibility for all acts of the temporary licensee; or
(ii) impose other requirements that are:
(A) designed to protect the insureds and the public; and
(B) similar to the condition described in Subsection (4)(a)(i).
(b) A trustee appointed under Subsection (2) shall receive the trustee's appointment and perform the trustee's duties subject to the conditions listed in Subsections (4)(b)(i) through (xv).
(i) A trustee appointed under this section shall be licensed under this chapter to perform the services required by the trustor's clients.
(ii) When possible, the commissioner shall appoint a trustee who is no longer actively engaged on the trustee's own behalf in business as an adjuster.
(iii) The commissioner shall only select a person to act as trustee who is trustworthy and competent to perform the necessary services.
(iv) If the deceased, disabled, or unlicensed person for whom the trustee is acting is an associated adjuster, the insurers through or with which the former adjuster's business was associated shall cooperate with the trustee in allowing the trustee to service the claims associated with or through the insurer.
(v) The trustee shall abide by the terms of any agreement between the former adjuster and the associated insurer, except that terms in those agreements terminating the agreement upon the death, disability, or license termination of the former agent do not bar the trustee from continuing to act under the agreement.
(vi) The commissioner shall set the trustee's compensation which:

(A) may be stated in terms of a percentage of commissions;
(B) shall be equitable; and
(C) paid exclusively from:
(I) the commissions generated by the former adjuster's accounts serviced by the trustee; and
(II) other funds the former adjuster or the former adjuster's successor in interest agree to pay.
(vii) The trustee has no special priority to commissions over the former adjuster's creditors.
(viii) The following may not be held liable for errors or omissions of the former adjuster or the trustee:
(A) the commissioner; or
(B) the state.
(ix) The trustee may not be held liable for errors and omissions that were caused in any material way by the negligence of the former adjuster.
(x) The trustee may be held liable for errors and omissions that arise solely from the trustee's negligence.
(xi) The trustee's compensation level shall be sufficient to allow the trustee to purchase errors and omissions coverage, if that coverage is not provided to the trustee by:
(A) the former adjuster; or
(B) the former adjuster's successor in interest.
(xii) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients, either directly or indirectly.
(xiii) The trustee may not purchase the accounts or expiration lists of the former adjuster, unless the commissioner expressly ratifies the terms of the sale.
(xiv) The commissioner may adopt rules that:
(A) further define the trustee's fiduciary duties; and
(B) explain how the trustee is to carry out the trustee's responsibilities.
(xv) The trust may be terminated by:
(A) the commissioner; or
(B) the person that requested the trust be established.
(c) A person described in Subsection (4)(b)(xv)(B) shall terminate the trust by sending written notice to:
(i) the trustee; and
(ii) the commissioner.
(5) (a) The commissioner may by order limit the authority of any temporary licensee or trustee in any way considered necessary to protect:
(i) persons being serviced; and
(ii) the public.
(b) The commissioner may by order revoke a temporary license or trustee's appointment if the interest of persons being serviced or the public are endangered.
(c) A temporary license or trustee's appointment may not continue after the owner or personal representative disposes of the business.

Amended by Chapter 366, 2011 General Session

31A-26-216. Portable electronics adjusting.

(1) As used in this section, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of a portable electronics insurance claim that:

(a) may only be used by a Utah licensed independent adjuster, a Utah licensed producer, or an individual supervised as provided in this section;

(b) complies with the claims payment requirements of this title; and

(c) is certified as compliant with this section by a Utah licensed independent adjuster that is an officer of an organization licensed under this chapter.

(2) An individual is exempt from licensure as an adjuster, if the individual for purposes of a portable electronics insurance claim:

(a) collects claim information from, or furnishes claim information to, insureds or claimants;

(b) conducts data entry, including entering data into an automated claims adjudication system;

(c) is an employee of a licensed independent adjuster or its affiliate; and

(d) is one of no more than 25 individuals who are under the supervision of:

(i) a Utah licensed independent adjuster; or

(ii) a Utah licensed producer who is exempt from licensure pursuant to Section 31A-26-201.

Enacted by Chapter 151, 2012 General Session

31A-26-301. Timely payment of claims.

(1) (a) Unless otherwise provided by law, an insurer shall timely pay every valid insurance claim made by an insured.

(b) By rule the commissioner may prescribe:

(i) the kinds of notice and proof of loss that will establish validity;

(ii) the manner in which an insurer may make a bona fide denial of a claim;

(iii) the periods of time within which payment is required to be made to be timely; and

(iv) the reasonable interest rates to be charged upon late claim payments.

(2) (a) Notwithstanding Subsection (1) and subject to Subsection (2)(b), the payment of a claim is not overdue during any period in which:

(i) the insurer is unable to pay the claim because there is no recipient legally able to give a valid release for the payment; or

(ii) the insurer is unable to determine who is entitled to receive the payment.

(b) Subsection (2)(a) applies only if the insurer:

(i) promptly notifies the claimant of the inability to pay the claim; and

(ii) offers in good faith to pay the claim promptly when the inability to pay the claim is removed.

(3) This section applies only to a claim for first party benefits made by a person who is:

(a) named or defined as an insured under the terms of an insurance policy;

(b) described as a covered person under the terms of a policy of health care insurance as defined in Section 31A-1-301; or

(c) named, defined, or described:
(i) as:
(A) an insured;
(B) a beneficiary;
(C) a policyholder; or
(D) otherwise covered person; and
(ii) under the terms of:
(A) a life insurance policy; or
(B) an annuity.

Amended by Chapter 309, 2002 General Session

31A-26-301.5. Health care claims practices.

(1) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for paying for health care services the insured receives. If a service is covered by one or more individual or group health insurance policies, all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies.

(2) (a) Except as provided in Section 31A-22-610.1, a health care provider may bill and collect for any deductible, copayment, or uncovered service.

(b) A health care provider may bill an insured for services covered by health insurance policies or may otherwise notify the insured of the expenses covered by the policies. However, a provider may not make any report to a credit bureau, use the services of a collection agency, or use methods other than routine billing or notification until the later of:

(i) the expiration of the time afforded to an insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim without penalty; or

(ii) in the case of medicare beneficiaries or retirees 65 years of age or older, 60 days from the date medicare determines its liability for the claim.

(c) Beginning October 31, 1992, all insurers covering the insured shall notify the insured of payment and the amount of payment made to the provider.

(3) The commissioner shall make rules consistent with this chapter governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process. These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:

(a) a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed; and

(b) a prohibition against an implication that the provider is charging excessively if the provider is:

(i) a participating provider; and

(ii) prohibited from balance billing.

Amended by Chapter 240, 2001 General Session

31A-26-301.6. Health care claims practices.

(1) As used in this section:

(a) "Articulable reason" may include a determination regarding:

(i) eligibility for coverage;

(ii) preexisting conditions;

(iii) applicability of other public or private insurance;

(iv) medical necessity; and

(v) any other reason that would justify an extension of the time to investigate a claim.

(b) "Health care provider" means a person licensed to provide health care under:

(i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(ii) Title 58, Occupations and Professions.

(c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(d) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) a health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3) (a) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation for the denial.

(b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a) may be extended by 15 days if the insurer:

(A) determines that the extension is necessary due to matters beyond the control of the insurer; and

(B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of:

(I) the circumstances requiring the extension of time; and

(II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim:

(A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and

(B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (3)(b)(ii)(A).

(4) (a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation of the denial.

(b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer:

(i) determines that the extension is necessary due to matters beyond the control of the insurer; and

(ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of:

(A) the circumstances requiring the extension of time; and

(B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the 30-day extension period ends, the insurer:

(i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and

(ii) notifies the insured of:

(A) the circumstances requiring the extension; and

(B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(d) A notice of extension under this Subsection (4) shall specifically explain:

(i) the standards on which entitlement to a benefit is based; and

(ii) the unresolved issues that prevent a decision on the claim.

(e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim:

(i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and

(ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c).

(5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information.

(6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c).

(7) (a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.

(b) Whenever an insurer denies any part of a claim under this section, the

insurer shall also send to the insured:

(i) a written explanation of the part of the claim that was denied; and

(ii) notice of the adverse benefit determination review process established under Section 31A-22-629.

(c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or federal law.

(8) (a) Beginning with health care claims submitted on or after January 1, 2002, a late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) For the first 90 days that a claim payment or a provider response to a request for information is late, the late fee shall be determined by multiplying together:

(i) the total amount of the claim;

(ii) the total number of days the response or the payment is late; and

(iii) .1%.

(c) For a claim payment or a provider response to a request for information that is 91 or more days late, the late fee shall be determined by adding together:

(i) the late fee for a 90-day period under Subsection (8)(b); and

(ii) the following multiplied together:

(A) the total amount of the claim;

(B) the total number of days the response or payment was late beyond the initial 90-day period; and

(C) the rate of interest set in accordance with Section 15-1-1.

(d) Any late fee paid or collected under this section shall be separately identified on the documentation used by the insurer to pay the claim.

(e) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1.

(9) Each insurer shall establish a review process to resolve claims-related disputes between the insurer and providers.

(10) An insurer or person representing an insurer may not engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:

(a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim;

(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;

(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;

(d) failing to maintain a payment process sufficient to comply with this section;

(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;

(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;

(g) failing to timely pay a valid claim in accordance with this section as a means

of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;

(h) failing to pay the sum when required and as required under Subsection (8) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for the provider applying this section;

(j) any material violation of this section; and

(k) any other unfair claim settlement practice established in rule or law.

(11) (a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.

(b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith insurance claim.

(c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.

(12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and beginning January 1, 2002, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection (9).

(13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

(14) Nothing in this section may be construed as limiting the ability of an insurer to:

(a) recover any amount improperly paid to a provider or an insured:

(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

(ii) within 24 months of the amount improperly paid for a coordination of benefits error;

(iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or

(iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program;

(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;

(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or

(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.

(15) A health care provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).

Amended by Chapter 11, 2009 General Session

31A-26-302. Settlement of claims in credit life and accident and health insurance.

(1) The creditor shall promptly report all claims to the insurer or its designated claim representative. The insurer shall maintain adequate claims files. All claims shall be settled as soon as possible in accordance with the terms of the insurance contract.

(2) The insurer shall pay all claims 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 that claimant to another.

(3) A person other than the insurer or its designated claim representative may not settle or adjust claims. The creditor may not be designated as a claims representative.

Amended by Chapter 116, 2001 General Session

31A-26-303. Unfair claim settlement practices.

(1) No insurer or person representing an insurer may engage in any unfair claim settlement practice under Subsections (2), (3), and (4).

(2) Each of the following acts is an unfair claim settlement practice:

(a) knowingly misrepresenting material facts or the contents of insurance policy provisions at issue in connection with a claim under an insurance contract; however, this provision does not include the failure to disclose information;

(b) attempting to use a policy application which was altered by the insurer without notice to, or knowledge, or consent of, the insured as the basis for settling or refusing to settle a claim; or

(c) failing to settle a claim promptly under one portion of the insurance policy coverage, where liability and the amount of loss are reasonably clear, in order to influence settlements under other portions of the insurance policy coverage, but this Subsection (2)(c) applies only to claims made by persons in direct privity of contract with the insurer.

(3) Each of the following is an unfair claim settlement practice if committed or performed with such frequency as to indicate a general business practice by an insurer or persons representing an insurer:

(a) failing to acknowledge and act promptly upon communications about claims under insurance policies;

(b) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims under insurance policies;

(c) 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 those insureds when the amounts claimed were reasonably near to the amounts recovered;

(d) failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment was made;

(e) failing to promptly provide to the insured a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement;

(f) appealing from substantially all arbitration awards in favor of insureds for the purpose of compelling them to accept settlements or compromises for less than the amount awarded in arbitration;

(g) 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 which contain substantially the same information; or

(h) not attempting in good faith to effectuate a prompt, fair, and equitable settlement of claims in which liability is reasonably clear.

(4) The commissioner may define by rule, acts or general business practices which are unfair claim settlement practices, after a finding that those practices are misleading, deceptive, unfairly discriminatory, overreaching, or an unreasonable restraint on competition.

(5) This section does not create any private cause of action.

Amended by Chapter 91, 1987 General Session

31A-26-304. Prohibition of conflicting roles.

A person licensed concurrently as both an independent and a public adjuster may not represent both the insurer and the insured in the same transaction.

Enacted by Chapter 242, 1985 General Session

31A-26-305. Request for accepted check.

If an insurance policy claimant entitled to receive money in settlement of a claim makes a timely request to the insurer for payment by accepted check, the insurer shall make payment to the claimant with a check accepted by the drawee under Sections 70A-3-410 through 70A-3-413.

Amended by Chapter 204, 1986 General Session

31A-26-306. Place of business -- Records.

(1) (a) An insurance adjuster licensed under this chapter shall register and maintain with the commissioner:

(i) the address and telephone number of the licensee's principal place of business;

(ii) a valid business email address at which the commissioner may contact the licensee; and

(iii) if the licensee is an individual, the licensee's residence address and telephone number.

(b) A licensee shall notify the commissioner within 30 days of a change in one of the following required to be registered under Subsection (1)(a):

(i) an address;
(ii) a telephone number; or
(iii) a business email address.
(2) Except as provided under Subsection (3), an insurance adjuster shall keep at the address registered under Subsection (1), a record of the transactions consummated under the insurance adjuster's license, including a record of:
(a) each investigation or adjustment undertaken or consummated; and
(b) a fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment.
(3) Subsection (2) is satisfied if the records specified in Subsection (2) can be obtained immediately from a central storage place elsewhere by on-line computer terminals located at the registered address.
(4) (a) A record maintained as to a transaction under Subsection (2) shall be kept available for the inspection of the commissioner during all business hours for a period of time after the date of the transaction specified by the commissioner by rule, but in no case for less than the current calendar year plus three years.
(b) Discarding a record after the then applicable record retention period is passed does not place the licensee in violation of a later-adopted longer record retention period.

Amended by Chapter 284, 2011 General Session

31A-26-307. Claim reports to commissioner.
On the commissioner's request, any insurer or licensed adjuster connected with a loss or claim shall report to the commissioner all facts relative to the loss or claim arising under any insurance contract covering a subject of insurance that is resident, located, or to be performed in this state.

Enacted by Chapter 242, 1985 General Session

31A-26-308. Settlement of liability insurance claim not admission of liability.
No settlement or partial settlement of a claim against any insured under a liability insurance policy is an admission, by either the insured or the insurer, of the liability of the insured on any claim arising from the same event or set of facts, whether the settlement is made by the insured, the insurer, or any other person on behalf of the insured or the insurer.

Enacted by Chapter 242, 1985 General Session

31A-26-309. Adjuster's duty to report illegal insurance.
Section 31A-15-110 applies to the adjuster's duty to report illegal insurance.

Enacted by Chapter 242, 1985 General Session

31A-26-310. Compensation of insurer's or insured's claims adjuster.

(1) (a) Except as provided in Subsection (2), an insurer or an insured may not pay a person who is representing the insurer or insured in connection with an insurance claim adjustment on any basis that is dependent, in whole or in part, upon the amounts paid an insured or claimant under an insurance policy.

(b) Subsection (1)(a) includes payments to:

(i) an employee of:

(A) the insurer; or

(B) the insured;

(ii) an independent contractor; or

(iii) a public adjuster.

(2) Subsection (1) does not prohibit a compensation arrangement:

(a) based upon the overall profitability of the insurer;

(b) based upon the discovery or proof of fraudulent insurance claims; or

(c) conforming to an order or rule of the commissioner that addresses the compensation of persons engaged in insurance adjusting on behalf of:

(i) an insurer; or

(ii) an insured.

Amended by Chapter 252, 2003 General Session

31A-26-311. Rescission of contracts with public adjusters.

(1) Except as provided in Subsection (2), an insured or claimant under an insurance policy who contracts with a public adjuster to assist in the settlement of a claim may rescind that contract by delivering written notice of rescission to the public adjuster within 10 days of entering into the contract.

(2) Subsection (1) does not apply if prior to the rescission the public adjuster has effected an acceptable settlement of the claim.

Enacted by Chapter 204, 1986 General Session

31A-27-501. Title -- Construction -- Commissioner's powers.

(1) This chapter is known as the "Delinquency Administrative Action Provisions."

(2) The proceedings authorized by this part may be applied to:

(a) all insurers and reinsurers:

(i) who are doing, or have done, an insurance business in this state; and

(ii) against whom claims arising from that business may exist;

(b) all insurers who have the appearance of or claim they do an insurance business in this state;

(c) all insurers who have insureds resident in this state; and

(d) all other persons organized or in the process of organizing to do an insurance business as an insurer in this state.

(3) This part shall be liberally construed to protect the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of owners, through:

(a) early detection of any potentially dangerous condition in an insurer;

(b) prompt application of appropriate regulatory corrective measures; and

(c) regulation of the insurance business by law relating to insolvency of insurers and by substantive rules on the entire insurance business.

(4) This part does not limit the powers granted the commissioner by other provisions of law.

Renumbered and Amended by Chapter 309, 2007 General Session

31A-27-502. Definitions.

As used in this part, "record" is as defined in Section 31A-27a-102.

Enacted by Chapter 309, 2007 General Session

31A-27-503. Commissioner's administrative actions.

(1) (a) The commissioner may take an action described in Subsection (1)(b) whenever the commissioner has reasonable cause to believe, and determines after a hearing that an insurer:

(i) has committed or engaged in an act, practice, or transaction that would subject the insurer to a formal delinquency proceeding under Chapter 27a, Insurer Receivership Act;

(ii) is committing or engaging in an act, practice, or transaction that would subject the insurer to a formal delinquency proceeding under Chapter 27a, Insurer Receivership Act;

(iii) is about to commit or engage in an act, practice, or transaction that would subject the insurer to a formal delinquency proceeding under Chapter 27a, Insurer Receivership Act;

(iv) is in or is about to be in a condition that would subject the insurer to a formal delinquency proceeding under Chapter 27a, Insurer Receivership Act; or

(v) is in hazardous financial condition or potentially hazardous financial condition, as defined by rule made under Subsection 31A-27a-101(3)(c).

(b) If the conditions of Subsection (1)(a) are met, the commissioner may make and serve upon the insurer and any other persons whose action or forbearance from action is reasonably necessary, those orders, other than a seizure order under Section 31A-27a-201, that are reasonably necessary to correct, eliminate, or remedy the act, practice, transaction, or condition described in Subsection (1)(a).

(c) The commissioner may issue an order for the insurer to submit to supervision by a supervisor appointed by the commissioner until the act, practice, transaction, or condition that is the ground for the order has been halted or corrected.

(2) (a) The commissioner may make and serve an order issued under Subsection (1) without notice and before a hearing if:

(i) the conditions of Subsection (1) are satisfied; and

(ii) it appears to the commissioner that irreparable harm to the property or business of the insurer or to the interests of its policyholders, creditors, or the public may occur unless the commissioner issues, with immediate effect, the order.

(b) The commissioner shall serve the insurer with an order described in this Subsection (2) and a notice of agency action, containing a statement of the reasons why irreparable harm is threatened unless the order is issued with immediate effect.

(3) (a) If the commissioner issues an order for supervision of an insurer under Subsection (1) or (2), the commissioner shall:

(i) notify the insurer that the insurer is under the supervision of the commissioner; and

(ii) explain the reasons for that supervision.

(b) During the period of supervision, the commissioner may prohibit the insurer from doing any of the following, without the prior approval of the commissioner or a supervisor appointed by the commissioner:

(i) transferring any of its assets or its business in force;

(ii) withdrawing funds from any of its bank accounts;

(iii) lending any of its funds;

(iv) investing any of its funds;

(v) transferring any of its property;

(vi) incurring any debt, obligation, or liability other than in the ordinary and usual course of business; or

(vii) entering into any new reinsurance contract or treaty.

(4) (a) If the commissioner issues a summary order before a hearing under Subsection (2), the insurer may waive the commissioner's hearing and apply for immediate judicial relief by any remedy afforded by law, without first exhausting the insurer's administrative remedies.

(b) If the insurer has a hearing before the commissioner, the insurer and any person whose interests are substantially affected are entitled to judicial review of any order issued by the commissioner.

Amended by Chapter 253, 2012 General Session

31A-27-504. Conduct of hearings.

(1) The commissioner shall hold a hearing conducted under Section 31A-27-503 privately unless the insurer requests a public hearing.

(2) All records of the insurer, other documents, and all department files and papers, so far as they pertain to or are a part of the record of a hearing conducted under Section 31A-27-503, shall be kept confidential:

(a) except as is necessary to obtain compliance with a hearing conducted under Section 31A-27-503; or

(b) unless the insurer requests that the matter be made public.

(3) Any person having possession or custody of and refusing to deliver any of the records of an insurer against which an order is issued by the commissioner is in accordance with a hearing conducted under Section 31A-27-503 subject to Section 31A-2-308.

Renumbered and Amended by Chapter 309, 2007 General Session

31A-27a-101. Title -- Construction -- Commissioner's powers.

(1) This chapter is known as the "Insurer Receivership Act."

(2) The proceedings authorized by this chapter may be applied to:

(a) all insurers and reinsurers:

(i) who are doing, or have done, an insurance business in this state; and
(ii) against whom claims arising from that business may exist;
(b) all insurers who have the appearance of or claim they do an insurance business in this state;
(c) all insurers who have insureds resident in this state; and
(d) all other persons organized or in the process of organizing to do an insurance business as an insurer in this state.
(3) This chapter shall be liberally construed to protect the interests of insureds, claimants, creditors, and the public generally through:
(a) early detection of any potentially hazardous condition in an insurer;
(b) prompt application of appropriate corrective measures;
(c) the commissioner making rules pertaining to Subsections (3)(a) and (b):
(i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
(ii) that are similar to those set forth in the Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition of the National Association of Insurance Commissioners;
(d) improved methods for conserving and rehabilitating insurers;
(e) enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;
(f) apportionment of any unavoidable loss in accordance with the statutory priorities set out in this chapter;
(g) lessening the problems of interstate receivership by:
(i) facilitating cooperation among states in delinquency proceedings; and
(ii) extending the scope of personal jurisdiction over debtors of the insurer outside this state;
(h) regulation of the business of insurance by the impact of the law relating to delinquency procedures and by substantive rules; and
(i) providing for a comprehensive scheme for the receivership of insurance companies and those subject to this chapter as part of the regulation of the business of insurance in this state.
(4) A proceeding in the case of insurer insolvency and delinquency are integral aspects of the business of insurance and are of vital public interest and concern.
(5) This chapter does not limit the powers granted the commissioner by other provisions of law.
(6) The powers and authority of a receiver under this chapter are:
(a) cumulative; and
(b) in addition to any power or authority available to a receiver under a law other than this chapter.

Amended by Chapter 253, 2012 General Session

31A-27a-102. Definitions.
As used in this chapter:
(1) "Admitted assets" is as defined by and is measured in accordance with the National Association of Insurance Commissioner's Statements of Statutory Accounting

Principles, as incorporated in this state by rules made by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection 31A-4-113(1)(b)(ii).

(2) "Affected guaranty association" means a guaranty association that is or may become liable for payment of a covered claim.

(3) "Affiliate" is as defined in Section 31A-1-301.

(4) Notwithstanding Section 31A-1-301, "alien insurer" means an insurer incorporated or organized under the laws of a jurisdiction that is not a state.

(5) Notwithstanding Section 31A-1-301, "claimant" or "creditor" means a person having a claim against an insurer whether the claim is:

(a) matured or not matured;

(b) liquidated or unliquidated;

(c) secured or unsecured;

(d) absolute; or

(e) fixed or contingent.

(6) "Commissioner" is as defined in Section 31A-1-301.

(7) "Commodity contract" means:

(a) a contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of:

(i) a board of trade or contract market under the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.; or

(ii) a board of trade outside the United States;

(b) an agreement that is:

(i) subject to regulation under Section 19 of the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.; and

(ii) commonly known to the commodities trade as:

(A) a margin account;

(B) a margin contract;

(C) a leverage account; or

(D) a leverage contract;

(c) an agreement or transaction that is:

(i) subject to regulation under Section 4c(b) of the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.; and

(ii) commonly known to the commodities trade as a commodity option;

(d) a combination of the agreements or transactions referred to in this Subsection (7); or

(e) an option to enter into an agreement or transaction referred to in this Subsection (7).

(8) "Control" is as defined in Section 31A-1-301.

(9) "Delinquency proceeding" means a:

(a) proceeding instituted against an insurer for the purpose of rehabilitating or liquidating the insurer; and

(b) summary proceeding under Section 31A-27a-201.

(10) "Department" is as defined in Section 31A-1-301 unless the context requires otherwise.

(11) "Doing business," "doing insurance business," and "business of insurance"

includes any of the following acts, whether effected by mail, electronic means, or otherwise:

(a) issuing or delivering a contract, certificate, or binder relating to insurance or annuities:

(i) to a person who is resident in this state; or

(ii) covering a risk located in this state;

(b) soliciting an application for the contract, certificate, or binder described in Subsection (11)(a);

(c) negotiating preliminary to the execution of the contract, certificate, or binder described in Subsection (11)(a);

(d) collecting premiums, membership fees, assessments, or other consideration for the contract, certificate, or binder described in Subsection (11)(a);

(e) transacting matters:

(i) subsequent to execution of the contract, certificate, or binder described in Subsection (11)(a); and

(ii) arising out of the contract, certificate, or binder described in Subsection (11)(a);

(f) operating as an insurer under a license or certificate of authority issued by the department; or

(g) engaging in an act identified in Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups.

(12) Notwithstanding Section 31A-1-301, "domiciliary state" means the state in which an insurer is incorporated or organized, except that "domiciliary state" means:

(a) in the case of an alien insurer, its state of entry; or

(b) in the case of a risk retention group, the state in which the risk retention group is chartered as contemplated in the Liability Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.

(13) "Estate" has the same meaning as "property of the insurer" as defined in Subsection (30).

(14) "Fair consideration" is given for property or an obligation:

(a) when in exchange for the property or obligation, as a fair equivalent for it, and in good faith:

(i) property is conveyed;

(ii) services are rendered;

(iii) an obligation is incurred; or

(iv) an antecedent debt is satisfied; or

(b) when the property or obligation is received in good faith to secure a present advance or an antecedent debt in amount not disproportionately small compared to the value of the property or obligation obtained.

(15) Notwithstanding Section 31A-1-301, "foreign insurer" means an insurer domiciled in another state.

(16) "Formal delinquency proceeding" means a rehabilitation or liquidation proceeding.

(17) "Forward contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(18) (a) "General assets" include all property of the estate that is not:

(i) subject to a properly perfected secured claim;

(ii) subject to a valid and existing express trust for the security or benefit of a specified person or class of person; or

(iii) required by the insurance laws of this state or any other state to be held for the benefit of a specified person or class of person.

(b) "General assets" include all property of the estate or its proceeds in excess of the amount necessary to discharge a claim described in Subsection (18)(a).

(19) "Good faith" means honesty in fact and intention, and in regard to Part 5, Asset Recovery, also requires the absence of:

(a) information that would lead a reasonable person in the same position to know that the insurer is financially impaired or insolvent; and

(b) knowledge regarding the imminence or pendency of a delinquency proceeding against the insurer.

(20) "Guaranty association" means:

(a) a mechanism mandated by Chapter 28, Guaranty Associations; or

(b) a similar mechanism in another state that is created for the payment of claims or continuation of policy obligations of a financially impaired or insolvent insurer.

(21) "Impaired" means that an insurer:

(a) does not have admitted assets at least equal to the sum of:

(i) all its liabilities; and

(ii) the minimum surplus required to be maintained by Section 31A-5-211 or 31A-8-209; or

(b) has a total adjusted capital that is less than its authorized control level RBC, as defined in Section 31A-17-601.

(22) "Insolvency" or "insolvent" means that an insurer:

(a) is unable to pay its obligations when they are due;

(b) does not have admitted assets at least equal to all of its liabilities; or

(c) has a total adjusted capital that is less than its mandatory control level RBC, as defined in Section 31A-17-601.

(23) Notwithstanding Section 31A-1-301, "insurer" means a person who:

(a) is doing, has done, purports to do, or is licensed to do the business of insurance;

(b) is or has been subject to the authority of, or to rehabilitation, liquidation, reorganization, supervision, or conservation by an insurance commissioner; or

(c) is included under Section 31A-27a-104.

(24) "Liabilities" is as defined by and is measured in accordance with the National Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as incorporated in this state by rules made by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection 31A-4-113(1)(b)(ii).

(25) (a) Subject to Subsection (21)(b), "netting agreement" means:

(i) a contract or agreement that:

(A) documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts; and

(B) provides for the netting, liquidation, setoff, termination, acceleration, or close out under or in connection with:

(I) one or more qualified financial contracts; or

(II) present or future payment or delivery obligations or payment or delivery entitlements under the agreement, including liquidation or close-out values relating to the obligations or entitlements, among the parties to the netting agreement;

(ii) a master agreement or bridge agreement for one or more master agreements described in Subsection (25)(a)(i); or

(iii) any of the following related to a contract or agreement described in Subsection (25)(a)(i) or (ii):

(A) a security agreement;

(B) a security arrangement;

(C) other credit enhancement or guarantee; or

(D) a reimbursement obligation.

(b) If a contract or agreement described in Subsection (25)(a)(i) or (ii) relates to an agreement or transaction that is not a qualified financial contract, the contract or agreement described in Subsection (25)(a)(i) or (ii) is considered a netting agreement only with respect to an agreement or transaction that is a qualified financial contract.

(c) "Netting agreement" includes:

(i) a term or condition incorporated by reference in the contract or agreement described in Subsection (25)(a); or

(ii) a master agreement described in Subsection (25)(a).

(d) A master agreement described in Subsection (25)(a), together with all schedules, confirmations, definitions, and addenda to that master agreement and transactions under any of the items described in this Subsection (25)(d), are treated as one netting agreement.

(26) (a) "New value" means:

(i) money;

(ii) money's worth in goods, services, or new credit; or

(iii) release by a transferee of property previously transferred to the transferee in a transaction that is neither void nor voidable by the insurer or the receiver under any applicable law, including proceeds of the property.

(b) "New value" does not include an obligation substituted for an existing obligation.

(27) "Party in interest" means:

(a) the commissioner;

(b) a nondomiciliary commissioner in whose state the insurer has outstanding claims liabilities;

(c) an affected guaranty association; and

(d) the following parties if the party files a request with the receivership court for inclusion as a party in interest and to be on the service list:

(i) an insurer that ceded to or assumed business from the insurer;

(ii) a policyholder;

(iii) a third party claimant;

(iv) a creditor;

(v) a 10% or greater equity security holder in the insolvent insurer; and

(vi) a person, including an indenture trustee, with a financial or regulatory interest in the delinquency proceeding.

(28) (a) Notwithstanding Section 31A-1-301, "policy" means, notwithstanding what it is called:

(i) a written contract of insurance;

(ii) a written agreement for or affecting insurance; or

(iii) a certificate of a written contract or agreement described in this Subsection (28)(a).

(b) "Policy" includes all clauses, riders, endorsements, and papers that are a part of a policy.

(c) "Policy" does not include a contract of reinsurance.

(29) "Preference" means a transfer of property of an insurer to or for the benefit of a creditor:

(a) for or on account of an antecedent debt, made or allowed by the insurer within one year before the day on which a successful petition for rehabilitation or liquidation is filed under this chapter;

(b) the effect of which transfer may enable the creditor to obtain a greater percentage of the creditor's debt than another creditor of the same class would receive; and

(c) if a liquidation order is entered while the insurer is already subject to a rehabilitation order and the transfer otherwise qualifies, that is made or allowed within the shorter of:

(i) one year before the day on which a successful petition for rehabilitation is filed; or

(ii) two years before the day on which a successful petition for liquidation is filed.

(30) "Property of the insurer" or "property of the estate" includes:

(a) a right, title, or interest of the insurer in property:

(i) whether:

(A) legal or equitable;

(B) tangible or intangible; or

(C) choate or inchoate; and

(ii) including choses in action, contract rights, and any other interest recognized under the laws of this state;

(b) entitlements that exist before the entry of an order of rehabilitation or liquidation;

(c) entitlements that may arise by operation of this chapter or other provisions of law allowing the receiver to avoid prior transfers or assert other rights; and

(d) (i) records or data that is otherwise the property of the insurer; and

(ii) records or data similar to those described in Subsection (30)(d)(i) that are within the possession, custody, or control of a managing general agent, a third party administrator, a management company, a data processing company, an accountant, an attorney, an affiliate, or other person.

(31) Subject to Subsection 31A-27a-611(10), "qualified financial contract" means any of the following:

(a) a commodity contract;

(b) a forward contract;

(c) a repurchase agreement;

(d) a securities contract;

(e) a swap agreement; or

(f) any similar agreement that the commissioner determines by rule or order to be a qualified financial contract for purposes of this chapter.

(32) As the context requires, "receiver" means a rehabilitator, liquidator, or ancillary receiver.

(33) As the context requires, "receivership" means a rehabilitation, liquidation, or ancillary receivership.

(34) Unless the context requires otherwise, "receivership court" refers to the court in which a delinquency proceeding is pending.

(35) "Reciprocal state" means any state other than this state that:

(a) enforces a law substantially similar to this chapter;

(b) requires the commissioner to be the receiver of a delinquent insurer; and

(c) has laws for the avoidance of fraudulent conveyances and preferential transfers by the receiver of a delinquent insurer.

(36) "Record," when used as a noun, means any information or data, in whatever form maintained, including:

(a) a book;

(b) a document;

(c) a paper;

(d) a file;

(e) an application file;

(f) a policyholder list;

(g) policy information;

(h) a claim or claim file;

(i) an account;

(j) a voucher;

(k) a litigation file;

(l) a premium record;

(m) a rate book;

(n) an underwriting manual;

(o) a personnel record;

(p) a financial record; or

(q) other material.

(37) "Reinsurance" means a transaction or contract under which an assuming insurer agrees to indemnify a ceding insurer against all, or a part, of any loss that the ceding insurer may sustain under the one or more policies that the ceding insurer issues or will issue.

(38) "Repurchase agreement" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(39) (a) "Secured claim" means, subject to Subsection (39)(b):

(i) a claim secured by an asset that is not a general asset; or

(ii) the right to set off as provided in Section 31A-27a-510.

(b) "Secured claim" does not include:

(i) a special deposit claim;

(ii) a claim based on mere possession; or

(iii) a claim arising from a constructive or resulting trust.

(40) "Securities contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(41) "Special deposit" means a deposit established pursuant to statute for the security or benefit of a limited class or classes of persons.

(42) (a) Subject to Subsection (42)(b), "special deposit claim" means a claim secured by a special deposit.

(b) "Special deposit claim" does not include a claim against the general assets of the insurer.

(43) "State" means a state, district, or territory of the United States.

(44) "Subsidiary" is as defined in Section 31A-1-301.

(45) "Swap agreement" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(46) (a) "Transfer" includes the sale and every other and different mode of disposing of or parting with property or with an interest in property, whether:

(i) directly or indirectly;

(ii) absolutely or conditionally;

(iii) voluntarily or involuntarily; or

(iv) by or without judicial proceedings.

(b) An interest in property includes:

(i) a set off;

(ii) having possession of the property; or

(iii) fixing a lien on the property or on an interest in the property.

(c) The retention of a security title in property delivered to an insurer and foreclosure of the insurer's equity of redemption is considered a transfer suffered by the insurer.

(47) Notwithstanding Section 31A-1-301, "unauthorized insurer" means an insurer transacting the business of insurance in this state that has not received a certificate of authority from this state, or some other type of authority that allows for the transaction of the business of insurance in this state.

Amended by Chapter 382, 2008 General Session

31A-27a-103. Insurer receivership laws.

(1) The state's insurer receivership laws consists of:

(a) this chapter; and

(b) Chapter 28, Guaranty Associations.

(2) The laws listed in Subsection (1) shall be construed together in a manner that is consistent.

Enacted by Chapter 309, 2007 General Session

31A-27a-104. Persons covered.

(1) This chapter applies to:

(a) an insurer who:

(i) is doing, or has done, an insurance business in this state; and

(ii) against whom a claim arising from that business may exist;

(b) a person subject to examination by the commissioner;
(c) an insurer who purports to do an insurance business in this state;
(d) an insurer who has an insured who is resident in this state; and
(e) in addition to Subsections (1)(a) through (d), a person doing business as follows:
(i) under Chapter 6a, Service Contracts;
(ii) under Chapter 7, Nonprofit Health Service Insurance Corporations;
(iii) under Chapter 8a, Health Discount Program Consumer Protection Act;
(iv) under Chapter 9, Insurance Fraternals;
(v) under Chapter 11, Motor Clubs;
(vi) under Chapter 13, Employee Welfare Funds and Plans;
(vii) under Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;
(viii) as a bail bond surety company under Chapter 35, Bail Bond Act;
(ix) under Chapter 37, Captive Insurance Companies Act;
(x) a title insurance company;
(xi) a prepaid health care delivery plan; and
(xii) a person not described in Subsections (1)(e)(i) through (xi) that is organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state.
(2) Notwithstanding Sections 31A-1-301 and 31A-27a-102, this chapter does not apply to a person licensed by the insurance commissioner as one or more of the following in this state unless the person engages in the business of insurance as an insurer:
(a) an insurance agency;
(b) an insurance producer;
(c) a limited line producer;
(d) an insurance consultant;
(e) a managing general agent;
(f) reinsurance intermediary;
(g) an individual title insurance producer or agency title insurance producer;
(h) a third party administrator;
(i) an insurance adjustor;
(j) a life settlement provider; or
(k) a life settlement producer.

Amended by Chapter 319, 2013 General Session

31A-27a-105. Jurisdiction -- Venue.

(1) (a) A delinquency proceeding under this chapter may not be commenced by a person other than the commissioner of this state.
(b) No court has jurisdiction to entertain, hear, or determine a delinquency proceeding commenced by any person other than the commissioner of this state.
(2) Other than in accordance with this chapter, a court of this state has no jurisdiction to entertain, hear, or determine any complaint:
(a) requesting the liquidation, rehabilitation, seizure, sequestration, or

receivership of an insurer; or

(b) requesting a stay, an injunction, a restraining order, or other relief preliminary to, incidental to, or relating to a delinquency proceeding.

(3) (a) The receivership court, as of the commencement of a delinquency proceeding under this chapter, has exclusive jurisdiction of all property of the insurer, wherever located, including property located outside the territorial limits of the state.

(b) The receivership court has original but not exclusive jurisdiction of all civil proceedings arising:

(i) under this chapter; or

(ii) in or related to a delinquency proceeding under this chapter.

(4) 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 Utah Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver if the person served:

(a) in an action resulting from or incident to a relationship with the insurer described in this Subsection (4)(a), is or has been an agent, broker, or other person who has at any time:

(i) written a policy of insurance for an insurer against which a delinquency proceeding is instituted; or

(ii) acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding is instituted;

(b) in an action on or incident to a reinsurance contract described in this Subsection (4)(b):

(i) is or has been an insurer or reinsurer who has at any time entered into the contract of reinsurance with an insurer against which a delinquency proceeding is instituted; or

(ii) is an intermediary, agent, or broker of or for the reinsurer, or with respect to the contract;

(c) in an action resulting from or incident to a relationship with the insurer described in this Subsection (4)(c), is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding is instituted;

(d) in an action concerning assets described in this Subsection (4)(d), is or was at the time of the institution of the delinquency proceeding against the insurer, holding assets in which the receiver claims an interest on behalf of the insurer; or

(e) in any action on or incident to the obligation described in this Subsection (4)(e), is obligated to the insurer in any way whatsoever.

(5) (a) Subject to Subsection (5)(b), service shall be made upon the person named in the petition in accordance with the Utah Rules of Civil Procedure.

(b) In lieu of service under Subsection (5)(a), upon application to the receivership court, service may be made in such a manner as the receivership court directs whenever it is satisfactorily shown by the commissioner's affidavit:

(i) in the case of a corporation, that the officers of the corporation cannot be served because they have departed from the state or have otherwise concealed themselves with intent to avoid service;

(ii) in the case of an insurer whose business is conducted, at least in part, by an

attorney-in-fact, managing general agent, or other similar entity including a reciprocal, Lloyd's association, or interinsurance exchange, that the individual attorney-in-fact, managing general agent, or other entity, or its officers of the corporate attorney-in-fact cannot be served because of the individual's departure or concealment; or

(iii) in the case of a natural person, that the person cannot be served because of the person's departure or concealment.

(6) If the receivership court on motion of any party finds that an action should as a matter of substantial justice be tried in a forum outside this state, the receivership court may enter an appropriate order to stay further proceedings on the action in this state.

(7) (a) Nothing in this chapter deprives a reinsurer of any contractual right to pursue arbitration except:

(i) as to a claim against the estate; and

(ii) in regard to a contract rejected by the receiver under Section 31A-27a-113.

(b) A party in arbitration may bring a claim or counterclaim against the estate, but the claim or counterclaim is subject to this chapter.

(8) An action authorized by this chapter shall be brought in the Third District Court for Salt Lake County.

(9) (a) At any time after an order is entered pursuant to Section 31A-27a-201, 31A-27a-301, or 31A-27a-401, the commissioner or receiver may transfer the case to the county of the principal office of the person proceeded against.

(b) In the event of a transfer under this Subsection (9), the court in which the proceeding is commenced shall, upon application of the commissioner or receiver, direct its clerk to transmit the court's file to the clerk of the court to which the case is to be transferred.

(c) After a transfer under this Subsection (9), the proceeding shall be conducted in the same manner as if it had been commenced in the court to which the matter is transferred.

(10) (a) Except as provided in Subsection (10)(c), a person may not intervene in a liquidation proceeding in this state for the purpose of seeking or obtaining payment of a judgment, lien, or other claim of any kind.

(b) Except as provided in Subsection (10)(c), the claims procedure set for this chapter constitute the exclusive means for obtaining payment of claims from the liquidation estate.

(c) (i) An affected guaranty association or the affected guaranty association's representative may intervene as a party as a matter of right and otherwise appear and participate in any court proceeding concerning a liquidation proceeding against an insurer.

(ii) Intervention by an affected guaranty association or by an affected guaranty association's designated representative conferred by this Subsection (10)(c) may not constitute grounds to establish general personal jurisdiction by the courts of this state.

(iii) An intervening affected guaranty association or the affected guaranty association's representative are subject to the receivership court's jurisdiction for the limited purpose for which the affected guaranty association intervenes.

(11) (a) Notwithstanding the other provisions of this section, this chapter does not confer jurisdiction on the receivership court to resolve coverage disputes between

an affected guaranty association and those asserting claims against the affected guaranty association resulting from the initiation of a receivership proceeding under this chapter, except to the extent that the affected guaranty association otherwise expressly consents to the jurisdiction of the receivership court pursuant to a plan of rehabilitation or liquidation that resolves its obligations to covered policyholders.

(b) The determination of a dispute with respect to the statutory coverage obligations of an affected guaranty association by a court or administrative agency or body with jurisdiction in the affected guaranty association's state of domicile is binding and conclusive as to the affected guaranty association's claim in the liquidation proceeding.

(12) Upon the request of the receiver, the receivership court or the presiding judge of the Third District Court for Salt Lake County may order that one judge hear all cases and controversies arising out of or related to the delinquency proceeding.

(13) A delinquency proceeding is exempt from any program maintained for the early closure of civil actions.

Enacted by Chapter 309, 2007 General Session

31A-27a-106. Exemption from fees.

The receiver may not be required to pay any of the following fees to a public officer of this state:

(1) filing fees;
(2) recording fees;
(3) transcript fees;
(4) copying fees;
(5) certification fees; or
(6) authentication fees.

Enacted by Chapter 309, 2007 General Session

31A-27a-107. Notice and hearing on matters submitted by the receiver for receivership court approval.

(1) (a) Upon written request to the receiver, a person shall be placed on the service list to receive notice of matters filed by the receiver.

(b) It is the responsibility of the person requesting notice to:

(i) inform the receiver in writing of any changes in the person's address; or

(ii) request that the person's name be deleted from the service list.

(c) (i) The receiver may serve on a person on the service list a request to confirm continuation on the service list by returning a form.

(ii) The request to confirm continuation may be served periodically but not more frequently than every 12 months.

(iii) A person who fails to return the form described in this Subsection (1)(c) may be removed from the service list.

(d) Inclusion on the service list does not confer standing in the delinquency proceeding to raise, appear, or be heard on any issue.

(e) The receiver shall:

(i) file a copy of the service list with the receivership court; and

(ii) periodically provide to the receivership court notice of changes to the service list.

(2) Except as otherwise provided by this chapter, notice and hearing of any matter submitted by the receiver to the receivership court for approval under this chapter shall be conducted in accordance with this Subsection (2).

(a) The receiver:

(i) shall file a motion:

(A) explaining the proposed action; and

(B) the basis for the proposed action; and

(ii) may include any evidence in support of the motion.

(b) If a document, material, or other information supporting the motion is confidential, the document, material, or other information may be submitted to the receivership court under seal for in camera inspection.

(c) (i) The receiver shall provide notice and a copy of the motion to:

(A) all persons on the service list; and

(B) any other person as may be required by the receivership court.

(ii) Notice may be provided by first-class mail postage paid, electronic mail, or facsimile transmission, at the receiver's discretion.

(iii) For purposes of this section, notice is considered to be given on the day on which it is deposited with the United States Postmaster or transmitted, as applicable, to the last-known address as shown on the service list.

(d) (i) A party in interest objecting to the motion shall:

(A) file an objection specifying the grounds for the objection within:

(I) 10 days of the day on which the notice of the filing of the motion is sent; or

(II) such other time as the receivership court may specify; and

(B) serve copies on:

(I) the receiver; and

(II) any other person served with the motion within the time period described in this Subsection (2)(d)(i).

(ii) In accordance with the Utah Rules of Civil Procedure, days may be added to the time for filing an objection if the notice of the motion is sent only by way of United States mail.

(iii) An objecting party has the burden of showing why the receivership court should not authorize the proposed action.

(e) (i) If no objection to the motion is timely filed:

(A) the receivership court may:

(I) enter an order approving the motion without a hearing; or

(II) hold a hearing to determine if the receiver's motion should be approved; and

(B) the receiver may request that the receivership court enter an order or hold a hearing on an expedited basis.

(ii) (A) If an objection is timely filed, the receivership court may hold a hearing.

(B) If the receivership court approves the motion and, upon a motion by the receiver, determines that the objection is frivolous or filed merely for delay or for other improper purpose, the receivership court may order the objecting party to pay the receiver's reasonable costs and fees of defending against the objection.

Enacted by Chapter 309, 2007 General Session

31A-27a-108. Injunctions and orders.

(1) The receivership court may issue an order, process, or judgment including stays, injunctions, or other orders necessary or appropriate to carry out:

(a) this chapter; or

(b) an approved rehabilitation plan.

(2) This chapter may not be construed to limit the ability of the receiver to apply to a court other than the receivership court in any jurisdiction:

(a) to carry out this chapter; or

(b) for the purpose of pursuing claims against any person.

(3) Except as provided in Subsections (5) and (6) or as otherwise provided in this chapter, the commencement of a delinquency proceeding under this chapter operates as a stay, applicable to all persons, of:

(a) the commencement or continuation, including the issuance or employment of process, of a judicial, administrative, an arbitration proceeding, or other action or proceeding against the insurer:

(i) that was or could have been commenced before the commencement of the delinquency proceeding under this chapter; or

(ii) to recover a claim against the insurer that arises before the commencement of the delinquency proceeding under this chapter;

(b) the enforcement against the insurer or against property of the insurer of a judgment obtained before the commencement of the delinquency proceeding under this chapter;

(c) an act to:

(i) obtain or retain possession of:

(A) property of the insurer; or

(B) property from the insurer; or

(ii) exercise control over property or records of the insurer;

(d) an act to create, perfect, or enforce a lien against property of the insurer;

(e) an act to collect, assess, or recover a claim against the insurer that arises before the commencement of a delinquency proceeding under this chapter;

(f) the commencement or continuation of an action or proceeding against a reinsurer of the insurer:

(i) by the holder of a claim against the insurer; and

(ii) seeking a reinsurance recovery that is contractually due to the insurer;

(g) the commencement or continuation of an action or proceeding by a governmental unit to terminate or revoke an insurance license; and

(h) (i) an action described in Subsection (3)(h)(ii):

(A) with respect to a contract, agreement, or lease including:

(I) a policy;

(II) an insurance or reinsurance contract;

(III) a surety bond; or

(IV) a surety undertaking;

(B) whether or not the insurer is a party to the contract, agreement, lease,

policy, bond, or undertaking; and

(C) if the sole basis for the action is:

(I) that the insurer is the subject of a delinquency proceeding;

(II) that one or more of the insurer's licenses have been suspended or revoked because the insurer is the subject of a delinquency proceeding; or

(III) both Subsections (3)(h)(i)(C)(I) and (II); and

(ii) as to a contract, agreement, lease, policy, bond, or undertaking described in Subsection (3)(h)(i), an action for:

(A) termination;

(B) failure to renew;

(C) suspension of performance;

(D) declaration of default;

(E) demand for additional, substitute, or replacement security or performance; or

(F) other adverse action.

(4) (a) Except as provided in Subsections (5) and (6) or as otherwise provided in this chapter, the commencement of a delinquency proceeding under this chapter operates as a stay, applicable to all persons, of the commencement or continuation, including the issuance or employment of process, of a judicial, administrative, or other action or proceeding, including the enforcement of any judgment:

(i) against an insured that is or could have been commenced before the commencement of the delinquency proceeding under this chapter; or

(ii) (A) to recover a claim against the insured that arises before or after the commencement of the delinquency proceeding under this chapter; and

(B) for which the insurer:

(I) is or may be liable under a policy of insurance; or

(II) is obligated to defend a party.

(b) Subject to Subsection (4)(c), the stay provided by this Subsection (4) terminates 90 days after the day on which the receiver is appointed unless extended by order of the receivership court:

(i) for good cause shown; and

(ii) after notice to any affected parties and any hearing the receivership court determines is appropriate.

(c) Notwithstanding the other provisions of this Subsection (4), any applicable statute of limitations with respect to any claim against an insured is tolled during the period of the stay provided by this Subsection (4) and any extensions.

(5) Notwithstanding Subsection (3), the commencement of a delinquency proceeding under this chapter does not operate as a stay or prohibition of:

(a) except as provided in Subsection (3)(g), a regulatory action by a commissioner of a nondomiciliary state, including the suspension of a license;

(b) a criminal action;

(c) an act to perfect, or to maintain or continue the perfection of, an interest in property to the extent that the act is accomplished within any relation back period under applicable law;

(d) a set off as permitted by Section 31A-27a-510;

(e) pursuit and enforcement of a nonmonetary governmental claim, judgment, or proceeding;

(f) (i) presentment of a negotiable instrument; and

(ii) the giving of notice of and protesting dishonor of the negotiable instrument;

(g) enforcement of a right against a single beneficiary trust established pursuant to and in compliance with Section 31A-17-404;

(h) under or in connection with a netting agreement or qualified financial contract as provided for in Section 31A-27a-611, a right to cause:

(i) the netting, liquidation, set off, termination, acceleration, or close out of an obligation; or

(ii) enforcement of a:

(A) security agreement;

(B) security arrangement; or

(C) other credit enhancement or guarantee or reimbursement obligation;

(i) discharge by an affected guaranty association of statutory responsibilities under any statute applicable to the affected guaranty association; or

(j) any of the following actions:

(i) an audit by a governmental unit to determine tax liability;

(ii) the issuance to the insurer by a governmental unit of a notice of tax deficiency;

(iii) a demand for a tax return; or

(iv) the making of an assessment for any tax and issuance of a notice and demand for payment of the assessment.

(6) Except as provided in Subsection (7):

(a) the stay of an act against property of the insurer under Subsection (3) continues until the property is no longer property of the receivership; and

(b) the stay of any other act under Subsection (3) continues until the earlier of the day on which the delinquency proceeding is closed or the day on which the delinquency proceeding is dismissed.

(7) (a) The receivership court may grant relief from a stay of Subsection (3) or (4), by terminating, annulling, modifying, or conditioning the stay:

(i) on request of a party in interest;

(ii) after notice and any hearing the receivership court determines appropriate; and

(iii) (A) for cause; or

(B) with respect to a stay of an act against property under Subsection (3) if:

(I) the insurer does not have any equity in the property; and

(II) the property is not necessary to an effective plan.

(b) For the purposes of this Subsection (7), "cause" includes if:

(i) the receiver cancels a policy, a surety bond, or a surety undertaking;

(ii) the creditor is entitled, by contract or law, to require the insured or the principal to have a policy, a surety bond, or a surety undertaking; and

(iii) the insured or the principal fails to obtain a replacement policy, surety bond, or surety undertaking within 30 days from the date of cancellation.

(8) In a hearing under Subsection (7), the party seeking relief from the stay has the burden of proof on each issue, which shall be established by clear and convincing evidence.

(9) (a) The estate of an insurer that is injured by a willful violation of a stay

provided by this section is entitled to actual damages, including costs and attorney fees.

(b) In appropriate circumstances, the receivership court may impose sanctions in addition to those under Subsection (9)(a).

(10) Notwithstanding any other provision of law, in relation to any stay or injunction under this section, a bond may not be required of:

(a) the commissioner; or

(b) a receiver.

Enacted by Chapter 309, 2007 General Session

31A-27a-109. Statutes of limitations.

(1) If applicable law, an order, or an agreement fixes a period within which the insurer may commence an action, and this period is not expired before the day on which the initial petition in a delinquency proceeding is filed, the receiver may not by reason of the filing of the initial petition in a delinquency proceeding be barred from commencing the action if the receiver commences the action on or before the later of:

(a) the end of the period, including any suspension of the period occurring on or after the day on which the initial petition in a delinquency proceeding is filed; or

(b) six years after the day on which the most recent receivership order is entered.

(2) (a) Except as provided in Subsection (1), if applicable law, an order, or an agreement fixes a period within which the insurer may do an act described in Subsection (2)(b) and the period described in this Subsection (2)(a) is not expired before the date on which the initial petition in a delinquency proceeding is filed, the receiver may not by reason of the filing of the petition initiating a formal delinquency proceeding be barred from taking the act if the receiver does the act on or before the later of:

(i) the end of the period, including any suspension of the period occurring on or after the day on which the initial petition in a delinquency proceeding is filed; or

(ii) 60 days after the day on which the most recent receivership order is entered.

(b) This Subsection (2) applies to:

(i) filing, curing, or performing:

(A) a pleading;

(B) a demand;

(C) a notice; or

(D) a proof of claim or loss;

(ii) curing a default in a case or proceeding; or

(iii) performing any act similar to one described in Subsection (2)(b)(i) or (ii).

(3) If applicable law, an order, or an agreement fixes a period for commencing or continuing a civil action in a court other than the receivership court on a claim against the insurer, and the period has not expired before the day on which the initial petition in a delinquency proceeding is filed, the period does not expire until the later of:

(a) the end of the period, including any suspension of the period occurring on or after the day on which the initial petition in a delinquency proceeding is filed; or

(b) 30 days after the day on which the stay pursuant to this section with respect to the claim is terminated or expires.

Enacted by Chapter 309, 2007 General Session

31A-27a-110. Cooperation of officers, owners, and employees.

(1) As used in this section:

(a) "Cooperate" includes to:

(i) reply promptly in writing to an inquiry from the commissioner or receiver requesting a reply; and

(ii) promptly make available to the commissioner or receiver any record, account, information, or property:

(A) of or pertaining to the insurer; and

(B) in the person's possession, custody, or control.

(b) "Person" includes a person who exercises control directly or indirectly over activities of the insurer through:

(i) a holding company; or

(ii) other affiliate of the insurer.

(2) The following shall cooperate with the commissioner or receiver in a proceeding under this chapter or an investigation preliminary to a proceeding under this chapter:

(a) a present or former officer, manager, director, trustee, owner, or employee of an insurer;

(b) a present or former agent of an insurer; or

(c) a person with authority over or in charge of any segment of the insurer's affairs.

(3) A person may not obstruct or interfere with the commissioner or receiver in the conduct of:

(a) a delinquency proceeding; or

(b) an investigation preliminary or incidental to a delinquency proceeding.

(4) This section may not be construed to abridge otherwise existing legal rights, including the right to resist:

(a) a petition for liquidation or other delinquency proceeding; or

(b) other orders.

(5) (a) A person described in Subsection (5)(b) is:

(i) guilty of a class B misdemeanor, except that the fine may exceed $1,000 but may not exceed $10,000; or

(ii) after a hearing, subject to:

(A) the commissioner imposing a civil penalty that may not exceed $10,000;

(B) the revocation or suspension of an insurance license issued by the commissioner; or

(C) a combination of Subsections (5)(a)(ii)(A) and (B).

(b) This Subsection (5) applies to:

(i) a person described in Subsection (2) who fails to cooperate with the commissioner or receiver;

(ii) a person who obstructs or interferes with the commissioner or receiver in the conduct of a delinquency proceeding or an investigation preliminary or incidental to a delinquency proceeding; or

(iii) a person who violates an order validly issued under this chapter.

Enacted by Chapter 309, 2007 General Session

31A-27a-111. Actions by and against the receiver.

(1) (a) An allegation by the receiver of improper or fraudulent conduct against a person may not be the basis of a defense to the enforcement of a contractual obligation owed to the insurer by a third party.

(b) Notwithstanding Subsection (1)(a), a third party described in this Subsection (1) is not barred by this section from seeking to establish independently as a defense that the conduct is materially and substantially related to the contractual obligation for which enforcement is sought.

(2) (a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present or former officer, manager, director, trustee, owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the receiver:

(i) under a theory of:

(A) estoppel;

(B) comparative fault;

(C) intervening cause;

(D) proximate cause;

(E) reliance; or

(F) mitigation of damages; or

(ii) otherwise.

(b) Notwithstanding Subsection (2)(a):

(i) the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract; and

(ii) a principal under a surety bond or a surety undertaking is entitled to credit against any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that:

(A) the receiver has possession or control of the property; or

(B) the insurer or its agents misappropriated, including commingling, the property.

(c) Evidence of fraud in the inducement is admissible only if it is contained in the records of the insurer.

(3) Action or inaction by an insurance regulatory authority may not be asserted as a defense to a claim by the receiver.

(4) (a) Subject to Subsection (4)(b), a judgment or order entered against an insured or the insurer in contravention of a stay or injunction under this chapter, or at any time by default or collusion, may not be considered as evidence of liability or of the quantum of damages in adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

(b) Subsection (4)(a) does not apply to an affected guaranty association's claim for amounts paid on a settlement or judgment in pursuit of the affected guaranty association's statutory obligations.

(5) The receiver may not be considered a governmental entity for the purposes of any state law awarding fees to a litigant who prevails against a governmental entity.

Enacted by Chapter 309, 2007 General Session

31A-27a-112. Unrecorded obligations and defenses of affiliates.

(1) This section applies to a person who in relation to an insurer is:

(a) an affiliate;

(b) a controlled or controlling person; or

(c) a present or former officer, manager, director, trustee, or shareholder.

(2) In a proceeding or claim by the receiver, a person described in Subsection (1) may not assert a defense unless evidence of the defense:

(a) is recorded in the records of the insurer at or about the time the event giving rise to the defense occurs; and

(b) if required by statutory accounting practices and procedures, is timely reported on the insurer's official financial statements filed with the commissioner.

(3) A person described in Subsection (1) may not assert a claim, unless the obligation:

(a) is recorded in the records of the insurer at or about the time the obligation is incurred; and

(b) if required by statutory accounting practices and procedures, is timely reported on the insurer's official financial statements filed with the commissioner.

(4) A claim by the receiver against a person described in Subsection (1) that is made on the basis of an unrecorded or unreported transaction is not barred by this section.

Enacted by Chapter 309, 2007 General Session

31A-27a-113. Executory contracts.

(1) Subject to the other provisions of this section, the receiver may assume or reject an executory contract or unexpired lease of the insurer.

(2) (a) If there is a default in an executory contract or unexpired lease of the insurer, the receiver may not assume the contract or lease unless, at the time of the assumption of the contract or lease, the receiver:

(i) cures or provides adequate assurance that the receiver will promptly cure the default; and

(ii) provides adequate assurance of future performance under the contract or lease.

(b) This Subsection (2) does not apply to a default that is a breach of a provision relating to:

(i) the insolvency or financial condition of the insurer at any time before the closing of the delinquency proceeding;

(ii) the appointment of or taking possession by:

(A) a receiver in a case under this chapter; or

(B) a custodian before the commencement of the delinquency proceeding; or

(iii) the satisfaction of a penalty rate or provision relating to a default arising from a failure of the insurer to perform a nonmonetary obligation under the executory contract or unexpired lease.

(3) A claim arising from a rejection under this section or under a plan of rehabilitation or liquidation of an executory contract or unexpired lease of the insurer that is not assumed shall be determined, and shall be treated and classified as though the claim arose before the day on which a successful petition commencing the delinquency proceeding is filed.

Enacted by Chapter 309, 2007 General Session

31A-27a-114. Immunity and indemnification.

(1) For purposes of this section:

(a) "Receiver's assistant" includes:

(i) a present or former special deputy or assistant special deputy engaged by contract or otherwise;

(ii) a person whom the receiver, a special deputy, or an assistant special deputy employs to assist in a delinquency proceeding under this chapter; and

(iii) a state employee acting with respect to a delinquency proceeding under this chapter.

(b) "Receiver's contractor" includes a person with whom the receiver, a special deputy, or an assistant special deputy contracts to assist in a delinquency proceeding under this chapter such as:

(i) an attorney;

(ii) an accountant;

(iii) an auditor;

(iv) an actuary;

(v) an investment banker;

(vi) a financial advisor;

(vii) any other professional or firm who is retained or contracted with by the receiver as an independent contractor; and

(viii) an employee of a person described in this Subsection (1)(b).

(2) For the purposes of this section, the following persons are entitled to immunity and indemnification, or only immunity, as applicable:

(a) a present or former receiver responsible for the conduct of a delinquency proceeding under this chapter;

(b) a present or former receiver's assistant; and

(c) a present or former receiver's contractor.

(3) The receiver, a receiver's assistant, and a receiver's contractor have immunity under this chapter, as follows:

(a) the receiver, a receiver's assistant, and a receiver's contractor have official immunity and are immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property, personal injury, or other civil liability caused by or resulting from an alleged act, error, or omission of the receiver, a receiver's assistant, or a receiver's contractor arising out of or by reason of the receiver's, receiver's assistant's, or receiver's contractor's duties or employment;

(b) the receiver, a receiver's assistant, and a receiver's contractor have absolute judicial immunity and are immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property, personal injury, or

other civil liability caused by or resulting from any alleged act, error, or omission of the receiver, a receiver's assistant, or a receiver's contractor arising out of or by reason of any matter that is subject to review by the receivership court after notice and opportunity to be heard, if the alleged act, error, or omission is not disapproved or disallowed by the receivership court; and

(c) this chapter may not be construed to provide official immunity, to provide judicial immunity, or to otherwise hold the receiver, a receiver's assistant, or a receiver's contractor immune from suit and liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the receiver, a receiver's assistant, or a receiver's contractor.

(4) The receiver or a receiver's assistant is entitled to indemnification under this chapter, as follows:

(a) the receiver and a receiver's assistant shall be indemnified from the assets of the insurer:

(i) if any legal action is commenced against the receiver or a receiver's assistant:

(A) whether against the receiver or receiver's assistant personally or in the official capacity; and

(B) alleging property damage, property loss, personal injury, or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or a receiver's assistant arising out of or by reason of the receiver's or receiver's assistant's duties or employment;

(ii) for all expenses, attorney fees, judgments, settlements, decrees, or amounts due and owing or paid in satisfaction of or incurred in the defense of the legal action; and

(iii) unless it is determined upon a final adjudication on the merits that the alleged act, error, or omission of the receiver or receiver's assistant giving rise to the claim:

(A) does not arise out of or by reason of the receiver's or receiver's assistant's duties or employment; or

(B) is caused by intentional or willful and wanton misconduct;

(b) attorney fees and related expenses incurred in defending a legal action for which immunity or indemnity is available under this section shall be paid from the assets of the insurer as they are incurred, in advance of the final disposition of the action upon receipt of an agreement by or on behalf of the receiver or receiver's assistant to repay the attorney fees and expenses if it is ultimately determined upon a final adjudication on the merits that the receiver or receiver's assistant is not entitled to immunity or indemnity under this section;

(c) the following paid pursuant to this section are an administrative expense of the insurer, an indemnification for:

(i) an expense payment;

(ii) a judgment;

(iii) a settlement;

(iv) a decree;

(v) attorney fees;

(vi) a surety bond premium; or

(vii) other amounts paid or to be paid from the insurer's assets pursuant to this section;

(d) in the event of actual or threatened litigation against a receiver or a receiver's assistant for which immunity or indemnity may be available under this section, a reasonable amount of funds which in the judgment of the receiver may be needed to provide immunity or indemnity shall be segregated and reserved from the assets of the insurer:

(i) as security for the payment of indemnity; and

(ii) until:

(A) all applicable statutes of limitations run;

(B) all actual or threatened actions against the receiver or a receiver's assistant are completely and finally resolved; and

(C) all obligations under this section are satisfied;

(e) in lieu of segregation and reserving of funds, the receiver may, in the receiver's discretion, obtain a surety bond or make other arrangements that will enable the receiver to fully secure the payment of all obligations under this section;

(f) if a legal action against a receiver's assistant for which indemnity may be available under this section is settled before final adjudication on the merits, the receiver shall pay the settlement amount on behalf of the receiver's assistant, or indemnify the receiver's assistant for the settlement amount, unless the receiver determines that the claim:

(i) does not arise out of or by reason of the receiver's assistant's duties or employment; or

(ii) is caused by the intentional or willful and wanton misconduct of the receiver's assistant; and

(g) in a legal action in which a claim is asserted against the receiver:

(i) that portion of any settlement relating to the alleged act, error, or omission of the receiver is subject to the approval of the receivership court; and

(ii) the receivership court may not approve that portion of the settlement if the receivership court determines that the claim:

(A) does not arise out of or by reason of the receiver's duties or employment; or

(B) is caused by the intentional or willful and wanton misconduct of the receiver.

(5) Nothing contained or implied in this section shall operate, or be construed or applied to deprive the receiver, a receiver's assistant, or a receiver's contractor of any immunity, indemnity, benefits of law, rights, or any defense otherwise available.

(6) The immunity and indemnification provided to a receiver's assistant and the immunity provided to a receiver's contractor under this section does not apply to an action by the receiver against the receiver's assistant or receiver's contractor.

(7) (a) Subsection (3) applies to any suit based in whole or in part on an alleged act, error, or omission that takes place on or after April 30, 2007.

(b) A legal action may not lie against the receiver or a receiver's assistant based in whole or in part on an alleged act, error, or omission that takes place before April 30, 2007, unless suit is filed and valid service of process is obtained on or after April 30, 2007, but on or before April 30, 2008.

(8) Subsection (4) applies to a suit that is pending on or filed after April 30, 2007, without regard to when the alleged act, error, or omission takes place.

Enacted by Chapter 309, 2007 General Session

31A-27a-115. Approval and payment of expenses.

(1) The receiver may pay an expense under a contract, lease, employment agreement, or other arrangement entered into by the insurer before receivership, as the receiver considers necessary for the purposes of this chapter. The receiver:

(a) is not required to pay an expense described in this Subsection (1) that the receiver determines is not necessary; and

(b) may reject a contract pursuant to Section 31A-27a-113.

(2) Receivership expenses other than those described in Subsection (1) shall be paid as follows:

(a) unless the court orders otherwise in the rehabilitation or liquidation order, the receiver may submit a motion pursuant to Section 31A-27a-107 to the receivership court to approve:

(i) the terms of compensation of each special deputy or contractor; or

(ii) any other expense in excess of an amount established by this chapter;

(b) the receiver may, as the receiver considers appropriate, submit a motion to approve any other compensation, anticipated expense, or incurred expense not described in Subsection (2)(a);

(c) the receiver may pay as incurred:

(i) an expense not requiring receivership court approval; and

(ii) an expense approved in the rehabilitation or liquidation order; and

(d) the approval of an expense by the receivership court may not prejudice the right of the receiver to seek recovery, recoupment, disgorgement, or reimbursement of a fee based on contract or a cause of action recognized in law or in equity.

(3) On an annual or more frequent basis, the receiver shall submit to the receivership court a report summarizing the expenses incurred in the prior period.

(4) Receivership court approval is not required to pay expenses incurred by the receiver in connection with the appeal of an order of the receivership court.

(5) All expenses of receivership shall be paid from the assets of the insurer, except as provided in this Subsection (5).

(a) If the property of the insurer does not contain sufficient cash or liquid assets to defray the expenses incurred, the commissioner may advance funds from the account established under Subsection 31A-27a-705(3).

(b) An amount advanced shall be repaid to the account out of the first available money of the insurer.

Enacted by Chapter 309, 2007 General Session

31A-27a-116. Financial reporting.

(1) (a) The receiver shall comply with all requirements for receivership financial reporting as specified by the commissioner by rule within:

(i) 180 days after the day on which the receivership court enters an order of receivership; and

(ii) 45 days following each calendar quarter after the period specified in

Subsection (1)(a)(i).

(b) The rule described in this Subsection (1) shall:

(i) comply with this section;

(ii) be made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(iii) require the receiver to file any financial report with the receivership court in addition to any other person specified in the rule.

(c) A financial report shall include, at a minimum, a statement of:

(i) the assets and liabilities of the insurer;

(ii) the changes in those assets and liabilities; and

(iii) all funds received or disbursed by the receiver during that reporting period.

(d) The receiver may qualify a financial report or provide notes to the financial statement for further explanation.

(e) The receivership court may order the receiver to provide any additional information as the receivership court considers appropriate.

(2) Each affected guaranty association shall file one or more reports with the liquidator:

(a) (i) within 180 days after the day on which the receivership court enters an order of liquidation; and

(ii) (A) within 45 days following each calendar quarter after the period described in Subsection (2)(a)(i); or

(B) at an interval:

(I) agreed to between the liquidator and the affected guaranty association; or

(II) required by the receivership court; and

(b) in no event less than annually.

(3) For good cause shown, the receivership court may grant:

(a) relief for an extension or modification of time to comply with Subsection (1) or (2); or

(b) such other relief as may be appropriate.

Amended by Chapter 382, 2008 General Session

31A-27a-117. Records.

(1) (a) Upon entry of an order of rehabilitation or liquidation, the receiver is vested with title to all of the records of the insurer:

(i) of whatever nature;

(ii) in whatever medium;

(iii) wherever located; and

(iv) regardless of whether the item is in the custody and control of:

(A) a third party administrator;

(B) a managing general agent;

(C) an attorney; or

(D) other representatives of the insurer.

(b) The receiver may immediately take possession and control of:

(i) all of the records of the insurer; and

(ii) the premises where the records are located.

(c) At the request of the receiver, a third party administrator, managing general agent, attorney, or other representatives of the insurer shall release all records of the insurer to:

(i) the receiver; or

(ii) the receiver's designee.

(d) With the receiver's approval, an affected guaranty association with an obligation under a policy issued by the insurer may take actions necessary to obtain directly from a third party administrator, managing general agent, attorney, or other representative of the insurer all records pertaining to the insurer's business that are appropriate or necessary for the affected guaranty association to fulfill its statutory obligations.

(2) The receiver may certify a record of a delinquent insurer described in Subsection (1) and a record of the receiver's office created and maintained in connection with a delinquent insurer, as follows:

(a) a record of a delinquent insurer may be certified by the receiver in an affidavit stating that the record is a true and correct copy of the record of the insurer that is received from the custody of the insurer, or found among the insurer's effects; or

(b) a record created by or filed with the receiver's office in connection with a delinquent insurer may be certified by the receiver's affidavit stating that the record is a true and correct copy of the record maintained by the receiver's office.

(3) (a) An original record or copy of a record certified under Subsection (2):

(i) when admitted in evidence is prima facie evidence of the facts disclosed; and

(ii) is admissible in evidence in the same manner as a document described in Utah Rules of Evidence, Rule 902(1).

(b) The receivership court may consider the certification of a record by the receiver pursuant to this section as satisfying the requirements of Utah Rules of Evidence, Rule 803(6).

(4) A record of a delinquent insurer held by the receiver:

(a) is not a record of the department for any purposes; and

(b) not subject to Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 382, 2008 General Session

31A-27a-118. Commissioner's reports.

(1) The commissioner shall include in the commissioner's annual report:

(a) the names of the insurers proceeded against under Sections 31A-27a-207 and 31A-27a-901;

(b) those facts which indicate in reasonable detail the commissioner's formal proceedings under this chapter; and

(c) those facts which generally explain the use and effectiveness of proceedings under Chapter 27, Part 5, Administrative Actions, and Section 31A-27a-901.

(2) The commissioner as receiver shall make and file annual reports and any other required reports for an insurer proceeded against under Sections 31A-27a-207 and 31A-27a-901 in the manner, in the form, and within the time required by law of an insurer authorized to do business in this state.

Renumbered and Amended by Chapter 309, 2007 General Session

31A-27a-119. Delinquency proceeding commenced before April 30, 2007.

This chapter does not apply to a delinquency proceeding ongoing on April 30, 2007.

Enacted by Chapter 309, 2007 General Session

31A-27a-120. Severability.

If any provision of this chapter or the application of this chapter to any person or circumstance is for any reason held invalid, the remainder of the chapter and the application of the provision to other persons or circumstances shall be given effect without the invalid provision or application. The provisions of this chapter are severable.

Enacted by Chapter 309, 2007 General Session

31A-27a-201. Receivership court's seizure order.

(1) The commissioner may file in the Third District Court for Salt Lake County a petition:

(a) with respect to:

(i) an insurer domiciled in this state;

(ii) an unauthorized insurer; or

(iii) pursuant to Section 31A-27a-901, a foreign insurer;

(b) alleging that:

(i) there exists grounds that would justify a court order for a formal delinquency proceeding against the insurer under this chapter; and

(ii) the interests of policyholders, creditors, or the public will be endangered by delay; and

(c) setting forth the contents of a seizure order considered necessary by the commissioner.

(2) (a) Upon a filing under Subsection (1), the receivership court may issue the requested seizure order:

(i) immediately, ex parte, and without notice or hearing;

(ii) that directs the commissioner to take possession and control of:

(A) all or a part of the property, accounts, and records of an insurer; and

(B) the premises occupied by the insurer for transaction of the insurer's business; and

(iii) that until further order of the receivership court, enjoins the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

(b) Any person having possession or control of and refusing to deliver any of the records or assets of a person against whom a seizure order is issued under this Subsection (2) is guilty of a class B misdemeanor.

(3) (a) A petition that requests injunctive relief:

(i) shall be verified by the commissioner or the commissioner's designee; and

(ii) is not required to plead or prove irreparable harm or inadequate remedy at law.

(b) The commissioner shall provide only the notice that the receivership court may require.

(4) (a) The receivership court shall specify in the seizure order the duration of the seizure, which shall be the time the receivership court considers necessary for the commissioner to ascertain the condition of the insurer.

(b) The receivership court may from time to time:

(i) hold a hearing that the receivership court considers desirable:

(A) (I) on motion of the commissioner;

(II) on motion of the insurer; or

(III) on its own motion; and

(B) after the notice the receivership court considers appropriate; and

(ii) extend, shorten, or modify the terms of the seizure order.

(c) The receivership court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to commence a formal proceeding under this chapter.

(d) An order of the receivership court pursuant to a formal proceeding under this chapter vacates the seizure order.

(5) Entry of a seizure order under this section does not constitute a breach or an anticipatory breach of any contract of the insurer.

(6) (a) An insurer subject to an ex parte seizure order under this section may petition the receivership court at any time after the issuance of a seizure order for a hearing and review of the seizure order.

(b) The receivership court shall hold the hearing and review requested under this Subsection (6) not more than 15 days after the day on which the request is received.

(c) A hearing under this Subsection (6):

(i) may be held privately in chambers; and

(ii) shall be held privately in chambers if the insurer proceeded against requests that it be private.

(7) (a) If, at any time after the issuance of a seizure order, it appears to the receivership court that a person whose interest is or will be substantially affected by the seizure order did not appear at the hearing and has not been served, the receivership court may order that notice be given to the person.

(b) An order under this Subsection (7) that notice be given may not stay the effect of any seizure order previously issued by the receivership court.

(8) Whenever the commissioner makes a seizure as provided in Subsection (2), on the demand of the commissioner, it shall be the duty of the sheriff of a county of this state, and of the police department of a municipality in the state to furnish the commissioner with necessary deputies or officers to assist the commissioner in making and enforcing the seizure order.

Enacted by Chapter 309, 2007 General Session

31A-27a-202. Commencement of formal delinquency proceeding.

(1) A formal delinquency proceeding against a person shall be commenced by filing a petition in the name of the commissioner or department.

(2) (a) The petition required by Subsection (1):

(i) shall state:

(A) the grounds upon which the proceeding is based; and

(B) the relief requested; and

(ii) may include a request for restraining orders and injunctive relief as described in Section 31A-27a-108.

(b) Upon the filing of a petition, the commissioner shall forward a notice of the petition by first-class mail or electronic communication, as permitted by the receivership court, to the commissioners and guaranty associations in states in which the insurer did business.

(3) (a) A petition that requests injunctive relief:

(i) shall be verified by the commissioner or the commissioner's designee; and

(ii) is not required to plead or prove irreparable harm or inadequate remedy at law.

(b) The commissioner shall provide only the notice the receivership court requires.

(4) If a temporary restraining order is requested:

(a) the receivership court may issue an initial order containing the relief requested;

(b) the order shall state the time and date of its issuance;

(c) the receivership court shall set a time and date for the return of summons:

(i) not more than 10 days from the time and date the initial order is issued; and

(ii) at which time the person proceeded against may appear before the receivership court for a summary hearing; and

(d) the order may not continue in effect beyond the time and date set for the return of summons, unless the receivership court expressly enters one or more orders extending the restraining order.

(5) (a) If no temporary restraining order is requested, the receivership court shall cause summons to be issued.

(b) The summons shall specify:

(i) a return date not more than 30 days after the day on which the summons is issued; and

(ii) that an answer shall be filed at or before the return date.

Amended by Chapter 297, 2011 General Session

31A-27a-203. Return of summons and summary hearing.

(1) The receivership court shall hold a summary hearing at the time and date for the return of summons on a petition to commence a formal delinquency proceeding.

(2) If a person is not served with summons on a petition to commence a formal delinquency proceeding and fails to appear for the summary hearing, the receivership court shall:

(a) continue the summary hearing not more than 10 days;

(b) provide for alternative service of summons upon the person; and
(c) extend any restraining order.
(3) Upon a showing of good faith efforts to effect personal service upon a person who fails to appear for a continued summary hearing, the receivership court shall order notice of the petition to commence a formal delinquency proceeding to be published. The order and notice shall specify:
(a) a return date not less than 10 nor more than 20 days after the day on which notice is published; and
(b) that the restraining order is extended to the continued hearing date.
(4) If a person fails to appear for a summary hearing on a petition to commence a formal delinquency proceeding after service of summons, the receivership court shall enter judgment in favor of the commissioner against that person.
(5) (a) A person who appears for the summary hearing on a petition to commence a formal delinquency proceeding shall file its answer at the hearing and the receivership court shall:
(i) determine whether to extend any temporary restraining order pending final judgment; and
(ii) set the case for trial on a date not more than 10 days from the day on which the summary hearing is held.
(b) The receivership court may not grant a continuance for filing an answer.

Enacted by Chapter 309, 2007 General Session

31A-27a-204. Proceedings for expedited trial -- Continuance -- Evidence -- Discovery.
(1) (a) The receivership court shall proceed to hear the case on the petition to commence a formal delinquency proceeding:
(i) at the time and date set forth for trial;
(ii) without a jury; and
(iii) without unnecessary delay.
(b) To the extent practicable, the receivership court shall give precedence to the matter over all other matters.
(c) To the extent authorized by law, the receivership court may assign the matter to another judge if necessary to comply with the need for expedited proceedings under this chapter.
(2) A continuance for trial shall be granted only in extreme circumstances.
(3) The receivership court shall admit as self authenticated a certified copy of the following when offered by the commissioner:
(a) a financial statement made by the insurer or an affiliate;
(b) an examination report of the insurer or an affiliate made by or on behalf of the commissioner; or
(c) any other document filed with any insurance department by the insurer or an affiliate.
(4) The facts contained in an examination report of the insurer or an affiliate made by or on behalf of the commissioner is presumed to be true as of the date of the hearing if the examination is made as of a date not more than 270 days before the day

on which the petition is filed. The presumption:

(a) is rebuttable; and

(b) shifts the burden of production and persuasion to the insurer.

(5) Discovery:

(a) is limited to grounds alleged in the petition; and

(b) shall be concluded on an expedited basis.

Enacted by Chapter 309, 2007 General Session

31A-27a-205. Decision and appeals.

(1) The receivership court shall enter judgment on the petition to commence formal delinquency proceeding within 15 days after the day on which the evidence is concluded.

(2) (a) An order entered pursuant to Subsection (1) is final when entered.

(b) An appeal shall be:

(i) handled on an expedited basis; and

(ii) taken within five days of the day on which judgment is entered.

(3) (a) Absent entry of an order staying the order pursuant to Subsection (4), the order has full force and effect and the receiver shall carry out the order's terms and this chapter.

(b) A request for reconsideration, review, or appeal, or posting of a bond, may not dissolve or stay the judgment.

(4) (a) The following motions shall first be presented to the receivership court:

(i) a motion for a stay of a judgment;

(ii) a motion for approval of a supersedes bond; or

(iii) a motion for other relief pending appeal.

(b) Except for a grant of a petition for rehabilitation which shall remain in effect pending a decision on appeal, during the pendency of an appeal the receivership court may do any of the following in accordance with the Utah Rules of Civil Procedure:

(i) suspend an order entered under Subsection (1);

(ii) modify an order entered under Subsection (1); or

(iii) make any other appropriate order governing the enforceability of an order entered under Subsection (1).

(c) The receivership court or an appellate court to which the matter is presented may condition any relief it grants under this Subsection (4) on the filing of a bond or other appropriate security with the receivership court.

(5) Section 31A-27a-114 applies to all acts taken during the pendency of an appeal regardless of the appeal's ultimate disposition.

(6) The reversal or modification on appeal of an order of rehabilitation or liquidation does not affect the validity of an act of the receiver pursuant to the order unless the order is stayed pending appeal.

Amended by Chapter 297, 2011 General Session

31A-27a-206. Confidentiality.

(1) (a) Except as provided in Subsection (1)(b), in a delinquency proceeding or a

judicial review under Section 31A-27a-201:

(i) all records of the insurer, department files, court records and papers, and other documents, so far as they pertain to or are a part of the record of the proceedings, are confidential; and

(ii) a paper filed with the clerk of the Third District Court for Salt Lake County shall be held by the clerk in a confidential file as permitted by law.

(b) The items listed in Subsection (1)(a) are subject to Subsection (1)(a):

(i) except to the extent necessary to obtain compliance with an order entered in connection with the proceeding; and

(ii) unless and until:

(A) the Third District Court for Salt Lake County, after hearing argument in chambers, orders otherwise;

(B) the insurer requests that the matter be made public; or

(C) the commissioner applies for an order under Section 31A-27a-207.

(2) (a) If the recipient agrees to maintain the confidentiality of the document, material, or other information, the commissioner or rehabilitator may share a document, materials, or other information in the possession, custody, or control of the department, pertaining to an insurer that is the subject of a delinquency proceeding under this chapter with:

(i) another state, federal, and international regulatory agency;

(ii) the National Association of Insurance Commissioners and its affiliates or subsidiaries;

(iii) a state, federal, and international law enforcement authority;

(iv) an auditor appointed by the receivership court in accordance with Section 31A-27a-805; or

(v) a representative of an affected guaranty association.

(b) If the domiciliary receiver believes that certain information is sensitive, the receiver may share that information subject to a continuation of the confidentiality obligations beyond the period allowed in Subsection (3).

(c) This section does not limit the power of the commissioner to disclose information under other applicable law.

(3) (a) A domiciliary receiver shall permit a commissioner or a guaranty association of another state to obtain a listing of policyholders and certificate holders residing in the requestor's state, including current addresses and summary policy information, if the commissioner or the guaranty association of another state agrees:

(i) to maintain the confidentiality of the record; and

(ii) that the record will be used only for regulatory or guaranty association purposes.

(b) Access to a record under this Subsection (3) may be limited to normal business hours.

(c) If the domiciliary receiver believes that certain information described in this Subsection (3) is sensitive and disclosure might cause a diminution in recovery, the receiver may apply for a protective order imposing additional restrictions on access.

(4) (a) The confidentiality obligations imposed by this section shall end upon the entry of an order of liquidation against the insurer, unless:

(i) otherwise agreed to by the parties; or

(ii) pursuant to an order of the receivership court.

(b) A continuation of confidentiality as provided in Subsection (2) does not apply to an insurer record necessary for a guaranty association to discharge its statutory responsibilities.

(5) A waiver of an applicable privilege or claim of confidentiality does not occur as a result of a disclosure, or any sharing of documents, materials, or other information, made pursuant to this section.

Enacted by Chapter 309, 2007 General Session

31A-27a-207. Grounds for rehabilitation or liquidation.

(1) The commissioner may file in the Third District Court for Salt Lake County a petition with respect to an insurer domiciled in this state or an unauthorized insurer for an order of rehabilitation or liquidation on any one or more of the following grounds:

(a) the insurer is impaired;

(b) the insurer is insolvent;

(c) subject to Subsection (2), the insurer is about to become insolvent;

(d) (i) the insurer neglects or refuses to comply with an order of the commissioner to make good within the time prescribed by law any deficiency;

(ii) if a stock company, if its capital and minimum required surplus is impaired; or

(iii) if a company other than a stock company, if its surplus is impaired;

(e) the insurer, its parent company, its subsidiary, or its affiliate:

(i) converts, wastes, or conceals property of the insurer; or

(ii) otherwise improperly disposes of, dissipates, uses, releases, transfers, sells, assigns, hypothecates, or removes the property of the insurer;

(f) the insurer is in such condition that the insurer could not meet the requirements for organization and authorization as required by law, except as to the amount of:

(i) the original surplus required of a stock company under Sections 31A-5-211 and 31A-8-209; and

(ii) the surplus required of a company other than a stock company in excess of the minimum surplus required to be maintained;

(g) the insurer, its parent company, its subsidiary, or its affiliate:

(i) conceals, removes, alters, destroys, or fails to establish and maintain records and other pertinent material adequate for the determination of the financial condition of the insurer by examination under Section 31A-2-203; or

(ii) fails to properly administer claims or maintain claims records that are adequate for the determination of its outstanding claims liability;

(h) at any time after the issuance of an order under Subsection 31A-2-201(4), or at the time of instituting a proceeding under this chapter, it appears to the commissioner that upon good cause shown, it is not in the best interest of the policyholders, creditors, or the public to proceed with the conduct of the business of the insurer;

(i) the insurer is in such condition that the further transaction of business would be hazardous financially, according to Subsection 31A-17-609(3) or otherwise, to its policyholders, creditors, or the public;

(j) there is reasonable cause to believe that:

(i) there has been:
(A) embezzlement from the insurer;
(B) wrongful sequestration or diversion of the insurer's property;
(C) forgery or fraud affecting the insurer; or
(D) other illegal conduct in, by, or with respect to the insurer; and
(ii) the act described in Subsection (1)(j)(i) if established would endanger assets in an amount threatening the solvency of the insurer;
(k) control of the insurer is in a person who is:
(i) dishonest;
(ii) untrustworthy; or
(iii) so lacking in insurance company managerial experience or capability as to be hazardous to policyholders, creditors, or the public;
(l) if:
(i) a person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director, trustee, employee, shareholder, or other person:
(A) refuses to be examined under oath by the commissioner concerning the insurer's affairs, whether in this state or elsewhere; or
(B) if examined under oath, refuses to divulge pertinent information reasonably known to the person; and
(ii) after reasonable notice of the facts described in Subsection (1)(l)(i), the insurer fails promptly and effectively to terminate:
(A) the employment or status of the person; and
(B) all of the person's influence on management;
(m) after demand by the commissioner under Section 31A-2-203 or under this chapter, the insurer fails to promptly make available for examination:
(i) any of its own property, accounts, or records; or
(ii) so far as it pertains to the insurer, property, accounts, or records of:
(A) a subsidiary or related company within the control of the insurer; or
(B) a person having executive authority in the insurer;
(n) without first obtaining the written consent of the commissioner, the insurer:
(i) transfers, or attempts to transfer, in a manner contrary to Section 31A-5-508 or 31A-16-103, substantially its entire property or business; or
(ii) enters into a transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person;
(o) the insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, sequestrator, or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state;
(p) within the previous five years the insurer willfully and continuously violates:
(i) its charter or articles of incorporation;
(ii) its bylaws;
(iii) an insurance law of this state; or
(iv) a valid order of the commissioner;
(q) the insurer fails to pay within 60 days after the due date:
(i) (A) an obligation to any state or any subdivision of a state; or

(B) a judgment entered in any state, if the court in which the judgment is entered has jurisdiction over the subject matter; and

(ii) except that nonpayment is not a ground until 60 days after a good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts;

(r) the insurer systematically:

(i) engages in the practice of:

(A) reaching settlements with and obtaining releases from claimants; and

(B) unreasonably delaying payment, or failing to pay the agreed-upon settlements; or

(ii) attempts to compromise with claimants or other creditors on the ground that it is financially unable to pay its claims or obligations in full;

(s) the insurer fails to file its annual report or other financial report required by statute within the time allowed by law;

(t) 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 specified in Section 31A-27a-104, request or consent to rehabilitation or liquidation under this chapter;

(u) (i) the insurer does not comply with its domiciliary state's requirements for issuance to it of a certificate of authority; or

(ii) the insurer's certificate of authority is revoked by its state of domicile; or

(v) when authorized by Chapter 17, Part 6, Risk-Based Capital.

(2) For purposes of this section, an insurer is about to become insolvent if it is reasonably anticipated that the insurer will not have liquid assets to meet its current obligations for the next 90 days.

Enacted by Chapter 309, 2007 General Session

31A-27a-208. Entry of order.

(1) If the commissioner establishes any of the grounds provided in Section 31A-27a-207, the receivership court shall:

(a) grant the petition; and

(b) issue the order of rehabilitation or liquidation requested in the petition.

(2) Upon the issuance of the order, the commissioner shall forward a copy of the order by first-class mail or electronic communication as permitted by the receivership court to the commissioners and guaranty associations in states in which the insurer did business.

Enacted by Chapter 309, 2007 General Session

31A-27a-209. Effect of order of rehabilitation or liquidation.

(1) The filing or recording of an order of receivership with the following imparts the same notice as a deed, bill of sale, or other evidence of title filed or recorded would have imparted:

(a) the Third District Court for Salt Lake County;

(b) the recorder of deeds of the county in which the principal business of the

insurer is conducted; or

(c) in the case of real estate, with the recorder of deeds of the county where the property is located.

(2) The filing of a petition commencing delinquency proceedings under this chapter or the entry of an order of seizure, rehabilitation, or liquidation does not constitute a breach or an anticipatory breach of any contract or lease of the insurer.

(3) (a) The receiver may appoint one or more special deputies.

(b) A special deputy:

(i) has the powers and responsibilities of the receiver granted under this section, unless specifically limited by the receiver; and

(ii) serves at the pleasure of the receiver.

(c) The receiver may employ or contract with:

(i) legal counsel;

(ii) one or more actuaries;

(iii) one or more accountants;

(iv) one or more appraisers;

(v) one or more consultants;

(vi) one or more clerks;

(vii) one or more assistants; and

(viii) other personnel as may be considered necessary.

(d) A special deputy or other person with whom the receiver contracts under this Subsection (3):

(i) is considered to be an agent of the commissioner only in the commissioner's capacity as receiver; and

(ii) is not considered an agent of the state.

(e) The provisions of any law governing the procurement of goods and services by the state do not apply to a contract entered into by the commissioner as receiver.

(f) The compensation of a special deputy, employee, or contractor and all expenses of taking possession of the insurer and of conducting the receivership shall be:

(i) determined by the receiver, with the approval of the receivership court in accordance with Section 31A-27a-115; and

(ii) paid out of the property of the insurer.

(g) (i) If the receiver, in the receiver's sole discretion, considers it necessary to the proper performance of the receiver's duties under this chapter, the receiver may appoint an advisory committee of policyholders, claimants, or other creditors including guaranty associations.

(ii) The committee described in this Subsection (3)(g) serves:

(A) at the pleasure of the receiver; and

(B) without compensation and without reimbursement for expenses.

(iii) The receiver or the receivership court in proceedings conducted under this chapter may not appoint any other committee of any nature.

Enacted by Chapter 309, 2007 General Session

31A-27a-301. Rehabilitation orders.

(1) (a) An order to rehabilitate the business of an insurer shall:
(i) appoint the commissioner and the commissioner's successors in office as the rehabilitator;
(ii) direct the rehabilitator to:
(A) take possession and title of the assets of the insurer; and
(B) administer the assets of the insurer under the general supervision of the court; and
(iii) require accountings to the receivership court by the rehabilitator.
(b) Accountings shall be at the intervals the receivership court specifies in its order, but no less frequently than semiannually.
(c) Each accounting shall include a report concerning the rehabilitator's opinion as to:
(i) the likelihood that a plan under Section 31A-27a-303 will be prepared by the rehabilitator; and
(ii) the timetable for preparing the plan described in Subsection (1)(c)(i).
(2) (a) In recognition of the need for a prompt and final resolution for all persons affected by a plan of rehabilitation, any appeal from an order of rehabilitation or an order approving a plan of rehabilitation shall be heard on an expedited basis.
(b) A stay of an order of rehabilitation or an order approving a plan of rehabilitation may not be granted unless the appellant demonstrates that extraordinary circumstances warrant delaying the recovery under the plan of rehabilitation of all other persons, including policyholders.
(c) If a plan of rehabilitation provides an appropriate mechanism for adjustment in the event of an adverse ruling from an appeal, a stay may not be granted.

Enacted by Chapter 309, 2007 General Session

31A-27a-302. Powers and duties of the rehabilitator.
(1) (a) With court approval, the rehabilitator may take an action the rehabilitator considers necessary or appropriate to reform and revitalize the insurer, including:
(i) canceling:
(A) a policy;
(B) an insurance or reinsurance contract, other than life insurance, health insurance, or an annuity;
(C) a surety bond; or
(D) a surety undertaking; or
(ii) transferring to a solvent assuming insurer:
(A) a policy;
(B) an insurance or reinsurance contract;
(C) a surety bond; or
(D) a surety undertaking.
(b) The rehabilitator has all the powers of the directors, officers, and managers of the insurer, whose authority is suspended, except as redelegated by the rehabilitator.
(c) The rehabilitator has full power to:
(i) direct and manage the insurer;
(ii) hire and discharge employees; and

(iii) deal with the property and business of the insurer.

(d) The rehabilitator is not liable as the result of good faith issuance or renewal of a policy while in rehabilitation.

(2) The rehabilitator may pursue all appropriate legal remedies on behalf of the insurer if it appears to the rehabilitator that there is or has been criminal or tortious conduct, or breach of a contractual or fiduciary obligation detrimental to the insurer by an officer, a manager, an agent, a broker, an employee, an affiliate, or other person.

(3) (a) The rehabilitator may assert all defenses available to the insurer as against a third person, including statutes of limitations, statutes of frauds, and the defense of usury.

(b) A waiver of a defense by the insurer after a petition pursuant to Section 31A-27a-201 or 31A-27a-207 is filed does not bind the rehabilitator.

(4) The enumeration of the powers and authority of the rehabilitator in this section:

(a) may not be construed as a limitation upon the rehabilitator; and

(b) does not exclude in any manner the right to do other acts:

(i) not specifically enumerated or otherwise provided for; and

(ii) as may be necessary or appropriate for the accomplishment of or in aid of the purpose of rehabilitation.

Enacted by Chapter 309, 2007 General Session

31A-27a-303. Filing of rehabilitation plans.

(1) (a) The rehabilitator shall prepare and file a plan to effect rehabilitation with the receivership court within:

(i) one year after the day on which the rehabilitation order is entered; or

(ii) such further time as the receivership court may allow.

(b) The receivership court may take an action described in Subsection (1)(c):

(i) upon application of the rehabilitator for approval of a plan; and

(ii) after the notice and hearings the receivership court may prescribe.

(c) If the conditions of Subsection (1)(b) are met, the receivership court may:

(i) approve the plan proposed;

(ii) disapprove the plan proposed; or

(iii) (A) modify the plan proposed; and

(B) approve the plan as modified.

(d) If the plan is approved, the rehabilitator shall carry out the plan.

(e) In the case of a life insurer, the plan proposed may:

(i) include the imposition of a lien upon a policy of the insurer, if all rights of shareholders are relinquished; and

(ii) propose imposition of a moratorium upon loan and cash surrender rights under a policy for a period not to exceed one year from the day on which the order approving the rehabilitation plan is entered, unless the receivership court, for good cause shown, extends the moratorium.

(2) Once a plan is filed, any party in interest may object to the plan.

(3) A plan shall:

(a) except as provided in Subsection (5), provide no less favorable treatment of

a claim or class of claims than would occur in liquidation, unless the holder of a particular claim or interest agrees to a less favorable treatment of that particular claim or interest;

(b) provide adequate means for the plan's implementation;

(c) contain information concerning the financial condition of the insurer and the operation and effect of the plan, as far as is reasonably practicable in light of:

(i) the nature and history of the insurer;

(ii) the condition of the insurer's records; and

(iii) the nature of the plan; and

(d) provide for the disposition of the records relevant to the duties and obligations covered by the plan.

(4) A plan may include any other provisions not inconsistent with this chapter, including:

(a) payment of distributions;

(b) (i) assumption or reinsurance of all or a portion of the insurer's remaining liabilities by a licensed insurer or other entity; and

(ii) transfer of assets and related records to the licensed insurer or other entity;

(c) to the extent appropriate, application of insurance company regulatory market conduct standards to any entity administering claims on behalf of the receiver or assuming direct liabilities of the insurer;

(d) contracting with a guaranty association or any other qualified entity to perform the administration of claims;

(e) annual independent financial and performance audits of any entity administering claims on behalf of the receiver that is not otherwise subject to examination pursuant to state insurance law; and

(f) termination of the insurer's liabilities other than those under policies of insurance as of a date certain.

(5) (a) A plan may designate and separately treat one or more separate subclasses consisting only of those claims within the subclasses that are for or reduced to de minimis amounts.

(b) For purposes of this Subsection (5), a "de minimis amount" is an amount equal to or less than a maximum de minimis amount approved by the receivership court as being reasonable and necessary for administrative convenience.

Enacted by Chapter 309, 2007 General Session

31A-27a-304. Termination of rehabilitation.

(1) (a) The rehabilitator may move for an order of liquidation whenever the rehabilitator believes further attempts to rehabilitate an insurer would:

(i) substantially increase the risk of loss to creditors, policyholders, or the public; or

(ii) be futile.

(b) In accordance with Section 31A-27a-305, the rehabilitator or the rehabilitator's designated representative shall coordinate with an affected guaranty association and any national association of guaranty associations to plan for transition to liquidation.

(2) The rehabilitator shall petition the receivership court for an order of liquidation or seek an order, on good cause shown, for a longer suspension period if:

(a) the payment of a policy obligation is suspended in substantial part for a period of six months at any time after the appointment of the rehabilitator; and

(b) the rehabilitator has not filed an application for approval of a plan under Section 31A-27a-303.

(3) (a) The receivership court may enter an order terminating rehabilitation of an insurer:

(i) on petition from the rehabilitator, which may be made at any time;

(ii) on petition from the directors of the insurer, which may be made at any time; or

(iii) on the receivership court's own motion.

(b) Subject to Section 31A-27a-801, if the receivership court finds that rehabilitation is accomplished and that grounds for rehabilitation under Section 31A-27a-207 no longer exist, the receivership court shall order that the insurer be restored to:

(i) title and possession of its property; and

(ii) the control of the business.

Enacted by Chapter 309, 2007 General Session

31A-27a-305. Coordination with guaranty associations and orderly transition to liquidation.

(1) No later than 30 days following the day on which an order of rehabilitation is entered the rehabilitator or the rehabilitator's designated representative shall:

(a) consult with any potentially affected guaranty association or the affected guaranty association's designated representative to determine the extent to which the affected guaranty association will be impacted by or may assist in the efforts to rehabilitate the insurer; and

(b) provide appropriate information to the affected guaranty association described in Subsection (1)(a) to allow the affected guaranty association to evaluate and discharge its statutory responsibilities.

(2) (a) The rehabilitator shall begin appropriate contingency planning and organizing so that an orderly transition to liquidation occurs, if liquidation is necessary.

(b) An orderly transition to liquidation requires, among other things, that the rehabilitator:

(i) to the fullest extent possible, reserve sufficient assets to continue to meet obligations under insurance policies of the insolvent insurer until guaranty associations are triggered; and

(ii) conduct affairs in such a way and cooperate as necessary with affected guaranty associations:

(A) to ensure that affected guaranty associations are provided with:

(I) appropriate information;

(II) necessary updates at reasonable intervals; and

(III) a reasonable period of time to plan and organize; and

(B) so that affected guaranty associations are able to properly discharge

statutory responsibilities upon being triggered.

(3) Appropriate information as referred to in this section:

(a) at a minimum includes the following for lines of business written by the insurer, whether covered or not covered by a guaranty association:

(i) a general description of the different types of business written or assumed by the insurer;

(ii) claim counts and policy counts by state and by line of business;

(iii) claim and policy reserves;

(iv) account values;

(v) cash surrender values;

(vi) policy loans;

(vii) interest crediting history;

(viii) premiums and mode of payment;

(ix) unpaid claims and amounts;

(x) sample policies and endorsements;

(xi) listing of different locations of claim files;

(xii) if a third party administrator is used, a copy of an executed contract and a description of the contractual arrangements; and

(xiii) information concerning claims in litigation or dispute, including a listing of claims with assigned defense counsel for those claims going to trial in the near future after a possible liquidation date;

(b) includes information concerning states in which the insurer is or was licensed;

(c) includes information concerning time periods for which the insurer is or was licensed; and

(d) includes other information reasonably requested by an affected guaranty association necessary for the affected guaranty association to fulfill its statutory duties.

(4) (a) The listing of information in Subsection (3) is not necessarily an exclusive list.

(b) To ensure that an orderly transition to liquidation occurs, information not listed in Subsection (3) may be needed and may be appropriately provided by the receiver.

(5) In the case of a property and casualty insurer, the rehabilitator, in cooperation with affected guaranty associations, shall make all reasonable efforts to prepare the insurer's electronic policy and claims data so that, upon the entry of an order of liquidation, the data will be ready for transmission using the Uniform Data Standards as promulgated by the National Association of Insurance Commissioners.

Enacted by Chapter 309, 2007 General Session

31A-27a-401. Liquidation orders.

(1) (a) An order to liquidate the business of an insurer shall:

(i) appoint the commissioner and any successor in office as the liquidator; and

(ii) direct the liquidator to:

(A) take possession of the property of the insurer; and

(B) administer the property subject to this chapter.

(b) As of the entry of the final order of liquidation, the liquidator is vested by operation of law with the title to the following, wherever located, of the insurer ordered liquidated:

(i) all property;

(ii) all contracts;

(iii) all rights of action; and

(iv) all records.

(2) Upon issuance of the order of liquidation, the rights and liabilities of the insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the day on which the order of liquidation is entered:

(a) except as provided in Sections 31A-27a-402, 31A-27a-403, and 31A-27a-605; and

(b) unless otherwise fixed by the liquidation court.

(3) An order to liquidate the business of an alien insurer in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer.

(4) (a) Whenever applicable, a petition for liquidation should include a request for a judicial declaration or finding of insolvency.

(b) After providing proper notice and hearing, the receivership court may at any time make the declaration of insolvency.

(5) If an order of liquidation is set aside upon appeal, the insurer is not released from delinquency proceedings except in accordance with Section 31A-27a-801.

Enacted by Chapter 309, 2007 General Session

31A-27a-402. Continuance of coverage.

(1) Notwithstanding any policy or contract language or any other statute, and unless ordered otherwise by the receivership court upon application by the receiver, a reinsurance contract by which the insurer assumes the insurance obligations of another insurer is cancelled upon entry of an order of liquidation.

(2) (a) Notwithstanding any policy or contract language or any other statute, and subject to Subsection (2)(c), the following in effect at the time of issuance of an order of liquidation shall continue in force as provided in this section until the time period specified in Subsection (2)(b):

(i) a policy;

(ii) an insurance contract, other than reinsurance by which the insurer has ceded insurance obligations to another person;

(iii) a surety bond; or

(iv) a surety undertaking.

(b) Any item listed in Subsection (2)(a) continues in force:

(i) until the earlier of:

(A) 30 days from the day on which the liquidation order is entered;

(B) the day on which the policy coverage expires;

(C) the day on which the insured:

(I) replaces the insurance coverage with equivalent insurance with another

insurer; or

(II) otherwise terminates the policy;

(D) the day on which the liquidator effects a transfer of the policy obligation pursuant to Subsection 31A-27a-405(1)(i); or

(E) the date proposed by the liquidator and approved by the receivership court to cancel coverage; or

(ii) unless further extended by the receiver with the approval of the receivership court.

(c) This Subsection (2) does not apply to:

(i) life insurance;

(ii) disability income insurance;

(iii) long-term care insurance;

(iv) health insurance; or

(v) an annuity.

(3) An order of liquidation under Section 31A-27a-401 terminates coverages at the time specified in Subsections (1) and (2) for purposes of any other statute.

(4) (a) A life insurance policy, disability income insurance policy, long-term care insurance policy, health insurance policy, or an annuity continues in force:

(i) if covered by an affected guaranty association or portions are covered by one or more affected guaranty associations, under applicable law;

(ii) subject to the terms of the policy or annuity, including any terms restructured pursuant to a court-approved rehabilitation plan; and

(iii) to the extent necessary to permit an affected guaranty association to discharge its statutory obligations.

(b) A life insurance policy, disability income insurance policy, long-term care insurance policy, health insurance policy, or an annuity not covered by one or more guaranty associations, or those portions not covered by one or more guaranty associations terminates as provided under Subsection (2), except to the extent that the liquidator proposes and the receivership court approves the use of property of the estate, consistent with Section 31A-27a-701, for the purpose of continuing the contract or coverage by transferring the contract or coverage to an assuming reinsurer.

(5) The cancellation of a bond or surety undertaking does not release any cosurety or guarantor.

(6) Except as otherwise provided in this chapter, the obligations of the insolvent insurer's reinsurers may not be released or discharged of a policy ceded to a reinsurer by a termination under this section.

(7) A contract by which the insurer reinsures obligations arising under a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity continues or terminates as provided in Section 31A-27a-513.

Enacted by Chapter 309, 2007 General Session

31A-27a-403. Continuance of coverage -- Health maintenance organizations.

(1) As used in this section:

(a) "Basic health care services" is as defined in Section 31A-8-101.

(b) "Enrollee" is as defined in Section 31A-8-101.
(c) "Health care" is as defined in Section 31A-1-301.
(d) "Health maintenance organization" is as defined in Section 31A-8-101.
(e) "Limited health plan" is as defined in Section 31A-8-101.
(f) (i) "Managed care organization" means an entity licensed by, or holding a certificate of authority from, the department to furnish health care services or health insurance.
(ii) "Managed care organization" includes:
(A) a limited health plan;
(B) a health maintenance organization;
(C) a preferred provider organization;
(D) a fraternal benefit society; or
(E) an entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D).
(iii) "Managed care organization" does not include:
(A) an insurer or other person that is eligible for membership in a guaranty association under Chapter 28, Guaranty Associations;
(B) a mandatory state pooling plan;
(C) a mutual assessment company or an entity that operates on an assessment basis; or
(D) an entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C).
(g) "Participating provider" means a provider who, under a contract with a managed care organization authorized under Section 31A-8-407, agrees to provide health care services to enrollees with an expectation of receiving payment:
(i) directly or indirectly, from the managed care organization; and
(ii) other than a copayment.
(h) "Participating provider contract" means the agreement between a participating provider and a managed care organization authorized under Section 31A-8-407.
(i) "Preferred provider" means a provider who agrees to provide health care services under an agreement authorized under Subsection 31A-22-617(1).
(j) "Preferred provider contract" means the written agreement between a preferred provider and a managed care organization authorized under Subsection 31A-22-617(1).
(k) (i) Except as provided in Subsection (1)(k)(ii), "preferred provider organization" means a person that:
(A) furnishes at a minimum, through a preferred provider, basic health care services to an enrollee in return for prepaid periodic payments in an amount agreed to before the time during which the health care may be furnished;
(B) is obligated to the enrollee to arrange for the services described in Subsection (1)(k)(i)(A); and
(C) permits the enrollee to obtain health care services from a provider who is not a preferred provider.
(ii) "Preferred provider organization" does not include:
(A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(B) an individual who contracts to render professional or personal services that the individual performs.

(l) "Provider" is as defined in Section 31A-8-101.

(m) "Uncovered expenditure" means a cost of health care services that is covered by an organization for which an enrollee is liable in the event of the managed care organization's insolvency.

(2) The rehabilitator or liquidator may take one or more of the actions described in Subsections (2)(a) through (g) to assure continuation of health care coverage for enrollees of an insolvent managed care organization.

(a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a participating provider or preferred provider to continue to provide the health care services the provider is required to provide under the provider's participating provider contract or preferred provider contract until the earlier of:

(A) 90 days after the day on which the following is filed:

(I) a petition for rehabilitation; or

(II) a petition for liquidation; or

(B) the day on which the term of the contract ends.

(ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a participating provider or preferred provider continue to provide health care services under the provider's participating provider contract or preferred provider contract expires when health care coverage for all enrollees of the insolvent managed care organization is obtained from another managed care organization or insurer.

(b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees a participating provider or preferred provider is otherwise entitled to receive from the managed care organization under the provider's participating provider contract or preferred provider contract during the time period in Subsection (2)(a)(i).

(ii) Notwithstanding Subsection (2)(b)(i), a rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the provider's participating provider contract or preferred provider contract.

(iii) An enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from a participating provider or preferred provider that the enrollee is required to pay before the day on which the following is filed:

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

(c) A participating provider or preferred provider shall:

(i) accept the amounts specified in Subsection (2)(b) as payment in full; and

(ii) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee.

(d) Subsections (2)(b) and (c) apply to the fees paid to a provider who agrees to provide health care services to an enrollee but is not a preferred or participating provider.

(e) If the managed care organization is a health maintenance organization, Subsections (2)(e)(i) through (vi) apply.

(i) A solvent health maintenance organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, shall extend to the enrollees of an insolvent health maintenance organization all rights, privileges, and obligations of

being an enrollee in the accepting health maintenance organization:

(A) subject to Subsections (2)(e)(ii), (iii), and (v);

(B) upon notification from and subject to the direction of the rehabilitator or liquidator of an insolvent health maintenance organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(C) if the solvent health maintenance organization operates within a portion of the insolvent health maintenance organization's service area.

(ii) Notwithstanding Subsection (2)(e)(i), the accepting health maintenance organization shall give credit to an enrollee for any waiting period already satisfied under the enrollee's contract with the insolvent health maintenance organization.

(iii) A health maintenance organization accepting an enrollee of an insolvent health maintenance organization under Subsection (2)(e)(i) shall charge the enrollee the premiums applicable to the existing business of the accepting health maintenance organization.

(iv) A health maintenance organization's obligation to accept an enrollee under Subsection (2)(e)(i) is limited in number to the accepting health maintenance organization's pro rata share of all health maintenance organization enrollees in this state, as determined after excluding the enrollees of the insolvent insurer.

(v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization shall take those measures that are possible to ensure that no health maintenance organization is required to accept more than its pro rata share of the adverse risk represented by the enrollees of the insolvent health maintenance organization.

(B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is one that can be expected to produce a reasonably equitable distribution of adverse risk, that methodology and its results are acceptable under this Subsection (2)(e)(v).

(vi) (A) Notwithstanding Section 31A-27a-402, the rehabilitator or liquidator may require all solvent health maintenance organizations to pay for the covered claims incurred by the enrollees of the insolvent health maintenance organization.

(B) As determined by the rehabilitator or liquidator, payments required under this Subsection (2)(e)(vi) may:

(I) begin as of the day on which the following is filed:

(Aa) the petition for rehabilitation; or

(Bb) the petition for liquidation; and

(II) continue for a maximum period through the time all enrollees are assigned pursuant to this section.

(C) If the rehabilitator or liquidator makes an assessment under this Subsection (2)(e)(vi), the rehabilitator or liquidator shall assess each solvent health maintenance organization its pro rata share of the total assessment based upon its premiums from the previous calendar year.

(D) (I) A solvent health maintenance organization required to pay for covered claims under this Subsection (2)(e)(vi) may file a claim against the estate of the insolvent health maintenance organization.

(II) Any claim described in Subsection (2)(e)(vi)(D)(I), if allowed by the rehabilitator or liquidator, shall share in any distributions from the estate of the insolvent

health maintenance organization as a Class 3 claim.

(f) (i) A rehabilitator or liquidator may transfer, through sale or otherwise, the group and individual health care obligations of the insolvent managed care organization to one or more other managed care organizations or other insurers, if those other managed care organizations and other insurers:

(A) are licensed to provide the same health care services in this state that are held by the insolvent managed care organization; or

(B) have a certificate of authority to provide the same health care services in this state that is held by the insolvent managed care organization.

(ii) The rehabilitator or liquidator may combine group and individual health care obligations of the insolvent managed care organization in any manner the rehabilitator or liquidator considers best to provide for continuous health care coverage for the maximum number of enrollees of the insolvent managed care organization.

(iii) If the terms of a proposed transfer of the same combination of group and individual policy obligations to more than one other managed care organization or insurer are otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group and individual policy obligations of an insolvent managed care organization as follows:

(A) from one category of managed care organization to another managed care organization of the same category, as follows:

(I) from a limited health plan to a limited health plan;

(II) from a health maintenance organization to a health maintenance organization;

(III) from a preferred provider organization to a preferred provider organization;

(IV) from a fraternal benefit society to a fraternal benefit society; and

(V) from an entity similar to an entity described in this Subsection (2)(f)(iii)(A) to a category that is similar;

(B) from one category of managed care organization to another managed care organization, regardless of the category of the transferee managed care organization; and

(C) from a managed care organization to a nonmanaged care provider of health care coverage, including insurers.

(g) If an insolvent managed care organization has required surplus, a rehabilitator or liquidator may use the insolvent managed care organization's required surplus to continue to provide coverage for the insolvent managed care organization's enrollees, including paying uncovered expenditures.

Enacted by Chapter 309, 2007 General Session

31A-27a-404. Sale or dissolution of the insurer's corporate entity.

(1) Notwithstanding the entry of a liquidation order, the liquidator may apply for an order to sell or dissolve the corporate entity or charter of a domestic insurer, or the United States branch of an alien insurer domiciled in this state:

(a) at any time after an order of liquidation of the insurer is granted; and

(b) consistent with this section.

(2) Upon an application to sell the corporate entity or charter, with notice as

prescribed in this chapter, the receivership court may enter an order:

(a) separating the corporate entity or charter, together with any of its licenses to do business and the assets the liquidator considers appropriate to the transaction, from:

(i) the remaining estate in liquidation;

(ii) all of the remaining estate's assets; and

(iii) the claims or interests of all claimants, creditors, policyholders, and stockholders;

(b) canceling all outstanding stock and other securities of, and other equity interests in, the corporate entity or charter, except that the cancellation may not affect any claim against the estate by holders of the equity interests;

(c) authorizing the issuance and sale of new stock or other securities for the purpose of transferring to one or more buyers control and ownership of the corporate entity or charter; and

(d) authorizing the sale of the corporate entity or charter, together with any of its licenses to do business and the general assets the liquidator considers appropriate to the transaction, free and clear from the claims or interests of all claimants, creditors, policyholders, and stockholders.

(3) (a) The sale of the corporate entity or charter may be made in the manner and on the terms and conditions:

(i) applied for by the liquidator; and

(ii) ordered by the receivership court.

(b) A sale is subject to the domiciliary state's laws regarding acquisition of an insurer under Chapter 16, Insurance Holding Companies.

(c) Upon the sale of a corporate entity or chapter:

(i) the proceeds from the sale become a part of the property of the estate in liquidation; and

(ii) the then separate corporate entity or charter, together with any of its licenses to do business and the assets the liquidator considers appropriate to the transaction, is free and clear from the claims or interests of all claimants, creditors, policyholders, and stockholders of the insurer in liquidation.

(d) The court has broad powers to effect the disposition of a corporate entity and its charter including, without limiting the statement of broad powers, a reorganization or conversion of the corporate entity.

(4) This section shall be liberally construed to:

(a) accomplish its purposes to provide an expeditious and effective procedure to realize the maximum proceeds possible from the sale of a corporate entity or charter separated from an estate in liquidation; and

(b) ensure that a purchaser receives clear and marketable title.

(5) If permission to sell the corporate entity or charter is not granted before discharge of the liquidator, in accordance with this section or otherwise with receivership court approval:

(a) the receivership court may order dissolution of the corporate entity or charter;

(b) dissolution is considered complete by operation of law upon the discharge of the liquidator if the insurer is insolvent; or

(c) dissolution may be ordered by the receivership court upon the discharge of

the liquidator if the insurer is under a liquidation order for some other reason.

Enacted by Chapter 309, 2007 General Session

31A-27a-405. Powers of the liquidator.

(1) The liquidator may:

(a) (i) hold hearings, subpoena a witness to compel the witness' attendance, administer oaths, examine a person under oath, and compel a person to subscribe to that person's testimony after the testimony is correctly reduced to writing; and

(ii) in connection with a power listed in Subsection (1)(a)(i), require the production of a record that the liquidator considers relevant to the inquiry;

(b) audit the records of all agents of the insurer to the extent that those records relate to the business activities of the insurer;

(c) collect all debts and money due and claims belonging to the insurer, wherever located, and for this purpose to:

(i) institute action in another jurisdiction, to forestall garnishment and attachment proceedings against the debt;

(ii) in addition to paying other Class 1 claims described in Subsection 31A-27a-701(2)(a), if the payment assists or results in the collection or recovery of property of the insurer that provides a net benefit to creditors of the estate, pay Class 1 administrative costs of the estate:

(A) upon approval of the receivership court; and

(B) only to the extent of the collection or recovery of the property;

(iii) do any other act as is necessary or expedient to collect, conserve, or protect the insurer's property, including the power to sell, compound, compromise, or assign a debt for purposes of collection upon the terms and conditions that the liquidator considers consistent with this chapter; and

(iv) pursue any creditor's remedies available to enforce a claim of the insurer;

(d) conduct public and private sales of the property of the insurer;

(e) subject to Subsection (6), use property of the estate of an insurer under a liquidation order to transfer:

(i) (A) a policy obligation; or

(B) (I) the insurer's obligations under a surety bond or a surety undertaking; and

(II) collateral held by the insurer with respect to the reimbursement obligations of the principals under the surety bond or surety undertaking;

(ii) to a solvent assuming insurer; and

(iii) if the transfer can be arranged without prejudice to applicable priorities under Section 31A-27a-701;

(f) subject to Subsection (4), acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any property of the estate:

(i) at its market value; or

(ii) upon terms and conditions that are fair and reasonable;

(g) execute, acknowledge, and deliver any deed, assignment, release, or other instrument necessary or proper to effectuate a sale of property or other transaction in connection with the liquidation;

(h) (i) subject to Subsection (7), borrow money for the purpose of facilitating the

liquidation:

(A) on the security of the property of the estate; or

(B) without security; and

(ii) execute and deliver a document necessary to the transaction to borrow money;

(i) (i) enter into a contract necessary to carry out the order to liquidate; and

(ii) subject to Section 31A-27a-113, assume or reject an executory contract or unexpired lease to which the insurer is a party;

(j) (i) continue to prosecute or to institute in the name of the insurer or in the liquidator's own name a suit or other legal proceeding, in this state or elsewhere; and

(ii) abandon the prosecution of a claim the liquidator considers unprofitable to pursue further;

(k) if the insurer is dissolved under Section 31A-27a-404, apply to a court in this state or elsewhere for leave to substitute the liquidator for the insurer as a party;

(l) subject to Subsection (8), prosecute or assert with exclusive standing an action that may exist on behalf of the public or a creditor, member, policyholder, or shareholder of the insurer against a person, except to the extent that:

(i) a claim is personal to a specific creditor, member, policyholder, or shareholder; and

(ii) recovery on the claim would not inure to the benefit of the estate;

(m) subject to Subsection (8), take possession of a record or property of the insurer as may be convenient for the purposes of efficient and orderly execution of the liquidation;

(n) deposit in one or more banks in this state sums required for meeting current administration expenses and dividend distributions;

(o) invest all sums not currently needed, unless the receivership court orders otherwise;

(p) file any necessary document for record in the office of a recorder of deeds or record office in this state or elsewhere where property of the insurer is located;

(q) subject to Subsection (9), assert all defenses available to the insurer as against a third person, including statutes of limitations, statutes of frauds, and the defense of usury;

(r) exercise and enforce all the rights, remedies, and powers of a creditor, shareholder, policyholder, or member, including any power to avoid a transfer or lien that may be voidable under this chapter or otherwise;

(s) (i) intervene in a proceeding wherever instituted that might lead to the appointment of a receiver or trustee for the insurer or any of its property; and

(ii) act as the receiver or trustee whenever the appointment is offered;

(t) enter into an agreement with a receiver or commissioner of any other state; and

(u) exercise all powers held on or conferred after April 30, 2007, on a receiver by the laws of this state not inconsistent with this chapter.

(2) The liquidator is vested with all the rights of the one or more entities in receivership.

(3) The enumeration of the powers and authority of the liquidator in this section:

(a) may not be construed as a limitation upon the liquidator; and

(b) does not exclude in any manner the right to do other acts:

(i) not specifically enumerated or otherwise provided for; and

(ii) to the extent necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(4) (a) The liquidator may take the following actions as provided in this Subsection (4):

(i) hypothecate, encumber, lease, sell, transfer, abandon, or otherwise dispose of or deal with property of the insurer;

(ii) settle or resolve a claim brought by the liquidator on behalf of the insurer; or

(iii) commute or settle a claim of reinsurance under a contract of reinsurance.

(b) The liquidator may take an action described in Subsection (4)(a) at the liquidator's discretion if the property or claim has a market or settlement value, as shown on the receivership's financial statements, that does not exceed:

(i) the lesser of:

(A) $1,000,000; or

(B) 10% of the general assets of the estate; or

(ii) an amount increased from the amount described in Subsection (4)(b)(i), if the receivership court increases the amount upon a petition of the liquidator and a showing that compliance with this Subsection (4)(b) is:

(A) burdensome to the liquidator in administering the estate; and

(B) unnecessary to protect the material interests of creditors.

(c) In all instances other than those described in Subsection (4)(b), the liquidator may take an action described in Subsection (4)(a) only after obtaining approval of the receivership court as provided in Section 31A-27a-107.

(d) The liquidator may, at the liquidator's discretion, request the receivership court to approve a proposed action as provided in Section 31A-27a-107:

(i) if the value of the property or claim appears to be less than the threshold provided in Subsection (4)(b) but cannot be ascertained with certainty; or

(ii) for any other reason as determined by the liquidator.

(e) (i) After obtaining approval of the receivership court as provided in Section 31A-27a-107, the liquidator may transfer rights to payment under a ceding reinsurance agreement covering policy to a third party transferee.

(ii) The transferee has the rights to collect and enforce collection of the reinsurance for the amount payable to the ceding insurer or to its receiver:

(A) without diminution because:

(I) of the insolvency; or

(II) the receiver failed to pay all or a portion of the claim; and

(B) on the basis of the amounts paid or allowed pursuant to Section 31A-27a-511.

(iii) The transfer of the rights described in Subsection (4)(e)(ii) does not give rise to any defense regarding the reinsurer's obligations under the reinsurance agreement regardless of whether the agreement or other applicable law prohibits the transfer of rights under the reinsurance agreement.

(iv) Except as provided in this Subsection (4), a transfer of rights pursuant to this Subsection (4)(e) may not impair any right or defense of the reinsurer that:

(A) exists before the transfer; or

(B) would have existed in the absence of the transfer.

(v) Except as otherwise provided in this Subsection (4), a transfer of rights pursuant to this Subsection (4)(e) does not relieve the transferee or the liquidator from an obligation owed to the reinsurer pursuant to the reinsurance or other agreement.

(5) (a) The liquidator is not obligated to defend an action against the insurer or insured.

(b) If a defense is an obligation of the insurer, an insured not defended by a guaranty association may:

(i) provide its own defense; and

(ii) include the cost of the defense as part of the insured's claim.

(c) The right of the liquidator to contest coverage on a particular claim is preserved without the necessity for an express reservation of rights.

(6) Once a liquidator makes a transfer described in Subsection (1)(e), the estate has no further liability under a transferred policy, surety bond, or surety undertaking after the transfer is made if:

(a) all insureds, principals, third party claimants, and obligees under the policy, surety bond, or surety undertaking consent; or

(b) the receivership court so orders.

(7) Funds borrowed under Subsection (1)(h):

(a) may be repaid as an administrative expense; and

(b) have priority over any other claims in Class 1 under the priority of distribution.

(8) (a) Subsection (1)(l) does not infringe or impair any of the rights provided to an affected guaranty association pursuant to its enabling statute or otherwise.

(b) Notwithstanding Subsection (1)(m), an affected guaranty association shall have reasonable access to the records of the insurer necessary for the affected guaranty association to carry out its statutory obligations.

(9) (a) A waiver of a defense by the insurer after a petition pursuant to Section 31A-27a-201 or 31A-27a-207 is filed does not bind the liquidator.

(b) Notwithstanding Subsection (1)(q), when an affected guaranty association determines it has an obligation to defend a suit, the liquidator:

(i) shall defer to that obligation; and

(ii) may defend only in cooperation with the affected guaranty association.

Enacted by Chapter 309, 2007 General Session

31A-27a-406. Notice to creditors and others.

(1) Unless the receivership court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(a) by first-class mail or electronic communication as permitted by the receivership court to the following at their last-known address:

(i) all of the insurer's agents, brokers, or producers of record with a current appointment or current license to represent the insurer; and

(ii) all other agents, brokers, or producers that the liquidator considers appropriate;

(b) by first-class mail or electronic communication as permitted by the

receivership court to:

(i) all current policyholders;

(ii) all pending claimants; and

(iii) as determined by the receivership court, former policyholders and other creditors; and

(c) by publication:

(i) once in a newspaper of general circulation in:

(A) the county in which the insurer has its principal place of business; and

(B) other locations that the liquidator considers appropriate; and

(ii) as required in Section 45-1-101.

(2) The notice of the entry of an order of liquidation shall contain or provide directions for obtaining the following information:

(a) a statement that the insurer has been placed in liquidation;

(b) a statement:

(i) explaining that certain acts are stayed under Section 31A-27a-108; and

(ii) describing any additional injunctive relief ordered by the receivership court;

(c) a statement whether, and to what extent, the insurer's policies continue in effect;

(d) to the extent applicable, a statement that coverage by guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws;

(e) a statement of:

(i) the deadline for filing claims, if established; and

(ii) the requirements for filing a proof of claim pursuant to Section 31A-27a-601 on or before that date;

(f) a statement of the date, time, and location of any initial status hearing scheduled at the time the notice is sent;

(g) a description of the process for obtaining notice of matters before the receivership court; and

(h) other information as the liquidator or the receivership court considers appropriate.

(3) If notice is given in accordance with this section, the distribution of property of the insurer under this chapter is conclusive with respect to all claimants, whether or not the claimant received notice.

(4) (a) Notwithstanding the other provisions of this section, the liquidator has no duty to locate any person if:

(i) no address is found in the records of the insurer; or

(ii) a mailing is returned to the liquidator because of inability to deliver at the address shown in the insurer's records.

(b) In the circumstances described in Subsection (4)(a), the notice by publication as required by this chapter or actual notice received is sufficient notice.

(c) Written certification by the liquidator or other knowledgeable person acting for the liquidator that a notice is deposited in the United States mail, postage prepaid, or that the notice is electronically transmitted is prima facie evidence of mailing and receipt.

(d) A claimant has a duty to keep the liquidator informed of any change of

address.

(5) Notwithstanding Subsection (1):

(a) upon application of the liquidator, the receivership court may find that notice by publication as required in this section is sufficient notice to those persons holding an occurrence policy:

(i) that expired more than four years before the day on which the order of liquidation is entered; and

(ii) under which there are no pending claims; or

(b) the receivership court may order other notice to those persons that the receivership court considers appropriate.

Amended by Chapter 388, 2009 General Session

31A-27a-407. Duties of agents.

(1) (a) At the request of the liquidator, an agent receiving notice of the entry of the liquidation order shall provide notice of that order:

(i) on a form prescribed by the liquidator;

(ii) to:

(A) each policyholder of a policy issued through the agent; and

(B) other person named in a policy issued through the agent; and

(iii) within:

(A) 15 days of the day on which the agent receives the notice; or

(B) a longer time as the liquidator may require.

(b) Within 30 days of the mailing required by Subsection (1)(a), the agent shall provide as prescribed by the liquidator:

(i) a certification of mailing; and

(ii) a list of insureds to which notice is provided.

(2) (a) A person who represents the insurer as an agent and receives notice in the form prescribed in Section 31A-27a-406, shall, within 30 days of the day on which the notice being sent, provide to the liquidator:

(i) the information the agent is required to provide pursuant to Section 31A-27a-110, if any;

(ii) the information in the agent's records related to any policy issued by the insurer through the agent; and

(iii) if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through an agent under contract to the general agent, including the name and address of the subagent.

(b) Except where the ownership of the expiration of the policy is transferred to another, a policy is considered issued through an agent if the agent:

(i) has a property interest in the expiration of the policy; or

(ii) has had in the agent's possession a copy of the declarations of the policy at any time during the life of the policy.

(3) If an agent fails to provide information to the liquidator as required in Subsection (2), the commissioner after holding a hearing may:

(a) impose against the agent a penalty of not more than $1,000; and

(b) suspend the agent's license.

(4) Notwithstanding an agent's property interest, if any, in the expiration of a policy, the liquidator has the exclusive power to determine whether, and under what terms, to cancel or transfer the policy.

Enacted by Chapter 309, 2007 General Session

31A-27a-501. Turnover of assets.

(1) (a) If the receiver determines that funds or property in the possession of another person are rightfully the property of the estate, the receiver shall deliver to the person a written demand for immediate delivery of the funds or property:

(i) referencing this section by number;

(ii) referencing the court and docket number of the receivership action; and

(iii) notifying the person that any claim of right to the funds or property by the person shall be presented to the receivership court within 20 days of the day on which the person receives the written demand.

(b) (i) A person who holds funds or other property belonging to an entity subject to an order of receivership under this chapter shall deliver the funds or other property to the receiver on demand.

(ii) If the person described in Subsection (1)(b)(i) alleges a right to retain the funds or other property, the person shall:

(A) file a pleading with the receivership court setting out that right within 20 days of the day on which the person receives the demand that the funds or property be delivered to the receiver; and

(B) serve a copy of the pleading on the receiver.

(iii) The pleading described in Subsection (1)(b)(ii) shall inform the receivership court as to:

(A) the nature of the claim to the funds or property;

(B) the alleged value of the property or amount of funds held; and

(C) what action has been taken by the person to preserve any funds or to preserve and protect the property pending determination of the dispute.

(c) The relinquishment of possession of funds or property by a person who receives a demand pursuant to this section is not a waiver of a right to make a claim in the receivership.

(2) (a) If requested by the receiver, the receivership court shall hold a hearing to determine where and under what conditions the funds or property shall be held by a person described in Subsection (1) pending determination of a dispute concerning the funds or property.

(b) The receivership court may impose the conditions the receivership court considers necessary or appropriate for the preservation of the funds or property until the receivership court can determine the validity of the person's claim to the funds or property.

(c) If funds or property are allowed to remain in the possession of the person after demand made by the receiver, that person is strictly liable to the estate for any waste, loss, or damage to or diminution of value of the funds or property retained.

(3) If a person files a pleading alleging a right to retain funds or property as provided in Subsection (1), the receivership court shall hold a subsequent hearing to

determine the entitlement of the person to the funds or property claimed by the receiver.

(4) If a person fails to deliver the funds or property or to file the pleading described by Subsection (1) within the 20-day period, the receivership court may issue a summary order:

(a) upon:

(i) petition of the receiver; and

(ii) a copy of the petition being served by the petitioner to that person;

(b) directing the immediate delivery of the funds or property to the receiver; and

(c) finding that the person waived all claims of right to the funds or property.

(5) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

Enacted by Chapter 309, 2007 General Session

31A-27a-502. Recovery from affiliates.

(1) (a) If a receivership order is entered under this chapter, the receiver appointed under the receivership order may recover on behalf of the insurer from an affiliate as defined in Subsection 31A-1-301(5) the value received by the affiliate at any time during the five years preceding the filing date of the delinquency proceedings.

(b) A person disputing that person's status as an affiliate shall prove by clear and convincing evidence the person's nonaffiliate status.

(c) Recovery from an affiliate is subject to the limitations of Subsections (2) and (6).

(2) If the insurer is a stock corporation, a stock dividend distribution to an affiliate is not recoverable if the recipient shows by a preponderance of the evidence that:

(a) when paid, the stock dividend distribution to an affiliate is lawful and reasonable;

(b) the department had notice to and approved the stock dividend; and

(c) the insurer did not know and could not reasonably have known that the stock dividend distribution to the affiliate might adversely affect the solvency of the insurer.

(3) The maximum amount recoverable under this section is the amount needed to pay all claims under the receivership:

(a) in excess of all other available recoverable assets; and

(b) reduced for each recipient affiliate by any amount that the recipient affiliate pays to any receiver under similar laws of other states.

(4) (a) A person who is an affiliate at the time value is received is liable up to the amount of value received by the affiliate.

(b) If two or more affiliates are liable regarding the same value received, they are jointly and severally liable.

(5) If any affiliate liable under Subsection (4) is insolvent or unable to pay within one year, all affiliates at the time the value is received are jointly and severally liable for any resulting deficiency in the amount that would have been recovered from the nonpaying affiliate.

(6) This section does not enlarge the personal liability of a director under

existing law.

(7) An action or proceeding under this section may not be commenced after the earlier of:

(a) six years after the day on which a receiver is appointed; or

(b) the day on which the receivership is terminated.

Amended by Chapter 297, 2011 General Session

31A-27a-503. Unauthorized postpetition transfers.

(1) Except as otherwise provided in this section, the receiver may avoid a transfer of an interest of the insurer in property, or an obligation incurred by the insurer, that is:

(a) made or incurred after the day on which a petition for receivership is filed; and

(b) not authorized by the receiver and approved by the receivership court.

(2) Except to the extent that a transfer or obligation voidable under this section is otherwise voidable under this chapter, a transferee or obligee of a transfer or obligation described in Subsection (1) has a lien on or may retain, at the option of the receivership court, an interest transferred or may enforce an obligation incurred, as the case may be:

(a) if the transferee or obligee takes it for value and in good faith; and

(b) to the extent that the transferee or obligee gave value to the insurer in exchange for the transfer or obligation.

Enacted by Chapter 309, 2007 General Session

31A-27a-504. Voidable preferences and liens.

(1) (a) A preference may be avoided by the rehabilitator or liquidator, if:

(i) the insurer is insolvent at the time of the transfer;

(ii) the transfer is made within four months before the day on which the petition is filed;

(iii) with reference to the transfer, one of the following at the time the transfer is made has reasonable cause to believe that the insurer is or is about to become insolvent:

(A) a creditor receiving the transfer;

(B) a creditor to be benefitted by the transfer; or

(C) an agent of a creditor described in this Subsection (1)(a)(iii); or

(iv) the creditor receiving the transfer is an officer, employee, attorney, or other person who is in fact in a position of comparable influence on the insurer to:

(A) an officer of the insurer;

(B) a shareholder holding directly or indirectly more than 5% of any class of equity security issued by the insurer; or

(C) any other person with whom the insurer did not deal at arm's length.

(b) (i) Subject to the other provisions of this Subsection (1)(b), if a preference is voidable, the rehabilitator or liquidator may recover the property or, if the property is converted, the property's value, from any person who receives or converts the property.

(ii) Notwithstanding Subsection (1)(b)(i), the rehabilitator or liquidator may not recover from a bona fide purchaser or lienor of the debtor's transferee for present fair consideration.

(iii) If a bona fide purchaser or lienor gives less than fair consideration, the bona fide purchaser or lienor has a lien upon the property to the extent of the consideration actually given by the bona fide purchaser or lienor.

(c) If 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 passes to the liquidator.

(d) A payment to which Subsection 31A-5-415(2) applies is a preference and is voidable under Subsection (1)(a):

(i) if it is made within the time period specified in Subsection 31A-27a-102(29); and

(ii) except that a payment made by an insurer for the purchase of insurance under Section 16-10a-302 is not a preference.

(2) Section 31A-27a-506 applies to the perfection of a transfer.

(3) Section 31A-27a-506 applies to a lien by a legal or equitable proceeding.

(4) The receiver may not avoid a transfer of property under this section for or because of:

(a) new and contemporaneous consideration;

(b) the payment, within 45 days after the day on which a debt is incurred, of a debt incurred:

(i) in the ordinary course of the business of the insurer; and

(ii) according to normal business terms;

(c) a transfer of a security interest in property:

(i) to enable the insurer to acquire the property; and

(ii) which is perfected within 10 days after the day on which the security interest attaches;

(d) a transfer to or for the benefit of a creditor:

(i) to the extent that after the transfer the creditor gives new value not secured by an unavoidable security interest; and

(ii) on account of which the insurer did not make an unavoidable transfer to or for the benefit of the creditor; or

(e) a transfer of a perfected security interest in inventory, a receivable, or the proceeds of either, except to the extent that the aggregate of all of those types of transfers to the transferee cause a reduction of the amount by which the debt secured by the security interest exceeds the value of the security interest four months before the date of liquidation or any time subsequent to the liquidation.

(5) (a) The receiver may avoid a transfer of property of the insurer transferred to secure reimbursement of a surety that furnishes a bond or other obligation to dissolve a judicial lien that would have been avoidable by the receiver under Subsection (1)(a).

(b) The liability of the surety under the bond or obligation described in Subsection (5)(a) shall be discharged to the extent of the value of the property recovered by the receiver or the amounts paid to the receiver.

(6) (a) Subject to Subsection (6)(b), the property affected by a lien that is considered voidable under Subsections (1)(a) and (5):

(i) is discharged from the lien; and

(ii) passes to the rehabilitator or liquidator with any of the indemnifying property transferred to or for the benefit of a surety.

(b) Notwithstanding Subsection (6)(a), the court may:

(i) on due notice, order the lien to be preserved for the benefit of the estate; and

(ii) direct that a conveyance be executed that is adequate to evidence the title of the rehabilitator or liquidator.

(7) (a) The court has jurisdiction of any proceeding by the rehabilitator or liquidator, to hear and determine the rights of any parties under this section.

(b) Reasonable notice of any hearing in a proceeding described in Subsection (7)(a) shall be given to all parties in interest, including the obligee of a releasing bond or other similar obligation.

(c) If an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien:

(i) the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien; and

(ii) if the value of the property or lien is less than the amount for which the property is an indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court:

(A) to the rehabilitator or liquidator; and

(B) within a reasonable time fixed by the court.

(8) The liability of a surety under a releasing bond or other similar obligation is discharged to the extent of the value of:

(a) the indemnifying property recovered;

(b) the indemnifying lien nullified and avoided; or

(c) if the property is retained under Subsection (7), the amount paid to the rehabilitator or liquidator.

(9) If a creditor is preferred and afterward in good faith gives the insurer further credit, without security of any kind, for property that becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition shall be set off against the preference which would otherwise be recoverable from the creditor.

(10) (a) If an insurer, directly or indirectly, pays money or transfers property within four months before the day on which a successful petition for rehabilitation or liquidation is filed under this chapter or at any time in contemplation of a proceeding to rehabilitate or liquidate the insurer, to an attorney for services rendered or to be rendered, the transaction:

(i) (A) may be examined by the court on its own motion; or

(B) shall be examined by the court on petition of the rehabilitator or liquidator; and

(ii) shall be held valid only to the extent that the transfer is a reasonable amount as determined by the court.

(b) The amount in excess of the amount held valid under Subsection (10)(a), may be recovered by the rehabilitator or liquidator for the benefit of the estate.

(c) If the attorney meets the description in Subsection (1)(a)(iv), Subsection

(1)(a)(iv) applies in place of this Subsection (10).

(11) (a) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving a preference when that person has reasonable cause to believe that the insurer is or is about to become insolvent at the time of the preference, is personally liable to the rehabilitator or liquidator for the amount of the preference.

(b) It is permissible to infer that there is "reasonable cause to so believe" if the transfer is made within four months before the date on which a successful petition for rehabilitation or liquidation is filed.

(c) A person receiving any property from the insurer or for the benefit of the insurer as a preference which is voidable under Subsection (1)(a) is:

(i) personally liable for that transfer and property; and

(ii) bound to account to the rehabilitator or liquidator.

(d) This Subsection (11) does not prejudice any other claim by the rehabilitator or liquidator against any person.

Enacted by Chapter 309, 2007 General Session

31A-27a-505. Avoidance of property title transfers.

(1) The rehabilitator or liquidator has the creditor's rights described in this Subsection (1), without regard to any knowledge of the rehabilitator or liquidator or any creditor.

(a) (i) The rehabilitator or liquidator is considered to:

(A) have extended credit to the insurer on the day on which the rehabilitation or liquidation petition is filed; and

(B) have obtained on the day described in Subsection (1)(a)(i) a judicial lien on all the insurer's property on which a creditor under a contract could obtain a judicial lien.

(ii) The rehabilitator or liquidator:

(A) may avoid a transfer that would be avoidable by the type of creditor described in this Subsection (1)(a); and

(B) has all the other rights and powers of the type of creditor described in this Subsection (1)(a).

(b) (i) The rehabilitator or liquidator is considered to:

(A) have extended credit to the insurer on the day on which the rehabilitation or liquidation petition filed; and

(B) have obtained on the day described in this Subsection (1)(b)(i), with respect to that credit extension, an execution against the insurer on that same date that is returned unsatisfied.

(ii) The rehabilitator or liquidator:

(A) may avoid a transfer that would be avoidable by the type of creditor described in this Subsection (1)(b); and

(B) has all the other rights and powers of the type of creditor described in this Subsection (1)(b).

(c) The rehabilitator or liquidator:

(i) is considered to be a bona fide purchaser of the insurer's real property on the day on which the rehabilitation or liquidation petition is filed; and

(ii) has the rights and powers of a bona fide purchaser to avoid other transfers of the insurer's realty.

(2) (a) The rehabilitator or liquidator may avoid a transfer of an interest of the insurer in property or an obligation incurred by the insurer that is voidable under applicable law by a creditor holding an unsecured claim.

(b) This Subsection (2) does not apply to secured claims.

(3) (a) Except as provided in Subsections (3)(b) and (c), the rehabilitator or liquidator may avoid a transfer of property of the estate that:

(i) occurs after the day on which the petition for rehabilitation or liquidation is filed; and

(ii) is not authorized under this chapter or by the court.

(b) (i) Subject to Subsection (3)(b)(ii), a transfer is valid against the rehabilitator or liquidator to the extent of any value, including services if it occurs:

(A) after the day on which the petition is filed; and

(B) before the day on which the order for rehabilitation or liquidation is entered.

(ii) The value described in Subsection (3)(b)(i) does not include the satisfaction or securing of a debt:

(A) that arises before the day on which the petition is filed;

(B) which is given after the date described in this Subsection (3)(b) in exchange for the transfer; and

(C) notwithstanding the transferee's knowledge or lack of knowledge of the petition.

(c) (i) Subject to Subsection (3)(c)(ii), the rehabilitator or liquidator may not avoid a transfer of real property under Subsection (3)(a) to:

(A) a good faith purchaser:

(I) if the good faith purchaser is without knowledge of the petition for rehabilitation or liquidation; and

(II) for present fair consideration; or

(B) a purchaser at a judicial sale.

(ii) Notwithstanding Subsection (3)(c)(i), the rehabilitator or liquidator may avoid a transfer of real property under Subsection (3)(a) if a copy of the petition is filed in the office of the county recorder before the transfer is so far perfected that a bona fide purchaser of the property against whom applicable law permits that type of transfer to be perfected cannot acquire an interest that is superior to the interest of the good faith purchaser or judicial sale purchaser.

(iii) Unless a copy of the petition is filed before the transfer is perfected, a good faith purchaser of real property under a transfer which the rehabilitator or liquidator may avoid under this section has a lien on the property transferred:

(A) if the good faith purchaser:

(I) is without knowledge of the petition for rehabilitation or liquidation at the time of the transfer; and

(II) pays less than present fair consideration; and

(B) to the extent of the present consideration given.

(4) An action or proceeding under Subsection (1) or (2) may not be commenced after the earlier of:

(a) two years after the day on which a rehabilitator is appointed under Section

31A-27a-301 or a liquidator is appointed under Section 31A-27a-401; or

(b) the day on which the rehabilitation is terminated under Subsection 31A-27a-304(3) or the liquidation is terminated under Section 31A-27a-802.

(5) An action or proceeding under Subsection (3) may not be commenced after the earlier of:

(a) two years after the day on which the transfer sought to be avoided is made; or

(b) the day on which the rehabilitation is terminated under Subsection 31A-27a-304(3) or the liquidation is terminated under Section 31A-27a-802.

Enacted by Chapter 309, 2007 General Session

31A-27a-506. Fraudulent transfers and obligations.

(1) For purposes of this section:

(a) A "transfer":

(i) is made when the transfer is so perfected that a bona fide purchaser from the insurer against whom applicable law permits the transfer to be perfected cannot acquire an interest in the property transferred that is superior to the interest in the property of the transferee; or

(ii) if the transfer is not perfected as provided in Subsection (1)(a)(i) before the commencement of the delinquency proceeding, is considered made immediately before the day on which the initial filing of the petition commencing delinquency proceedings is filed.

(b) "Value" means property or satisfaction or securing of a present or antecedent debt of the insurer.

(2) (a) If the conditions of Subsection (2)(b) are met, the receiver may avoid the following:

(i) a transfer of an interest of the insurer in property;

(ii) a reinsurance transaction; or

(iii) an obligation incurred by an insurer.

(b) Subsection (2)(a) applies if:

(i) the transfer or obligation is made or incurred on or within two years before the day on which the initial filing of a petition commencing delinquency proceedings is filed under this chapter; and

(ii) the insurer voluntarily or involuntarily:

(A) makes the transfer or incurs the obligation with actual intent to hinder, delay, or defraud a person to which the insurer is or becomes indebted on or after the day on which the transfer is made or the obligation is incurred; or

(B) receives less than a reasonably equivalent value in exchange for the transfer or obligation.

(3) Except to the extent that a transfer or obligation voidable under this section is voidable under other provisions of this chapter, a transferee or obligee of a transfer or obligation voidable under this section that takes for value and in good faith:

(a) as the case may be:

(i) has a lien on or may retain any interest transferred; or

(ii) may enforce any obligation incurred; and

(b) to the extent that the transferee or obligee gave value to the insurer in exchange for the transfer or obligation.

(4) If a reinsurance transaction is avoided under this section:

(a) the receiver shall tender to the reinsurer the value of any consideration transferred to the insurer in connection with the transaction less the amount of matured and liquidated liabilities owing by the reinsurer to the estate; and

(b) the parties shall be returned to their relative positions before the implementation of the transaction avoided.

Enacted by Chapter 309, 2007 General Session

31A-27a-507. Receiver as lien creditor.

(1) The receiver may avoid a transfer of or lien on the property of, or obligation incurred by, an insurer that the insurer or a policyholder, creditor, member, or stockholder of the insurer:

(a) may have avoided without regard to any knowledge of:

(i) the receiver;

(ii) the commissioner;

(iii) the insurer; or

(iv) a policyholder, creditor, member, or stockholder of the insurer; and

(b) whether or not a policyholder, creditor, member, or stockholder described in this Subsection (1) exists.

(2) The receiver is considered a creditor without knowledge for purposes of pursuing claims under:

(a) Title 25, Chapter 6, Uniform Fraudulent Transfer Act; or

(b) similar provisions of state or federal law.

Enacted by Chapter 309, 2007 General Session

31A-27a-508. Liability of transferee.

(1) Except as otherwise provided in this section, to the extent that the receiver obtains an order pursuant to Section 31A-27a-501, or avoids a transfer under Section 31A-27a-502, 31A-27a-503, 31A-27a-504, 31A-27a-506, or 31A-27a-507, the receiver may recover the property transferred, or the value of the property, from:

(a) the initial transferee of the transfer or the entity for whose benefit the transfer is made; or

(b) subject to Subsection (2), an immediate or mediate transferee of the initial transferee.

(2) The receiver may not recover under Subsection (1)(b) from:

(a) a transferee that takes for value, including satisfaction or securing of a present or antecedent debt:

(i) in good faith; and

(ii) without knowledge of the voidability of the transfer avoided; or

(b) an immediate or mediate good faith transferee of the transferee.

(3) A transfer avoided in accordance with this chapter is preserved for the benefit of the receivership estate, but only with respect to property of the insurer.

(4) In addition to the remedies specifically provided in Sections 31A-27a-501, 31A-27a-502, 31A-27a-503, 31A-27a-504, 31A-27a-506, and 31A-27a-507 and Subsection (1), if the receiver is successful in establishing a claim to the property or any part of the property, the receiver may recover judgment for the following:

(a) rental for the use of tangible property from the later of:

(i) the day on which the receivership order is entered; or

(ii) the date of the transfer; and

(b) in the case of funds or intangible property:

(i) the greater of:

(A) the actual interest;

(B) income earned by the property; or

(C) interest at the statutory rate for judgments; and

(ii) from the later of:

(A) the day on which the receivership order is entered; or

(B) the date of the transfer.

(5) In an action pursuant to this section, the receivership court may allow the receiver to seek recovery of the property involved or its value.

(6) In an action pursuant to Sections 31A-27a-501, 31A-27a-502, 31A-27a-503, 31A-27a-504, 31A-27a-506, 31A-27a-507, and 31A-27a-510:

(a) the receiver has the burden of proving the avoidability of a transfer; and

(b) the person against whom recovery or avoidance is sought has the burden of proving the nature and extent of any affirmative defense.

Enacted by Chapter 309, 2007 General Session

31A-27a-509. Claims of holders of void or voidable rights.

(1) (a) The receiver may disallow a claim of a creditor who receives or acquires a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this chapter, unless the creditor surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance.

(b) If an avoidance is effected by a proceeding in which a final judgment is entered, a creditor's claim is not allowed unless the money is paid or the property is delivered to the receiver within 30 days from the day on which the final judgment is entered, except that the receivership court may allow further time if there is an appeal or other continuation of the proceeding.

(2) A claim allowable under Subsection (1) by reason of an avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under Subsection 31A-27a-601(2) if filed within:

(a) 30 days from the date of the avoidance; or

(b) the further time allowed by the receivership court under Subsection (1).

Enacted by Chapter 309, 2007 General Session

31A-27a-510. Setoffs.

(1) (a) A mutual debt or mutual credit shall be set off and the balance only

allowed or paid:

(i) whether arising out of one or more contracts between the insurer and another person in connection with an action or proceeding under this chapter; and

(ii) except as provided in Subsection (2) and Sections 31A-27a-513 and 31A-27a-514.

(b) An obligation arising out of the termination of a life, disability income, or long-term care reinsurance contract pursuant to Section 31A-27a-513 may be set off against other debts and credits arising out of a contract between the insurer and the reinsurer.

(2) (a) A setoff is not allowed after the commencement of a delinquency proceeding under this chapter in favor of any person if:

(i) the claim against the insurer is disallowed;

(ii) the claim against the insurer is purchased by or transferred to the person:

(A) on or after the day on which the receivership petition is filed; or

(B) within 120 days preceding the day on which the receivership petition is filed;

(iii) the obligation of the insurer is owed to an affiliate or entity other than the person, absent written assignment of the obligation made more than 120 days before the day on which the petition for receivership is filed;

(iv) the obligation of the person is owed to an affiliate or entity other than the insurer, absent written assignment of the obligation made more than 120 days before the day on which the petition for receivership is filed;

(v) the obligation of the person is:

(A) to pay:

(I) an assessment levied against a member or subscriber of the insurer; or

(II) a balance upon a subscription to the capital stock of the insurer; or

(B) in any other way in the nature of a capital contribution;

(vi) an obligation between the person and the insurer arises out of a transaction by which either the person or the insurer:

(A) assumes a risk or obligation from the other party; and

(B) then cedes back to that party substantially the same risk or obligation;

(vii) the obligation of the person arises out of an avoidance action taken by the receiver; or

(viii) the obligation of the insured is for the payment of earned premiums or retrospectively rated earned premiums in accordance with Section 31A-27a-514.

(b) Notwithstanding Subsection (2)(a)(vi), the receiver may permit a setoff if, in the receiver's discretion, a setoff is appropriate because of specific circumstances relating to a transaction.

(3) The receiver may avoid pursuant to Sections 31A-27a-504, 31A-27a-506, and 31A-27a-507 and subject to defenses under those sections, a setoff that occurs before the commencement of the delinquency proceeding under this chapter if the setoff would otherwise be disallowed pursuant to Subsection (2).

Enacted by Chapter 309, 2007 General Session

31A-27a-511. Assessments.

(1) As soon as practicable but not more than four years from the day on which

an order of receivership of an insurer issuing assessable policies is entered, the receiver shall make a report to the receivership court setting forth:

(a) the reasonable value of the assets of the insurer;

(b) the insurer's probable total liabilities;

(c) 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

(d) a recommendation as to:

(i) whether or not an assessment should be made; and

(ii) what amount of assessment.

(2) (a) Upon the basis of the report provided in Subsection (1), including any supplement or amendment to the report, the receivership court may approve, solely on application by the receiver, one or more assessments against all members of the insurer who are subject to assessment.

(b) An order approving an assessment under this Subsection (2) shall provide instructions regarding:

(i) notice of the assessment;

(ii) deadlines for payment; and

(iii) other instructions to the receiver for collection of the assessment.

(3) Subject to any applicable legal limit on an ability to assess and with due regard given to assessments that cannot be collected economically, the aggregate assessment shall be for the amount by which the sum of the following exceeds the value of existing assets:

(a) probable liabilities;

(b) the expenses of administration; and

(c) the estimated cost of collection of the assessment.

(4) (a) After levy of an assessment under Subsection (2), the receiver shall petition the receivership court for an order directing each member who has not paid the assessment pursuant to the levy to show cause why a judgment for the failure to pay the assessment should not be entered.

(b) At least 20 days before the return day of the order to show cause described in Subsection (4)(a), the receiver shall give notice of the order to show cause by:

(i) publication or by first-class mail to each member liable on the assessment mailed to the member's last-known address as it appears on the insurer's records; or

(ii) such other method of notification as the receivership court may direct.

(c) Failure of the member or subscriber to receive the notice of the assessment or of the order to show cause either within the time specified in the order or at all, is no defense in a proceeding to collect the assessment.

(5) If a member does not appear and serve verified objections upon the receiver on or before the return day of the order to show cause under Subsection (4):

(a) the receivership court shall make an order adjudging the member liable for the sum of:

(i) the amount of the assessment against the member pursuant to Subsection (4); and

(ii) the costs; and

(b) the receiver has a judgment against the member for the amount described in

Subsection (5)(a).

(6) If on or before the return day in the order to show cause described in Subsection (4) the member appears and serves verified objections on the receiver, the receivership court may:

(a) (i) hear and determine the matter; or

(ii) appoint a referee to hear the matter; and

(b) make such order as the facts warrant.

(7) The receiver may enforce an order or collect a judgment under Subsection (5) by any lawful means.

(8) An assessment of a subscriber or member of an insurer made by the receiver is prima facie correct if it is pursuant to the order of receivership court:

(a) fixing the aggregate amount of the assessment against all members or subscribers; and

(b) approving the classification and formula made by the receiver under this section.

(9) A claim filed by an assessee who fails to pay an assessment, after the conclusion of a legal action by the assessee objecting to the assessment, is considered a late filed claim under Section 31A-27a-701.

Enacted by Chapter 309, 2007 General Session

31A-27a-512. Reinsurer's liability.

(1) (a) Except as otherwise provided in this chapter, the amount recoverable by the receiver from a reinsurer may not be reduced as a result of a delinquency proceeding with a finding of insolvency, regardless of any provision in the reinsurance contract or other agreement.

(b) An agreement, written, oral, or otherwise, may not be enforced to the extent it is in conflict, or not in strict compliance with this section.

(c) Except as expressly provided in this section, a person other than the receiver whether as a creditor, third party beneficiary, or otherwise does not have a direct right to reinsurance proceeds from any reinsurer of the insolvent insurer:

(i) on the basis of any written or oral agreement; or

(ii) pursuant to an action or cause of action seeking any equitable or legal remedy.

(d) This section applies to all the insurer's reinsurance contracts including:

(i) treaty reinsurance;

(ii) quota share reinsurance;

(iii) facultative reinsurance; or

(iv) a fronting or captive reinsurance arrangement.

(2) Except as otherwise provided in Subsection (9), the amount recoverable by the liquidator from a reinsurer is payable under one or more contracts reinsured by the reinsurer on the basis of:

(a) proof of payment of the insured claim by an affected guaranty association, the insurer, or the receiver, to the extent of the payment; or

(b) the allowance of the claim pursuant to:

(i) Section 31A-27a-608;

(ii) an order of the receivership court; or

(iii) a plan of rehabilitation.

(3) If the insurer takes credit for a reinsurance contract in a filing or submission made to the commissioner and the reinsurance contract does not contain the provisions required with respect to the obligations of reinsurers in the event of insolvency of the reinsured, the reinsurance contract is considered to contain the provisions required with respect to:

(a) the obligations of reinsurers in the event of insolvency of the reinsured in order to obtain credit for reinsurance; or

(b) other applicable statutes.

(4) A reinsurance contract that under Subsection (3) is considered to contain certain provisions, is considered to contain a provision that:

(a) in the event of insolvency and the appointment of a receiver, the reinsurance obligation is payable to the ceding insurer or to its receiver without diminution because of the insolvency or because the receiver fails to pay all or a portion of the claim;

(b) payment shall be made upon either:

(i) to the extent of the payment, proof of payment of the insured claim by an affected guaranty association, the insurer, or the receiver; or

(ii) the allowance of the claim pursuant to:

(A) Section 31A-27a-608;

(B) an order of the receivership court; or

(C) a plan of rehabilitation; and

(c) if a reinsurer does not pay the amount billed by the receiver within 60 days after the mailing by the receiver, interest on the unpaid billed amount will begin to accrue at the statutory legal rate provided in Subsection 15-1-1(2), except that all or a portion of the interest may be waived as part of an arbitration proceeding.

(5) (a) The receiver shall notify in writing, in accordance with the terms of the contract, each reinsurer obligated in relation to the claim or the pendency of a claim against the reinsured company.

(b) The receiver's failure to give notice of a pending claim pursuant to a provision in a reinsurance contract:

(i) does not excuse the obligation of the reinsurer unless the reinsurer is prejudiced by the receiver's failure; and

(ii) if the reinsurer is prejudiced, reduces the reinsurer's obligations only to the extent of the prejudice.

(c) A reinsurer may interpose, at its own expense, in a proceeding in which a claim is to be adjudicated, any one or more defenses that the reinsurer considers available to the reinsured company or its receiver.

(6) The entry of an order of rehabilitation or liquidation:

(a) may not be considered a breach or an anticipatory breach of a reinsurance contract; and

(b) is not grounds for retroactive revocation or retroactive cancellation of a reinsurance contract by the reinsurer.

(7) (a) If a reinsurance payment to a receiver of a ceding insurer is later determined to be a payment in excess of the amounts actually due to the receiver, the excess shall be:

(i) credited against future payments due to the receiver; or

(ii) repaid to the reinsurer as an administrative expense of the estate pursuant to Subsection 31A-27a-701(2)(g).

(b) A repayment under this Subsection (7) may be limited on the basis of the property remaining in the estate.

(8) (a) Subject to Subsection (1):

(i) except as provided in Subsection (8)(a)(ii):

(A) a payment made by the reinsurer directly to an insured or other creditor does not diminish the reinsurer's obligation to the insurer's estate; and

(B) a payment made by the reinsurer shall be made directly to the ceding insurer or its receiver;

(ii) Subsection (8)(a)(i) does not apply when:

(A) the reinsurance contract or other written agreement to which the insured, ceding insurer, and reinsurer are all parties:

(I) specifically provides another payee, other than an affiliate of the ceding insurer or reinsurer, of the reinsurance in the event of the insolvency or receivership of the ceding insurer; and

(II) the provision described in this Subsection (8)(a)(ii)(A) is contained in:

(Aa) the reinsurance contract as it is written on the day on which the reinsurance contract is initially executed; or

(Bb) the other written agreement as it is written on the day on which the initial policy is issued;

(B) the reinsurance contract, as it is written on the day on which the reinsurance contract is initially executed, contains a provision where the assuming insurer with the consent of the direct insured and the ceding insurer assumes all policy obligations of the ceding insurer:

(I) as a direct obligation of the assuming insurer to the payees under the policies; and

(II) in substitution for the entire obligations of the ceding insurer to the payees; or

(C) a life and health insurance guaranty association makes the election to succeed to the rights and obligations of the insolvent insurer under a contract of reinsurance:

(I) in accordance with:

(Aa) Section 31A-27a-513; or

(Bb) the life and health guaranty association laws of its domiciliary state; or

(II) pursuant to other applicable law, rule, order, or assignment contract; and

(iii) in the circumstances described in Subsection (8)(a)(ii)(C), a payment shall be made directly to or at the direction of the guaranty association.

(b) Both the receiver and the reinsurer are entitled to recover from a person, other than the receiver or a guaranty association, who unsuccessfully makes a claim directly against the reinsurer the following incurred in preventing any collection by that person:

(i) the person's attorney fees; and

(ii) expenses.

(9) This chapter may not be construed to authorize the liquidator or any other

entity to compel payment from a nonlife reinsurer:

(a) on the basis of estimated incurred but not reported losses, loss expenses, or case reserves for unpaid losses and loss expenses, except under Sections 31A-27a-515 and 31A-27a-516; and

(b) with respect to a claim allowed in accordance with Section 31A-27a-605.

Enacted by Chapter 309, 2007 General Session

31A-27a-513. Reinsurance continuation and termination.

(1) For purposes of this section:

(a) "Coverage date" is the day on which an order of liquidation is entered.

(b) "Election date" is the day on which an affected guaranty association elects to assume under this section the rights and obligations of a ceding insurer that relate to a policy or annuity covered, in whole or in part, by the affected guaranty association.

(2) A contract reinsuring a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity issued by a ceding insurer that is placed in rehabilitation proceedings pursuant to this chapter shall be continued or terminated pursuant to:

(a) the terms or conditions of each contract; and

(b) this section.

(3) A contract reinsuring a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity issued by a ceding insurer that is placed into liquidation pursuant to this chapter shall be continued, subject to this section, unless:

(a) the contract is terminated pursuant to the contract's terms before the coverage date; or

(b) the contract is terminated pursuant to the order of liquidation, in which case Subsection (10) applies.

(4) (a) (i) At any time within 180 days of the coverage date, an affected guaranty association covering a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity, in whole or in part, may elect to assume the rights and obligations of the ceding insurer that relate to the policy or annuity covered, in whole or in part, by the affected guaranty association, under one or more reinsurance contracts between the insolvent insurer and the insolvent insurer's reinsurers selected by the affected guaranty association.

(ii) An assumption under this Subsection (4)(a) is effective as of the coverage date.

(iii) The election described in this Subsection (4)(a) is made by the affected guaranty association or a nationally recognized association of guaranty associations that is designated by the affected guaranty association to act on the affected guaranty association's behalf for purposes of this Subsection (4)(a) by sending written notice, return receipt requested, to the affected reinsurers.

(b) (i) To facilitate the earliest practicable decision about whether to assume a contract of reinsurance and to protect the financial position of the estate, the receiver and each reinsurer of the ceding insurer shall make available the information described in Subsection (4)(b)(ii):

(A) upon request to an affected guaranty association; or

(B) to a nationally recognized association of guaranty associations that is designated by the affected guaranty association to act on behalf of the affected guaranty associations for purposes of this Subsection (4) as soon as possible after commencement of formal delinquency proceedings.

(ii) The information described in Subsection (4)(b)(i) is:

(A) copies of all in-force contracts of reinsurance;

(B) all records related to in-force contracts of reinsurance relevant to the determination of whether the in-force contracts of reinsurance should be assumed; and

(C) notice of:

(I) a default under the in-force contracts of reinsurance; or

(II) a known event or condition that with the passage of time could become a default under the in-force contracts of reinsurance.

(c) Subsections (4)(c)(i) through (vi) apply to a reinsurance contract assumed by an affected guaranty association under this Subsection (4).

(i) The guaranty association is responsible for the following that relates to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the guaranty association:

(A) all unpaid premiums due under a reinsurance contract, for the periods both before and after the coverage date; and

(B) the performance of all other obligations to be performed after the coverage date.

(ii) The affected guaranty association:

(A) may charge a policy of insurance or annuity covered in part by the affected guaranty association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the affected guaranty association; and

(B) if it imposes a charge under this Subsection (4)(c)(ii), shall provide notice and an accounting of the charge to the liquidator.

(iii) The affected guaranty association is entitled to any amount payable by the reinsurer under the reinsurance contract with respect to a loss or event:

(A) that:

(I) occurs in a period on or after the coverage date; and

(II) relates to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the affected guaranty association; and

(B) except that upon receipt of the amount, the affected guaranty association is obliged to pay to the beneficiary under the insurance policy or annuity on account of which the amount is paid a portion of the amount equal to the lesser of:

(I) the amount received by the affected guaranty association; and

(II) an amount calculated by:

(Aa) determining the excess of the amount received by the affected guaranty association over the amount equal to the benefits paid by the affected guaranty association on account of the policy or annuity; and

(Bb) subtracting the retention of the insurer applicable to the loss or event.

(iv) (A) Within 30 days following the election date, the affected guaranty association and each reinsurer under a contract assumed by the affected guaranty

association shall calculate the net balance due to or from the affected guaranty association under each reinsurance contract as of the election date with respect to a policy or annuity covered, in whole or in part, by the affected guaranty association.

(B) The calculation required by Subsection (4)(c)(iv)(A) shall give full credit to all items paid by the insurer, the insurer's receiver, or the reinsurer before the election date.

(C) The reinsurer shall pay the receiver an amount due for a loss or event before the coverage date, subject to any setoff for premiums unpaid for periods before the coverage date.

(D) Within five days of the completion of the calculation required by Subsection (4)(c)(iv)(A), the affected guaranty association or reinsurer shall pay any balance due the other after completion of the calculation.

(E) A dispute over an amount due to either the affected guaranty association or the reinsurer shall be resolved by arbitration:

(I) pursuant to the terms of the affected reinsurance contract; or

(II) if the affected reinsurance contract contains no arbitration clause, as provided in Subsection (10)(d).

(v) If the receiver receives an amount due the affected guaranty association pursuant to Subsection (4)(c)(iii), the receiver shall remit that amount to the affected guaranty association as promptly as practicable.

(vi) If the affected guaranty association or the receiver on the affected guaranty association's behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the affected guaranty association, the reinsurer may not:

(A) terminate the reinsurance contract for failure to pay premiums, insofar as the reinsurance contract relates to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the affected guaranty association; and

(B) set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the affected guaranty association, against amounts due the affected guaranty association.

(5) (a) If pursuant to court approval under Section 31A-27a-402 a receiver continues a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity in force following an order of liquidation, and the policy of insurance or annuity is not covered in whole or in part by one or more affected guaranty associations, the receiver may elect to assume the rights and obligations of the ceding insurer under one or more of the reinsurance contracts that relate to the policy or annuity:

(i) within 180 days of the coverage date; and

(ii) if the contract is not terminated as set forth in Subsection (2).

(b) The election described in this Subsection (5) shall be made by sending written notice, return receipt requested, to the affected reinsurers.

(c) If the election described in this Subsection (5) is made:

(i) payment of premiums on the reinsurance contract for the policy or annuity, for periods both before and after the coverage date, shall be chargeable against the estate

as a Class 1 administrative expense; and

(ii) amounts paid by the reinsurer on account of losses on the policy or annuity shall be to the estate of the insolvent insurer.

(6) During the period beginning on the coverage date and ending on the election date:

(a) (i) neither the affected guaranty association nor the reinsurer has any rights or obligations under a reinsurance contract that the affected guaranty association has the right to assume under Subsection (4), whether for a period before or after the coverage date;

(ii) (A) with respect to the period after the coverage date, neither the receiver nor the reinsurer has any rights or obligations under a reinsurance contract that the receiver has the right to assume under Subsection (5); and

(B) with respect to the period before the coverage date, the rights and obligations of the affected guaranty association and the reinsurer remain unchanged; and

(iii) the reinsurer, the receiver, and an affected guaranty association shall, to the extent practicable, provide each other data and records reasonably requested; and

(b) once the affected guaranty association or the receiver, as the case may be, elects or declines to elect to assume a reinsurance contract, the parties' rights and obligations are governed by Subsection (4), (5), or (10), as applicable.

(7) (a) If an affected guaranty association does not elect to assume a reinsurance contract by the election date pursuant to Subsection (4), the affected guaranty association has no rights or obligations, in each case for periods both before and after the coverage date, with respect to the reinsurance contract.

(b) If a receiver does not elect to assume a reinsurance contract by the election date pursuant to Subsection (5), the receiver and the reinsurer:

(i) retain their respective rights and obligations with respect to the reinsurance contract for the period before the coverage date; and

(ii) have no rights or obligations to each other for the period after the coverage date, except as provided in Subsection (10).

(c) (i) If an affected guaranty association or the receiver, as the case may be, does not elect to assume a reinsurance contract by the election date, the reinsurance contract terminates retroactively effective on the coverage date.

(ii) A reinsurance contract covering a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity that is terminated pursuant to Section 31A-27a-402 terminates effective on the coverage date.

(iii) Subsection (10) applies to a reinsurance contract described in Subsection (7)(c)(i) or (ii).

(8) (a) Subject to Subsection (8)(b), when a life insurance policy, disability income insurance policy, long-term care insurance policy, an annuity, or guaranty association obligation with respect to that policy or annuity is transferred to an assuming insurer, reinsurance on the policy or annuity may also be transferred:

(i) by the affected guaranty association, in the case of a contract assumed under Subsection (4); or

(ii) by the receiver, in the case of a contract assumed under Subsection (5).

(b) A transfer under Subsection (8)(a), is subject to the following:

(i) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred may not cover a new policy of insurance or new annuity in addition to those transferred;

(ii) the obligations described in Subsections (4) and (5) do not apply with respect to matters arising after the effective date of the transfer; and

(iii) notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days before the effective date of the transfer.

(9) (a) This section shall, to the extent provided in this chapter, supersede a law or an affected reinsurance contract that provides for or requires a payment of reinsurance proceeds on account of a loss or event:

(i) that occurs in a period after the coverage date; and

(ii) to the receiver of the insolvent insurer or to any other person.

(b) The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contract with respect to a loss or event that occurs in a period before the coverage date, subject to this chapter including applicable setoff provisions.

(10) If a contract reinsuring a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity is terminated pursuant to this chapter, the procedures of this Subsection (10) apply.

(a) The reinsurer and the receiver shall, upon written notice to the other party to the reinsurance contract no later than 30 days after the receipt by the reinsurer of notice of termination, commence a mandatory negotiation and arbitration procedure in accordance with this Subsection (10).

(b) (i) Each party shall appoint an actuary to determine an estimated sum due as a result of the termination of the reinsurance contract calculated in a way expected to make the parties economically indifferent as to whether the reinsurance contract continues or terminates, giving due regard to the economic effects of the insolvency.

(ii) The estimated sum described in this Subsection (10)(b) shall:

(A) take into account the present value of future cash flows expected under the reinsurance contract; and

(B) be based on a gross premium valuation of net liability using current assumptions:

(I) that reflect postinsolvency experience expectations, with no additional margins;

(II) that are net of any amounts payable and receivable; and

(III) with a market value adjustment to reflect premature sale of assets to fund the settlement.

(c) (i) Within 90 days of the day on which the written request pursuant to Subsection (10)(a) is made, each party shall provide the other party with:

(A) its estimate of the sum due as a result of the termination of the reinsurance contract; and

(B) all relevant documents and other information supporting the estimate.

(ii) The parties shall make a good faith effort to reach agreement on the sum due.

(d) (i) If the parties are unable to reach agreement within 90 days following the day on which the materials required in Subsection (10)(c) are submitted, either party

may initiate arbitration proceedings:

(A) as provided in the reinsurance contract; or

(B) if the reinsurance contract does not contain an arbitration clause, pursuant to this Subsection (10)(d) by providing the other party with a written demand for arbitration.

(ii) Arbitration under Subsection (10)(d)(i)(B) shall be conducted pursuant to the following procedures:

(A) Venue for the arbitration shall be within the county of the court's jurisdiction or another location agreed to by the parties.

(B) Within 30 days of the responding party's receipt of the arbitration demand, each party shall appoint an arbitrator who is:

(I) a disinterested active or retired officer or executive of a life insurance or reinsurance company; or

(II) other professional with no less than 10 years experience in or relating to the field of life insurance or life reinsurance.

(C) The two arbitrators appointed under Subsection (10)(d)(ii)(B) shall appoint an independent, impartial, disinterested umpire who is an:

(I) active or retired officer or executive of a life insurance or reinsurance company; or

(II) other professional with no less than 10 years experience in the field of life insurance or life reinsurance.

(D) If the arbitrators appointed under Subsection (10)(d)(ii)(B) are unable to agree on an umpire:

(I) each arbitrator shall provide the other with the names of three qualified individuals;

(II) each arbitrator shall strike two names from the other's list; and

(III) the umpire shall be chosen by drawing lots from the remaining individuals.

(E) Within 60 days following the day on which the umpire is appointed, each party shall, unless otherwise ordered by the arbitration panel, submit to the arbitration panel:

(I) the party's estimates of the sum due as a result of the termination of the reinsurance contract; and

(II) all relevant documents and other information supporting the estimate.

(F) The time periods set forth in this Subsection (10)(d)(ii) may be extended upon mutual agreement of the parties.

(G) The arbitration panel has all powers necessary to conduct the arbitration proceedings in a fair and appropriate manner, including the power to:

(I) request additional information from the parties;

(II) authorize discovery;

(III) hold hearings; and

(IV) hear testimony.

(H) The arbitration panel may, if the arbitration panel considers it necessary, appoint one or more independent actuarial experts, the expense of which shall be shared equally between the parties.

(I) An arbitration panel considering the matters set forth in this Subsection (10)(d) shall:

(I) apply the standards set forth in Subsection (10)(b); and

(II) issue a written award specifying a net settlement amount due from one party or the other as a result of the termination of the reinsurance contract.

(e) The supervising court shall confirm an award issued under Subsection (10)(d)(ii)(I) absent proof of statutory grounds for vacating or modifying arbitration awards under the Federal Arbitration Act, 9 U.S.C. Sec. 1 et seq.

(f) (i) If the net settlement amount agreed or awarded pursuant to this Subsection (10) is payable by the reinsurer, the reinsurer shall pay the amount due to the estate subject to any applicable setoff under Section 31A-27a-510.

(ii) If the net settlement amount agreed or awarded pursuant to this Subsection (10) is payable by the insurer, the reinsurer is considered to have a timely filed claim against the estate for that amount, which claim shall be paid pursuant to the priority established in Subsection 31A-27a-701(2)(f).

(iii) A guaranty association:

(A) is not entitled to receive the net settlement amount, except to the extent it is entitled to share in the estate assets as creditors of the estate; and

(B) has no responsibility for the net settlement amount.

(11) (a) Except as otherwise provided in this section, this section does not alter or modify the terms and conditions of a reinsurance contract.

(b) This section does not abrogate or limit any rights of a reinsurer to claim that it is entitled to rescind a reinsurance contract.

(c) This section does not give a policyholder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract.

(d) This section does not limit or affect any guaranty association's rights as a creditor of the estate against the assets of the estate.

(e) This section does not apply to a reinsurance agreement covering property or casualty risks.

Amended by Chapter 345, 2008 General Session

31A-27a-514. Recovery of premiums owed.

(1) (a) An insured shall pay any unpaid earned premium or retrospectively rated premium due the insurer:

(i) directly to the receiver; or

(ii) to an agent that pays or is obligated to pay the receiver on behalf of the insured.

(b) (i) Premium on surety business is considered earned at inception if no policy term can be determined.

(ii) All premium other than that described in Subsection (1)(b)(i) is considered earned and is prorated equally over the determined policy term, regardless of any provision in the bond, guaranty, contract, or other agreement.

(2) (a) A person, other than the insured, responsible for the remittance of a premium, shall turn over to the receiver any unpaid premium due and owing as shown on the records of the insurer for the full policy term due the insurer at the time of the entry of the receivership order:

(i) including any amount representing commissions; and

(ii) whether earned or unearned based on the termination of coverage under Sections 31A-27a-402 and 31A-27a-403.

(b) The unpaid premium due the receiver from any person other than the insured excludes any premium not collected from the insured and not earned based on the termination of coverage under Sections 31A-27a-402 and 31A-27a-403.

(3) (a) A person, other than the insured, responsible for the remittance of a premium, shall turn over to the receiver any unearned commission of that person based on the termination of coverage under Sections 31A-27a-402 and 31A-27a-403.

(b) A credit, setoff, or both may not be allowed to an agent, broker, premium finance company, or any other person for an:

(i) amount advanced to the insurer by the person on behalf of, but in the absence of a payment by, the insured; or

(ii) other amount paid by the person to any other person after the day on which the order of receivership is entered.

(4) Regardless of any provision to the contrary in an agency contract or other agreement, a person that collects premium or finances premium under a premium finance contract, that is due the insurer in receivership is considered to:

(a) hold that premium in trust as a fiduciary for the benefit of the insurer; and

(b) have availed itself of the laws of this state.

(5) (a) A premium finance company is obligated to pay an amount due the insurer from a premium finance contract, whether the premium is earned or unearned.

(b) The receiver may collect an unpaid financed premium directly from:

(i) the premium finance company by taking an assignment of the underlying premium finance contract; or

(ii) the insured that is a party to the premium finance contract.

(6) Upon satisfactory evidence of a violation of this section by a person other than an insured, the commissioner may pursue one or more of the following courses of action:

(a) suspend, revoke, or refuse to renew the license of an offending party;

(b) impose a penalty of not more than $1,000 for each act in violation of this section by a party; and

(c) impose any other sanction or penalty allowed for by law.

(7) (a) Before the commissioner may take an action set forth in Subsection (6), written notice shall be given to the person accused of violating the law:

(i) stating specifically the nature of the alleged violation; and

(ii) fixing a time and place, at least 10 days after the day on which the notice is sent, when a hearing on the matter is to be held.

(b) After a hearing, or upon failure of the accused to appear at a hearing, the commissioner, if a violation is found, shall impose the penalties under Subsection (6) that the commissioner considers advisable.

(c) If the commissioner takes action under this Subsection (7), the party aggrieved may appeal from that action as provided in Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 382, 2008 General Session

31A-27a-515. Commutation and release agreements.

(1) For purposes of this section, "casualty claims" means the insurer's aggregate claims arising out of insurance contracts in the following lines:

(a) farm owner multiperil;

(b) homeowner multiperil;

(c) commercial multiperil;

(d) medical malpractice;

(e) workers' compensation;

(f) other liability;

(g) products liability;

(h) auto liability;

(i) aircraft, all peril; and

(j) international, for lines listed in Subsections (1)(a) through (i).

(2) (a) Notwithstanding Section 31A-27a-512, the liquidator and a reinsurer may negotiate a voluntary commutation and release of all obligations arising from a reinsurance agreement in which the insurer is the ceding party.

(b) A commutation and release agreement voluntarily entered into by the parties shall be commercially reasonable, actuarially sound, and in the best interests of the creditors of the insurer.

(c) (i) An agreement subject to this Subsection (2) that has a gross consideration in excess of $250,000 shall be submitted pursuant to Section 31A-27a-107 to the receivership court for approval.

(ii) An agreement described in this Subsection (2)(c) shall be approved by the receivership court if it meets the standards described in this Subsection (2).

(3) Without derogating from Section 31A-27a-512, if the liquidator is unable to negotiate a voluntary commutation with a reinsurer with respect to a reinsurance agreement between the insurer and that reinsurer, the liquidator may, in addition to any other remedy available under applicable law, apply to the receivership court, with notice to the reinsurer, for an order requiring that the parties submit commutation proposals with respect to the reinsurance agreement to a panel of three arbitrators:

(a) at any time after 75% of the actuarially estimated ultimate incurred liability for all of the casualty claims against the liquidation estate is reached by allowance of claims in the liquidation estate pursuant to Sections 31A-27a-603 and 31A-27a-605, calculated:

(i) as of the day on which the order of liquidation is entered by or at the instance of the liquidator; and

(ii) for purposes of this Subsection (3), not performed during the five-year period subsequent to the day on which the order of liquidation is entered; or

(b) at any time in regard to a reinsurer if that reinsurer has a total adjusted capital that is less than 250% of its authorized control level RBC as defined in Section 31A-17-601.

(4) Venue for the arbitration is within the district of the receivership court's jurisdiction or at another location agreed to by the parties.

(5) (a) If the liquidator determines that commutation would be in the best interests of the creditors of the liquidation estate, the liquidator may petition the receivership court to order arbitration.

(b) If the liquidator petitions the receivership court under Subsection (5)(a), the receivership court shall require that the liquidator and the reinsurer each appoint an arbitrator within 30 days after the day on which the order for arbitration is entered.

(c) If either party fails to appoint an arbitrator within the 30-day period, the other party may appoint both arbitrators and the appointments are binding on the parties.

(d) The two arbitrators shall be active or retired executive officers of insurance or reinsurance companies, not under the control of or affiliated with the insurer or the reinsurer.

(e) (i) Within 30 days after the day on which both arbitrators have been appointed, the two arbitrators shall agree to the appointment of a third independent, impartial, disinterested arbitrator.

(ii) If agreement to the disinterested arbitrator is not reached within the 30-day period, the third arbitrator shall be appointed by the receivership court.

(f) The disinterested arbitrator shall be a person who:

(i) is or, if retired, has been, an executive officer of a United States domiciled insurance or reinsurance company that is not under the control of or affiliated with either of the parties; and

(ii) has at least 15 years experience in the reinsurance industry.

(6) (a) The arbitration panel may choose to retain as an expert to assist the panel in its determinations, a retired, disinterested executive officer of a United States domiciled insurance or reinsurance company having at least 15 years loss reserving actuarial experience.

(b) If the arbitration panel is unable to unanimously agree on the identity of the expert within 14 days of the day on which the disinterested arbitrator is appointed, the expert shall be:

(i) designated by the commissioner:

(A) by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(B) on the basis of recommendations made by a nationally recognized society of actuaries; and

(ii) a disinterested person that has knowledge, experience, and training applicable to the line of insurance that is the subject of the arbitration.

(c) The expert:

(i) may not vote in the proceeding; and

(ii) shall issue a written report and recommendations to the arbitration panel within 60 days after the day on which the arbitration panel receives the commutation proposals submitted by the parties pursuant to Subsection (7), which report shall:

(A) be included as part of the arbitration record; and

(B) accompany the award issued by the arbitration panel pursuant to Subsection (8).

(d) The cost of the expert is to be paid equally by the parties.

(7) Within 90 days after the day on which the disinterested arbitrator is appointed under Subsection (5), each party shall submit to the arbitration panel:

(a) the party's commutation proposals; and

(b) other documents and information relevant to the determination of the parties' rights and obligations under the reinsurance agreement to be commuted, including:

(i) a written review of any disputed paid claim balances;

(ii) any open claim files and related case reserves at net present value; and

(iii) any actuarial estimates with the basis of computation of any other reserves and any incurred-but-not-reported losses at net present value.

(8) (a) Within 90 days after the day on which the parties submit the information required by Subsection (7), the arbitration panel:

(i) shall issue an award, determined by a majority of the arbitration panel, specifying the terms of a commercially reasonable and actuarially sound commutation agreement between the parties; or

(ii) may issue an award declining commutation between the parties for a period not to exceed two years if a majority of the arbitration panel determines that it is unable to derive a commercially reasonable and actuarially sound commutation on the basis of:

(A) the submissions of the parties; and

(B) if applicable, the report and recommendation of the expert retained in accordance with Subsection (6).

(b) Following the expiration of the two-year period described in Subsection (8)(a), the liquidator may again invoke arbitration in accordance with Subsection (2), in which event Subsections (2) through (9) apply to the renewed proceeding, except that the arbitration panel is obliged to issue an award under Subsection (8)(a).

(9) Once an award is issued, the liquidator shall promptly submit the award to the receivership court for confirmation.

(10) (a) Within 30 days of the day on which the receivership court confirms the award, the reinsurer shall give notice to the receiver that the reinsurer:

(i) will commute the reinsurer's liabilities to the insurer for the amount of the award in return for a full and complete release of all liabilities between the parties, whether past, present, or future; or

(ii) will not commute the reinsurer's liabilities to the insurer.

(b) If the reinsurer's liabilities are not commuted under Subsection (10)(a), the reinsurer shall:

(i) establish and maintain in accordance with Section 31A-27a-516 a reinsurance recoverable trust in the amount of 102% of the award; and

(ii) pay the costs and fees associated with establishing and maintaining the trust established under this Subsection (10)(b).

(11) (a) If the reinsurer notifies the liquidator that it will commute the reinsurer's liabilities pursuant to Subsection (10)(a)(i), the liquidator has 30 days from the day on which the reinsurer notifies the liquidator to:

(i) tender to the reinsurer a proposed commutation and release agreement:

(A) providing for a full and complete release of all liabilities between the parties, whether past, present, or future; and

(B) that requires that the reinsurer make payment of the commutation amount within 14 days from the day on which the agreement is consummated; or

(ii) reject the commutation in writing, subject to receivership court approval.

(b) If the liquidator rejects the commutation subject to approval of the receivership court in accordance with Subsection (11)(a)(ii), the reinsurer shall establish and maintain a reinsurance recoverable trust in accordance with Section 31A-27a-516.

(c) The liquidator and the reinsurer shall share equally in the costs and fees

associated with establishing and maintaining the trust established under Subsection (11)(b).

(12) Except for the period provided in Subsection (8)(b), the time periods established in Subsections (6), (7), (8), (10), and (11) may be extended:

(a) upon the consent of the parties; or

(b) by order of the receivership court, for good cause shown.

(13) Subject to Subsection (14), this section may not be construed to supersede or impair any provision in a reinsurance agreement that establishes a commercially reasonable and actuarially sound method for valuing and commuting the obligations of the parties to the reinsurance agreement by providing in the contract the specific methodology to be used for valuing and commuting the obligations between the parties.

(14) (a) A commutation provision in a reinsurance agreement is not effective if it is demonstrated to the receivership court that the provision is entered into in contemplation of the insolvency of one or more of the parties.

(b) A contractual commutation provision entered into within one year of the day on which the liquidation order of the insurer is entered is rebuttably presumed to have been entered into in contemplation of insolvency.

Amended by Chapter 345, 2008 General Session
Amended by Chapter 382, 2008 General Session

31A-27a-516. Reinsurance recoverable trust provisions.

(1) As used in this section:

(a) "Beneficiary" means the domiciliary insurance commissioner, as liquidator of the insurer for whose sole benefit a reinsurance recoverable trust is established.

(b) "Grantor" means the reinsurer who has established a reinsurance recoverable trust for the sole benefit of the beneficiary.

(c) "Qualified United States financial institution" means an institution that:

(i) (A) is organized under the laws of the United States or any state of the United States; or

(B) in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state of the United States;

(ii) is granted authority to operate with fiduciary powers; and

(iii) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(d) "Reinsurance recoverable trust" means a trust established pursuant to Section 31A-27a-515.

(2) (a) The trustee of a reinsurance recoverable trust shall be a qualified United States financial institution.

(b) The trust agreement governing a reinsurance recoverable trust shall:

(i) be entered into by the beneficiary, the grantor, and a trustee;

(ii) create a trust account into which assets shall be deposited in accordance with Section 31A-27a-515;

(iii) provide that the beneficiary may withdraw assets from the trust only:

(A) (I) on the basis of a filed claim allowed pursuant to Section 31A-27a-603 or

31A-27a-605;

(II) where the grantor is notified, in writing, of the allowance of the claim;

(III) to the extent that the amount to be withdrawn exceeds any setoff permitted by Section 31A-27a-510 due to the grantor; and

(IV) when 60 days expires during which the grantor fails to:

(Aa) pay the claim; or

(Bb) subject to and without derogation from Section 31A-27a-512, which at all times governs and remains binding on the reinsurer, file notice of a written dispute with respect to the claim under and in terms of the reinsurance agreement; or

(B) if the beneficiary complies with any different or other terms and conditions mutually agreed to by the beneficiary and the grantor in the trust agreement;

(iv) require the trustee to:

(A) receive assets and hold all assets at the trustee's office in the United States in a safe place;

(B) determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate the assets, without consent or signature from the grantor or any other person;

(C) furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter; and

(D) notify the grantor and the beneficiary within 10 days of a deposit to or withdrawal from the trust account;

(v) be made subject to and governed by the laws of this state;

(vi) prohibit the invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee;

(vii) provide that the trustee is liable for the trustee's negligence, willful misconduct, or lack of good faith;

(viii) subject to Subsection (2)(c), provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after the day on which the beneficiary and grantor receive the notice;

(ix) subject to Subsection (2)(c), provide that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after the day on which the trustee and the beneficiary receive the notice;

(x) provide that the grantor has the full and unqualified right to vote any shares of stock in the trust account except that, subject to other provisions of this section, an interest or dividend paid on shares of stock or other obligation in the trust account shall remain in the trust;

(xi) specify categories of investments reasonably acceptable to the beneficiary;

(xii) authorize the trustee to invest funds and to accept substitutions, by the grantor, that the trustee determines are at least equal in market value to the assets withdrawn provided that no investment or substitution shall be made without prior approval from the beneficiary, which may not be unreasonably or arbitrarily withheld;

(xiii) subject to Subsection (2)(d), provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred;

(xiv) specify the types of assets that may be included in the trust account:

(A) which shall consist only of:

(I) cash in United States dollars;

(II) certificates of deposit issued by a United States bank and payable in United States dollars;

(III) investments permitted by this state's insurance law; or

(IV) any combination of the types specified by this Subsection (2)(b)(xiv)(A);

(B) except that if investments in or issued by an entity controlling, controlled by, or under common control with either the grantor or the beneficiary of the trust, may not exceed 5% of total investments; and

(C) subject to the assets deposited in the trust account being valued according to the asset's current fair market value;

(xv) give the grantor the right to seek approval from the beneficiary, which may not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the grantor, if:

(A) the grantor, at the time of withdrawal, replaces the withdrawn assets with other qualified assets so as to maintain at all times the deposit in the required amount; or

(B) after withdrawal and transfer, the market value of the trust account is no less than 102% of the award made pursuant to Subsection 31A-27a-515(8)(a);

(xvi) provide for the return of any amount withdrawn in excess of the actual amounts required for:

(A) payment of reported allowed claims under Subsection (2)(b)(iii); and

(B) interest payments at a rate not in excess of the prime rate of interest on the excess amounts withdrawn; and

(xvii) provide for termination of the reinsurance recoverable trust in accordance with Subsection (6).

(c) Notwithstanding Subsection (2)(b)(viii) or (ix), a resignation or removal may not be effective until:

(i) a successor trustee is appointed and approved by the beneficiary and the grantor; and

(ii) all assets in the trust are transferred to the new trustee.

(d) Notwithstanding Subsection (2)(b)(xiii), a transfer may be conditioned upon the trustee receiving, before or simultaneously with, other specified assets.

(e) Subsection (2)(b) may not be construed to alter the rights or obligations of the parties pursuant to contractual and statutory provisions providing for notice and the determination of a claim.

(3) The grantor shall, before depositing assets with the trustee, execute assignments or endorsements in blank, or transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the beneficiary, or the trustee upon the direction of the beneficiary, may whenever necessary negotiate these assets without consent or signature from the grantor or any other person.

(4) (a) Without derogating Section 31A-27a-512, the grantor or the beneficiary may request that the receivership court review the amount held if:

(i) the grantor and beneficiary fail to reach agreement on the extent, if any, to which supplementation or reduction of a reinsurance recoverable trust should be occasioned;

(ii) (A) the reinsurance recoverable trust is exhausted; or

(B) the reinsurance recoverable trust is insufficient to respond to claims allowed pursuant to Section 31A-27a-603 or 31A-27a-605; and

(iii) the grantor or the beneficiary believe that the amount held in the reinsurance recoverable trust is either deficient or overstated.

(b) The review described in this Subsection (4) shall be conducted applying procedures and terms as the receivership court shall, in its sole discretion, direct.

(5) A reinsurance recoverable trust shall terminate upon the earlier of:

(a) receivership court approval of a voluntary commutation between the grantor and the beneficiary pursuant to Subsection 31A-27a-515(2);

(b) the mutual agreement of the grantor and the beneficiary; or

(c) a finding by the receivership court that the grantor has discharged its liabilities to the beneficiary.

(6) Upon termination of a reinsurance recoverable trust, all assets not previously withdrawn by the beneficiary, pursuant to Subsection (2)(b)(iii), shall, with written approval of the beneficiary, be delivered to the grantor.

Amended by Chapter 345, 2008 General Session

31A-27a-601. Filing of claims.

(1) (a) Subject to the other provisions of this Subsection (1), proof of a claim shall be filed with the liquidator in the form required by Section 31A-27a-602 on or before the last day for filing specified in the notice required under Section 31A-27a-406.

(b) The last day for filing specified in the notice may not be later than 18 months after the day on which the order of liquidation is entered unless the receivership court, for good cause shown, extends the time.

(c) Proof of a claim for the following does not need to be filed unless the liquidator expressly requires filing of proof:

(i) cash surrender value in life insurance and annuities;

(ii) investment value in life insurance and annuities other than cash surrender value; and

(iii) any other policy insuring the life of a person.

(d) Only upon application of the liquidator, the receivership court may allow alternative procedures and requirements for the filing of proof of a claim or for allowing or proving a claim.

(e) Upon application, if the receivership court dispenses with the requirements of filing a proof of claim by a person, class, or group of persons, a proof of claim for that person, class, or group is considered as being filed for all purposes, except that the receivership court's waiver of proof of claim requirements may not impact guaranty association proof of claim filing requirements or coverage determinations to the extent that the guaranty association statute or filing requirements are inconsistent with the receivership court's waiver of proof.

(2) The liquidator may permit a claimant that makes a late filing to share ratably in distributions, whether past or future, as if the claim were not filed late, to the extent that the payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) the eligibility to file a proof of claim was not known to the claimant, and the claimant files a proof of claim within 90 days after the day on which the claimant first learns of the eligibility;

(b) (i) a transfer to a creditor is:

(A) avoided under Section 31A-27a-503, 31A-27a-504, 31A-27a-506, or 31A-27a-507; or

(B) voluntarily surrendered under Section 31A-27a-509; and

(ii) the filing satisfies the conditions of Section 31A-27a-509; or

(c) the valuation of security held by a secured creditor under Section 31A-27a-610 shows a deficiency and the claim for the deficiency is filed within 30 days after the valuation.

(3) If a reinsurer's reinsurance contract terminates pursuant to Section 31A-27a-513:

(a) a claim filed by the receiver which arises from the termination may not be considered late if the claim is filed within 90 days of the day on which the reinsurance contract terminates; and

(b) the reinsurer shall receive a ratable share of distributions, whether past or future, as if the claim described in Subsection (3)(a) is not late.

(4) Notwithstanding any other provision of this chapter, the liquidator may petition the receivership court, subject to Section 31A-27a-107, to set a date certain after which no further claims may be filed.

Enacted by Chapter 309, 2007 General Session

31A-27a-602. Proof of claim.

(1) Proof of claim shall consist of a statement signed by the claimant or on behalf of the claimant that includes all of the following that are applicable:

(a) the particulars of the claim including the consideration given for the claim;

(b) the identity and amount of the security on the claim;

(c) the payments made on the debt, if any;

(d) that the sum claimed is justly owing and there is no setoff, counterclaim, or defense to the claim;

(e) any right of priority of payment or other specific right asserted by the claimant;

(f) the name and address of the claimant and the attorney, if any, who represents the claimant; and

(g) the claimant's Social Security number or federal employer identification number.

(2) The liquidator may require that:

(a) a prescribed form be used under this section; and

(b) other information and documents be included.

(3) At any time the liquidator may:

(a) require the claimant to present information or evidence supplementary to that required under Subsection (1);

(b) take testimony under oath;

(c) require production of one or more affidavits or depositions; or

(d) otherwise obtain additional information or evidence.

(4) (a) An affected guaranty association may file a single omnibus proof of claim for all claims of the affected guaranty association in connection with payment of claims of the insurer.

(b) The omnibus proof of claim may be periodically updated by the affected guaranty association without regard to the deadline specified in Subsection 31A-27a-601(1).

(c) An affected guaranty association may be required to submit a reasonable amount of documentation in support of the claim.

Enacted by Chapter 309, 2007 General Session

31A-27a-603. Allowance of claims.

(1) (a) Except as provided in Subsections (11) and (12), the liquidator shall:

(i) review all claims filed in the liquidation proceeding in accordance with this chapter; and

(ii) further investigate a claim, as the liquidator considers necessary.

(b) Consistent with this chapter, the liquidator may allow, disallow, or compromise a claim that will be recommended to the receivership court unless the liquidator is required by law to accept the claim as settled by a person, including an affected guaranty association, subject to a statutory or contractual right of the affected reinsurers to participate in the claims allowance process.

(c) Notwithstanding any other provision of this chapter, a claim under a policy of insurance may not be allowed for an amount in excess of the applicable policy limits.

(2) (a) Pursuant to the review required by Subsection (1), the liquidator shall provide notice of the claim determination to the claimant or the claimant's attorney.

(b) The notice required by this Subsection (2) shall set forth:

(i) the amount of the claim allowed by the liquidator, if any;

(ii) the priority class of the claim as established in Section 31A-27a-701; and

(iii) if the claim is denied, the reason for the denial.

(c) In regard to a claim to be allowed pursuant to Section 31A-27a-605, preliminary notice of the amount of the claim determination shall be provided to any reinsurer that is or may be liable in respect to the claim at least 45 days before the day on which notice is provided to the claimant pursuant to this Subsection (2).

(d) In regard to a claim being allowed other than pursuant to Section 31A-27a-605, the notice sent to the claimant may be provided to any reinsurer that is or may be liable in respect to the claim.

(e) If no timely objection is submitted, the claim determination is binding on the reinsurer upon allowance.

(3) (a) Within 45 days after the day on which the notice described in Subsection (2) is mailed, the claimant noticed may submit a written objection to the liquidator.

(b) An objection provided for under this Subsection (3) shall clearly set out:

(i) all facts and the legal basis, if any, for the objection; and

(ii) the reasons why the claim should be allowed at a different amount or in a different priority class.

(c) If no timely objection is submitted, the claimant may not further object, and

the determination is final.

(d) The liquidator may accelerate the allowance of a claim by obtaining a waiver of an objection.

(4) (a) A claim that is not mature as of the coverage termination date established under Section 31A-27a-402 may be allowed as if it were mature, except the claim shall be discounted to present value.

(b) A claim is not mature if payment on the claim is not yet due.

(5) The following is not required to be considered as evidence of liability or of the amount of damages:

(a) a judgment or order against an insured or the insurer entered:

(i) after the day on which a successful petition for receivership is initially filed; or

(ii) within 120 days before the day on which the petition is initially filed; or

(b) a judgment or order against an insured or the insurer entered at any time by default or by collusion.

(6) A claim under an employment contract by a director, officer, or person in fact performing similar functions or having similar powers is limited to payment for services rendered before an order of receivership, unless explicitly approved in writing by:

(a) the commissioner before an order of receivership;

(b) the rehabilitator before the day on which the order of liquidation is entered; or

(c) the liquidator after the day on which the order of liquidation is entered.

(7) The total liability of the liquidator to all claimants arising out of the same act or policy shall be no greater than the insurer's total liability would have been were the insurer not in liquidation.

(8) (a) The liquidator shall disallow a claim that is for or determined to be for a de minimis amount.

(b) A de minimis amount is an amount equal to or less than a maximum de minimis amount approved by the receivership court as being reasonable and necessary for administrative convenience.

(9) A claim that does not contain all the applicable information required by Section 31A-27a-602:

(a) does not need to be further reviewed or adjudicated; and

(b) may be denied or disallowed by the liquidator subject to the notice and objection procedures in this section.

(10) (a) The liquidator may reconsider a claim on the basis of additional information and amend the recommendation to the receivership court.

(b) The claimant shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in the claim's initial determination.

(c) The receivership court may amend the receivership court's allowance or disallowance as appropriate.

(11) (a) The liquidator is not required to process claims for any class until it appears reasonably likely that property will be available for a distribution to that class.

(b) If there are insufficient assets to justify processing all claims for a class listed in Section 31A-27a-701, the liquidator shall:

(i) report the facts to the receivership court; and

(ii) make appropriate recommendations for handling the remainder of the claims.

(12) A claim of a lessor for damages resulting from the termination of a lease of

real property shall be disallowed to the extent that the claim exceeds the sum of:

(a) the rent reserved by the lease, without acceleration, for the greater of one year, or 15%, not to exceed three years, of the remaining term of the lease, following the earlier of:

(i) the day on which the petition is filed; and

(ii) the day on which the lessor repossessed, or the lessee surrendered, the leased property; and

(b) any unpaid rent due under the lease, without acceleration, on the earlier of the dates specified in Subsection (12)(a).

Enacted by Chapter 309, 2007 General Session

31A-27a-604. Claims under an occurrence policy, surety bond, surety undertaking.

(1) Subject to Section 31A-27a-603, an insured may file a claim for the protection afforded under the insured's policy, irrespective of whether a claim is known at the time of filing, if the policy is an occurrence policy.

(2) Subject to Section 31A-27a-603, an obligee may file a claim for the protection afforded under a surety bond or a surety undertaking issued by the insurer as to which the obligee is the beneficiary, irrespective of whether a claim is known at the time of filing.

(3) After a claim is filed under Subsection (1) or (2), when a specific claim is made by or against the insured or by the obligee:

(a) the insured or the obligee shall supplement the claim; and

(b) the receiver shall treat the claim as a contingent or unliquidated claim under Section 31A-27a-605.

Enacted by Chapter 309, 2007 General Session

31A-27a-605. Allowance of contingent and unliquidated claims.

(1) As used in this section, "claim" means a demand for payment pursuant to Section 31A-27a-601 under the terms and conditions of a contract issued by the insurer as a result of a known accident, casualty, disaster, loss, event, or occurrence.

(2) (a) A claim of an insured or third party may be allowed under Section 31A-27a-603, regardless of the fact that it is contingent or unliquidated if:

(i) any contingency is removed in accordance with Subsection (3); and

(ii) the value of the claim is determined in accordance with Subsection (4).

(b) A claim is contingent if:

(i) the accident, casualty, disaster, loss, event, or occurrence insured, reinsured, or bonded against occurs on or before the date fixed under Section 31A-27a-601; and

(ii) the act or event triggering the insurer's obligation to pay has not occurred as of the date fixed under Section 31A-27a-401.

(c) A claim is unliquidated if the insurer's obligation to pay is established, but the amount of the claim has not been determined.

(3) (a) Unless the receivership court directs otherwise, a contingent claim may be allowed if:

(i) the claimant presents proof of the insurer's obligation to pay reasonably satisfactory to the liquidator; or

(ii) subject to Subsection (3)(b), the claim is based on a cause of action against an insured of the insurer, and:

(A) it may be reasonably inferred from proof presented upon the claim that the claimant would be able to obtain a judgment; and

(B) the person furnishes suitable proof.

(b) A contingent claim may not be allowed under Subsection (3)(a)(ii)(B) if the receivership court for good cause shown shall otherwise direct that no further valid claims can be made against the insurer arising out of the cause of action other than those already presented.

(4) (a) An unliquidated claim may be allowed if its amount has been determined.

(b) If the amount of an unliquidated claim filed pursuant to Section 31A-27a-601 remains undetermined, the valuation of the unliquidated claim may be made by estimate whenever the liquidator determines that:

(i) liquidation of the claim would unduly delay the administration of the liquidation proceeding; or

(ii) the administrative expense of processing and adjudicating the claim or group of claims of a similar type would be unduly excessive when compared with the property that is estimated to be available for distribution with respect to the claim.

(c) Any estimate shall be based on an accepted method of valuing a claim with reasonable certainty at the claim's net present value, such as an actuarial evaluation.

(5) (a) Notwithstanding the other provisions of this section, a claim for the value or breach of a life insurance policy, disability income insurance policy, long-term care insurance policy, or annuity may not result in or serve as the basis of any liability of a reinsurer of the insurer.

(b) A reinsurer's liability to the insurer shall be determined exclusively on the basis of its contracts of reinsurance and Section 31A-27a-513.

(6) (a) The liquidator may petition the receivership court to set a date certain before which all claims under this section shall be final.

(b) In addition to the notice requirements of Section 31A-27a-107, the liquidator shall give notice of the filing of the petition to all claimants with claims that remain contingent or unliquidated under this section.

Enacted by Chapter 309, 2007 General Session

31A-27a-606. Special provisions for third party claims.

(1) Whenever a 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 on or before the last day for filing claims.

(2) Whether or not the third party files a claim, the insured may file a claim on the insured's own behalf in the liquidation.

(3) (a) The liquidator may make recommendations to the receivership court for the allowance of an insured's claim after consideration of:

(i) the probable outcome of any pending action against the insured on which the claim is based;

(ii) the probable damages recoverable in the action; and

(iii) the probable costs and expenses of defense.

(b) After allowance by the receivership court, the liquidator shall withhold any distribution payable on the claim, pending the outcome of litigation and negotiation between the insured and the third party.

(c) The liquidator may reconsider the claim as provided in Subsection 31A-27a-603(10).

(d) As a claim against the insured is settled or barred, the insured or third party, as appropriate, shall be paid, from the amount withheld, the same percentage distribution as is paid on other claims of like priority, on the basis of the lesser of:

(i) the amount actually due from the insured by action or paid by agreement plus the reasonable costs and expense of defense; or

(ii) the amount allowed on the claim by the receivership court.

(e) After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed property of the insurer.

(4) (a) If several claims founded upon one policy are timely filed, whether by third parties or as claims by the insured under this section, and the aggregate amount of the timely filed allowed claims exceeds the aggregate policy limits, the liquidator may:

(i) apportion the policy limits ratably among the timely filed allowed claims; or

(ii) give notice to the insured, known third parties, and affected guaranty associations that the aggregate policy limits have been exceeded.

(b) Thirty days after the day on which the liquidator's notice is given under this Subsection (4):

(i) no further amounts shall be allowed;

(ii) the policy limits shall be apportioned ratably among the timely filed allowed claims; and

(iii) any additional claims shall be rejected.

(c) A claim by the insured shall be evaluated as in Subsection (3). If an insured's claim is subsequently reduced under Subsection (3), the amount freed shall be apportioned ratably among the claims that have been reduced under this Subsection (4).

(5) A claim may not be allowed under this section to the extent the claim is covered by a guaranty association.

(6) A claimant may withdraw a proof of claim with the liquidator's approval. The liquidator may approve the withdrawal:

(a) after giving notice of the withdrawal to the insured; and

(b) only upon a showing of good cause.

(7) The filing of a proof of claim in connection with a claim against an insured shall have the following effect on the rights of the claimant and the insured:

(a) By filing a proof of claim, a claimant:

(i) waives any right to pursue the personal assets of the insured with respect to the claim, to the extent of the coverage or policy limits provided by the insurer; and

(ii) except as provided in this section, agrees that, to the extent of the coverage or policy limits provided by the insurer, the claimant shall seek satisfaction of the claim against the insured solely from:

(A) distributions paid by the liquidator on the claim; and

(B) any payments that an affected guaranty association may pay on account of the claim.

(b) The waiver provided under this section:

(i) is conditioned upon the cooperation of the insured with:

(A) the liquidator in the defense of the claim; and

(B) any applicable guaranty association in defense of the claim; and

(ii) does not operate to:

(A) discharge the guaranty association from any of its responsibilities and duties;

(B) release the insured with respect to any claim in excess of the coverage or policy limits provided by the insurer or any other responsible party; or

(C) release the insured to the extent of the guaranty association's claim for reimbursement from the insured under a guaranty association statutory provision instituting a right to recover from high net worth insureds.

(c) The waiver provided under this section is void if:

(i) a claimant withdraws the claimant's proof of claim under Subsection (6); or

(ii) the liquidator avoids insurance coverage in connection with a proof of the claim.

(d) The liquidator shall provide, where applicable, notice of the election of remedies provision in this section on any proof of claim form it distributes that shall:

(i) be inserted above the claimant's signature line in typeface:

(A) no smaller than the typeface of the rest of the notice; and

(B) in no event smaller than font size 14; and

(ii) include a statement substantially similar to the following: "I understand by filing this claim in the estate of the insurer I am waiving any right to pursue the personal assets of the insured to the extent that there are policy limits or coverage provided by the now insolvent insurer."

Enacted by Chapter 309, 2007 General Session

31A-27a-607. Disputed claims.

(1) (a) When a claim is disallowed in whole or in part by the liquidator, written notice of the determination and of the right to object shall be given promptly to the claimant or the claimant's attorney of record, if any, by first-class mail at the addresses shown in the proof of claim.

(b) (i) Within 45 days from the day on which the notice required by Subsection (1)(a) is mailed, the claimant may file an objection with the liquidator.

(ii) If an objection is not filed within the period provided in Subsection (1)(b)(i), the claimant may not further object to the determination.

(2) (a) If an objection is filed in accordance with Subsection 31A-27a-603(3)(a) and the liquidator does not alter the liquidator's ruling, the liquidator shall ask the court for a hearing as soon as practicable.

(b) If the liquidator asks for a hearing under Subsection (2)(a), the court shall issue an order setting a date as early as possible.

(c) At the request of the liquidator, the court may establish procedures for the objections hearing.

(d) The liquidator shall give notice of a hearing under this Subsection (2) by first-class mail to:
(i) the claimant or the claimant's attorney; and
(ii) any other persons directly affected.
(e) A hearing under this Subsection (2):
(i) shall be heard without a jury; and
(ii) may be heard by:
(A) the court; or
(B) a court appointed referee.
(f) A hearing under this Subsection (2) shall be limited to the evidence upon which the liquidator made the determination of the claim.
(g) If a referee is appointed under this Subsection (2), the referee shall submit to the court:
(i) findings of fact;
(ii) recommendations; and
(iii) a transcript of the hearing.
(h) The court shall review the referee's findings of fact and recommendations for correctness by reviewing the record, including the hearing transcript.
(i) Consistent with Section 31A-27a-608, the court may approve, disapprove, or modify:
(i) the liquidator's determination of a claim; or
(ii) a referee's recommendations on a claim.
(3) A court order issued after a hearing and pursuant to this section may be appealed as a final order for purposes of Rule 54, Utah Rules of Civil Procedure.
(4) This section is not applicable to a dispute with respect to a coverage determination by an affected guaranty association as part of the affected guaranty association's statutory obligations.

Enacted by Chapter 309, 2007 General Session

31A-27a-608. Liquidator's recommendations to the receivership court.
(1) The liquidator shall, from time to time as determined by the liquidator, present to the receivership court for approval, reports of claims settled or determined by the liquidator under Section 31A-27a-603.
(2) A report required by this section shall include information identifying:
(a) the claim;
(b) the amount of the claim; and
(c) the priority class of the claim.

Enacted by Chapter 309, 2007 General Session

31A-27a-609. Claims of codebtor.
If a creditor does not timely file a proof of the creditor's claim, the following may file a proof of the claim:
(1) a person who is liable to the creditor together with the insurer; or
(2) a person who has secured the creditor.

Enacted by Chapter 309, 2007 General Session

31A-27a-610. Secured creditor's claims.

(1) The value of a security held by a secured creditor shall be determined in one of the following ways:

(a) by converting the security into money according to the terms of the agreement pursuant to which the security is delivered to the creditor; or

(b) by agreement or litigation between the creditor and the liquidator.

(2) (a) The receiver has the first priority to use collateral to reimburse a prepetition loss or expense if:

(i) a surety pays a loss or loss adjustment expense under its own surety instrument before any petition for a delinquency proceeding;

(ii) the principal posts collateral that remains available to reimburse the loss, the loss adjustment expense, or both; and

(iii) at the time of the petition, the collateral posted under this Subsection (2)(a) has not been credited against the payments made.

(b) If the principal under a surety bond or a surety undertaking pledges collateral, including a guaranty or a letter of credit, to secure the principal's reimbursement obligation to the insurer, the claim of an obligee or, subject to the discretion of the receiver, completion contractor under the surety bond or surety undertaking shall be satisfied first out of the collateral or the collateral's proceeds.

(c) In making a distribution to an obligee or completion contractor, the receiver shall retain a sufficient reserve for any other potential claim against the collateral under Subsection (2)(b).

(d) If the collateral is insufficient to satisfy in full all potential claims against it under Subsections (2)(b) and (f):

(i) the claims shall be paid on a pro rata basis; and

(ii) the obligees or completion contractor shall have claims, subject to allowance pursuant to Section 31A-27a-603, for any deficiency.

(e) If the time to assert a claim against a surety bond or a surety undertaking expires and all claims have been satisfied in full, any remaining collateral for the surety bond or surety undertaking shall be returned to the principal.

(f) (i) To the extent that a guaranty association has made a payment relating to a claim against a surety bond, the guaranty association shall first be reimbursed for the payment and related expenses out of the available collateral or proceeds related to the surety bond.

(ii) To the extent the collateral is sufficient, the guaranty association will be reimbursed for 100% of the guaranty association's payment.

(iii) If the collateral is insufficient to satisfy in full all potential claims against it under this Subsection (2)(f) and Subsection (2)(b), the one or more guaranty associations that pay claims on a surety bond:

(A) are entitled to a pro rata share of the available collateral in accordance with Subsection (2)(d); and

(B) have claims against the general assets of the estate in accordance with Section 31A-27a-603 for any deficiency.

(iv) A payment made to a guaranty association from the collateral may not be considered early access or otherwise considered a distribution out of the general assets or property of the estate.

(v) A guaranty association shall subtract any payment from the collateral from the guaranty association's final claims against the estate.

(3) (a) The amount determined pursuant to Subsection (1) shall be credited upon the secured claim, and the claimant may file a proof of claim, subject to the other provisions of this chapter, for any deficiency, which shall be treated as an unsecured claim.

(b) If the claimant surrenders the claimant's security to the liquidator, the entire claim shall be treated as if unsecured.

(4) The liquidator may recover from property securing an allowed secured claim the reasonable, necessary costs and expenses of preserving, or disposing of, the property to the extent of any benefit to the holder of the allowed secured claim.

Enacted by Chapter 309, 2007 General Session

31A-27a-611. Qualified financial contracts.

(1) As used in this section:

(a) (i) "Actual direct compensatory damages" does not include:

(A) punitive or exemplary damages;

(B) damages for lost profit or lost opportunity; or

(C) damages for pain and suffering.

(ii) "Actual direct compensatory damages" includes:

(A) normal and reasonable costs of cover; or

(B) other reasonable measures of damages used in the derivatives, securities, or other market for the contract or agreement claim.

(b) "Business day" means a day other than:

(i) a Saturday;

(ii) a Sunday; or

(iii) day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

(c) "Contractual right" includes:

(i) a right set forth:

(A) in a rule or bylaw of:

(I) a derivatives clearing organization, as defined in the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.;

(II) a multilateral clearing organization, as defined in the Federal Deposit Insurance Corporation Improvement Act of 1991, 12 U.S.C. Sec. 4421;

(III) a national securities exchange;

(IV) a national securities association;

(V) a securities clearing agency;

(VI) a contract market designated under the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.;

(VII) a derivatives transaction execution facility registered under the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.; or

(VIII) a board of trade, as defined in the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.; or

(B) in a resolution of the governing board of an entity described in Subsection (1)(c)(i)(A); and

(ii) a right, whether or not evidenced in writing, arising:

(A) under statutory or common law;

(B) under law merchant; or

(C) by reason of normal business practice.

(d) For purposes of Subsection (3), "walkaway clause" means a provision in a qualified financial contract that suspends, conditions, or extinguishes a payment obligation of a party, in whole or in part, or does not create a payment obligation of a party that would otherwise exist:

(i) solely because of:

(A) the party's status as a nondefaulting party in connection with the insolvency of an insurer that is subject to this chapter and a party to the contract; or

(B) the appointment of or the exercise of rights or powers by a receiver of an insurer that is subject to this chapter and a party to the contract; and

(ii) not as a result of a party's exercise of any right to offset, setoff, or net obligations that exist under:

(A) the contract;

(B) any other contract between those parties; or

(C) applicable law.

(2) Notwithstanding any other provision of this chapter, including any provision of this chapter permitting the modification of a contract, or other law of a state:

(a) a person may not be stayed or prohibited from exercising:

(i) a contractual right to cause the termination, liquidation, acceleration, or close out of an obligation under or in connection with a netting agreement or qualified financial contract with an insurer because of:

(A) the insolvency, financial condition, or default of the insurer at any time, if the right is enforceable under applicable law other than this chapter; or

(B) the commencement of a formal delinquency proceeding under this chapter;

(ii) a right under any of the following relating to one or more netting agreements or qualified financial contracts:

(A) a pledge agreement or arrangement;

(B) a security agreement or arrangement;

(C) a collateral agreement or arrangement;

(D) a reimbursement agreement or arrangement;

(E) a guarantee agreement or arrangement;

(F) any other similar security agreement or arrangement; or

(G) other credit enhancement; or

(iii) subject to Subsection 31A-27a-510(2), a right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with one or more qualified financial contracts where the counterparty or its guarantor is organized under the laws of:

(A) the United States;

(B) a state; or

(C) a foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting; or

(b) if a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this chapter terminates, liquidates, closes out, or accelerates the master netting agreement or qualified financial contract:

(i) damages shall be measured as of the date or dates of termination, liquidation, close out, or acceleration; and

(ii) the amount of a claim for damages shall be actual direct compensatory damages calculated in accordance with Subsection (7).

(3) (a) Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition is filed under this chapter shall be transferred to or on the order of the receiver for the insurer:

(i) even if the insurer is the defaulting party; and

(ii) notwithstanding any walkaway clause in the netting agreement or qualified financial contract.

(b) (i) A limited two-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that defaults is considered to be a full two-way payment or second method provision as against the defaulting insurer.

(ii) Property or an amount described in this Subsection (3)(b) shall, except to the extent it is subject to one or more secondary liens or encumbrances or rights of netting or setoff, be a general asset of the insurer.

(4) In making a transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this chapter, the receiver shall either:

(a) transfer to one party, other than an insurer subject to a proceeding under this chapter, all netting agreements and qualified financial contracts between a counterparty or an affiliate of the counterparty and the insurer that is the subject of the proceeding, including:

(i) all rights and obligations of each party under each netting agreement and qualified financial contract; and

(ii) all property, including any guarantees or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract; or

(b) transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in Subsection (4)(a) with respect to the counterparty and an affiliate of the counterparty.

(5) If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12 noon, the receiver's local time, on the business day following the transfer.

(6) (a) Notwithstanding any other provision of this chapter and except for Subsection (6)(b), a receiver may not avoid a transfer of money or other property arising under or in connection with any of the following that is made before the commencement of a formal delinquency proceeding under this chapter:

(i) a netting agreement;
(ii) a qualified financial contract; or
(iii) one of the following relating to a netting agreement or qualified financial contract:
(A) a pledge agreement;
(B) a security agreement;
(C) a collateral agreement;
(D) a guarantee agreement;
(E) any other similar security arrangement; or
(F) a credit support document.
(b) A transfer may be avoided under Subsection 31A-27a-507(1) if the transfer is made with actual intent to hinder, delay, or defraud:
(i) the insurer;
(ii) a receiver appointed for the insurer; or
(iii) an existing or future creditor.
(7) (a) In exercising the rights of disaffirmance or repudiation of a receiver with respect to a netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:
(i) disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or an affiliate of the counterparty and the insurer that is the subject of the proceeding; or
(ii) disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in Subsection (7)(a)(i) with respect to the person or an affiliate of the person.
(b) Notwithstanding any other provision of this chapter, a claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding rehabilitation case shall be determined and shall be allowed or disallowed:
(i) as if the claim arose before the day on which the petition for liquidation is filed; or
(ii) if a rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the day on which the petition for rehabilitation is filed.
(c) The amount of a claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.
(8) This section does not apply to a person who is an affiliate of the insurer that is the subject of the proceeding.
(9) All rights of a counterparty under this chapter apply to a netting agreement or qualified financial contract entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.
(10) (a) The definition of "qualified financial contract" in Section 31A-27a-102 shall be interpreted to be consistent with the definitions applicable under federal law in instances of insolvency of other types of financial institutions.

(b) The definition of "qualified financial contract" and this section do not:
(i) affect the scope of permissible investments of insurers or the valuation of those investments; or
(ii) modify any other regulatory framework applicable to investments or investment practices of insurers.

Enacted by Chapter 309, 2007 General Session

31A-27a-612. Administration of deductible policies and insured collateral.
(1) As used in this section:
(a) "Collateral" means any of the following that secures an insured's obligation to pay or to reimburse the insurer for deductible claim payments and to reimburse or pay to the insurer other secured obligations:
(i) cash;
(ii) a letter of credit of the insured;
(iii) a surety bond posted by the insured; or
(iv) any other form of security posted by the insured.
(b) "Deductible claim" means a claim, including a loss or allocated loss adjustment expense, under a deductible policy within the insured's obligation to pay a portion of a claim or claim expense that the insurer is obligated to pay to a person other than the insured by the deductible policy or by operation of law.
(c) (i) "Deductible limit" means a limit on an amount to be paid or reimbursed by the insured under a deductible policy that is equal to or greater than $5,000.
(ii) A deductible limit may be any amount of the risk exposure before the insurer agrees to become liable for the insurance risk without a right of recoupment from the insured for the insurer's payment of claims or expenses related to a claim under the deductible policy.
(d) (i) "Deductible policy" means any combination of one or more policies, endorsements, contracts, or security agreements in which the insured agrees with the insurer to:
(A) pay directly:
(I) the initial portion of a claim under the policy, endorsement, contract, or agreement up to a specified dollar amount; or
(II) the expenses related to a claim; or
(B) reimburse the insurer for the insurer's payment of:
(I) a claim under the policy, endorsement, contract, or agreement up to a specified dollar amount; or
(II) the expenses related to a claim.
(ii) "Deductible policy" includes a policy, endorsement, contract, or agreement that contains an aggregate limit on the insured's liability for all deductible claims in addition to a deductible limit for each claim.
(iii) "Deductible policy" does not include:
(A) a policy, endorsement, contract, or agreement that provides that the initial portion of a covered claim shall be self-insured and the insurer has no payment obligation within the self-insured retention;
(B) a policy, endorsement, contract, or agreement that provides for

retrospectively rated premium payments by the insured; or

(C) a reinsurance arrangement or agreement.

(e) "Other secured obligation" means an obligation, such as a reinsurance or retrospective premium obligation, that is:

(i) payable by the insured to the insurer; and

(ii) secured by collateral that also secures a deductible obligation.

(f) "Uncovered claim" means a deductible claim that is secured by collateral but that:

(i) is not defined as a covered claim under any relevant guaranty association statute;

(ii) the insured fails to fund or pay; and

(iii) is filed with the receiver pursuant to the receivership proof of claim process.

(2) (a) If an insurer agrees to allow an insured to fund or pay deductible claims directly or through a third party administrator, except as prohibited by applicable workers' compensation insurance law:

(i) the insured shall fulfill the insured's obligations notwithstanding a delinquency proceeding; and

(ii) the receiver shall allow the funding or payment agreements to continue notwithstanding a delinquency proceeding.

(b) To the extent the insured funds or pays a deductible claim, the insured's funding or payment of a deductible claim:

(i) bars any deductible claim in a delinquency proceeding including a claim by the insured or third party claimant; and

(ii) extinguishes the obligation, if any, of the receiver or an affected guaranty association to pay the deductible claim.

(c) The insured is responsible for providing timely notice to the receiver and to all affected guaranty associations for any claim that may exceed the deductible limit.

(d) A charge of any kind may not be made against a receiver or an affected guaranty association on the basis of an insured's funding or payment of a deductible claim.

(e) The failure of an insured to fulfill the insured's obligation pursuant to a funding agreement entitles the following to the full benefit of all collateral and other rights of recovery and reimbursement under the other provisions of this section:

(i) the receiver that pays a deductible claim; or

(ii) pursuant to Subsection (6)(b), an affected guaranty association that pays a deductible claim.

(3) Any reimbursement owed to an insurer under a deductible policy issued by an insurer subject to a delinquency proceeding shall be administered as follows:

(a) (i) A reimbursement from an insured for the payment of a deductible claim is a general asset of the estate to the extent that:

(A) the insolvent insurer is owed reimbursement for deductible payments made before the entry of a final order of liquidation; or

(B) the receiver is owed reimbursement for a deductible payment.

(ii) The receiver shall determine if a reimbursement is a general asset of the estate in accordance with this section.

(b) The receiver shall bill an insured for reimbursement of a deductible claim:

(i) paid by the insurer before the commencement of delinquency proceedings;

(ii) paid by an affected guaranty association upon receipt of notice of a reimbursable payment; or

(iii) paid or allowed by the receiver.

(c) The receiver may take all commercially reasonable actions necessary to collect a reimbursement owed if the insured does not make payment within:

(i) the time specified in the deductible policy; or

(ii) within 60 days after the day of billing if no time is specified in the deductible policy.

(d) The following is not a defense to the insured's reimbursement obligation under a deductible policy:

(i) the insolvency of the insurer;

(ii) the insurer's inability to perform any of the insurer's obligations under a deductible policy; or

(iii) an allegation of improper handling or payment of a deductible claim by:

(A) the insurer;

(B) the receiver;

(C) an affected guaranty association; or

(D) any combination of Subsections (3)(d)(iii)(A) through (C).

(4) The receiver shall adjust and pay uncovered claims as provided in Subsection (5). The receiver's obligation under this Subsection (4) terminates once all available collateral is exhausted. Once all available collateral is exhausted, any unpaid uncovered claims shall continue to be handled as a proof of claim in the receivership estate.

(5) (a) (i) Except where a deductible policy or other agreement conflicts with this section, any collateral held by an insurer subject to a delinquency proceeding under this chapter held under a deductible policy issued by the insurer, held for other secured obligations, or held under both shall be maintained and administered in accordance with:

(A) the deductible policy;

(B) any applicable security agreement;

(C) any agreement regarding other secured obligations; or

(D) any applicable combination of the deductible policy and other agreement.

(ii) This Subsection (5) applies to collateral regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer under a deductible policy, agreement, or other secured obligation.

(b) (i) Subject to this Subsection (5), collateral shall be used to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations under Subsection (8).

(ii) Collateral shall be considered as property of the receivership estate solely for the purpose of the receiver administering and handling the collateral.

(iii) Collateral may not be considered as a general asset of the estate, except as provided in Subsections (5)(c) and (8).

(c) (i) Subject to Subsection (5)(c)(ii), collateral held to secure the insured's performance of obligations is a general asset of the estate to the extent that:

(A) the insurer pays or has paid a deductible claim before the day on which a

final order of liquidation is entered and the deductible is not reimbursed by the insured;

(B) the receiver pays or has paid a deductible claim; or

(C) the insured fails to pay or reimburse to the insurer other secured obligations to the extent the payment or reimbursement is due or payable before the day on which a final order of liquidation is entered and remains unpaid.

(ii) The receiver shall determine the extent that collateral described in this Subsection (5)(c) is a general asset.

(d) The receiver shall draw down collateral to the extent necessary if the insured fails to:

(i) perform the insured's funding or payment obligations under any deductible policy;

(ii) pay deductible reimbursements within:

(A) the time specified in the deductible policy; or

(B) 60 days after the date of the billing if no time is specified in the deductible policy;

(iii) timely fund any other secured obligation; or

(iv) timely pay expenses defined in Subsection (8).

(e) (i) The receiver shall first apply or reserve collateral to the insured's obligations referenced in Subsections (5)(c)(i)(A) and (C).

(ii) The receiver shall use any collateral remaining after the application of Subsection (5)(e)(i) to:

(A) reimburse deductible claims submitted by an affected guaranty association;

(B) adjust and pay uncovered claims allowed by the liquidator;

(C) pay other secured obligations of the insured that become due and payable after the date of liquidation; or

(D) pay expenses as defined in Subsection (8).

(iii) The receiver shall:

(A) use collateral under Subsection (5)(e)(ii) in the order that the deductible claims or charges against the collateral listed in Subsection (5)(e)(ii) are received and accepted by the receiver; and

(B) continue until all valid deductible claims or charges are fully reimbursed or paid or the collateral is exhausted.

(iv) If there are amounts payable or reimbursable under this Subsection (5)(e) and the receiver for any reason has been precluded from drawing the collateral, the receiver may establish a reserve against the collateral for those amounts. Only the collateral exceeding the reserve shall be considered remaining collateral under this Subsection (5)(e).

(f) Once all claims, other secured obligations, or expenses under Subsection (8) covered by collateral have been paid and the receiver is satisfied that no new claims, other secured obligations, or expenses under Subsection (5)(e) may be presented, the receiver shall release any remaining collateral to the insured in accordance with the deductible policy or agreement relating to other secured obligations.

(6) To the extent an affected guaranty association pays a deductible claim for which the insurer would have been entitled to reimbursement from the insured, the following provisions apply:

(a) (i) When an affected guaranty association pays a deductible claim, the

affected guaranty association shall report the claim to the receiver.

(ii) The receiver shall collect from the insured all deductible amounts due as reimbursement. Subject to Subsection (8), when the insured reimbursements are collected, the receiver shall reimburse the affected guaranty association for deductible claims.

(iii) A reimbursement paid to the affected guaranty association pursuant to this Subsection (6)(a) may not be treated as a distribution under Section 31A-27a-703 or as an early access payment under Section 31A-27a-704.

(iv) If an affected guaranty association pays a deductible claim that is also subject to reimbursement under statutory net worth provisions, the affected guaranty association shall:

(A) bill the insured directly;

(B) notify the insurer of the payment; and

(C) notify the receiver of any receipt of a reimbursement under net worth provisions, which shall be credited against the insured's deductible reimbursement obligations to the extent that the reimbursement applies to deductible claims.

(b) (i) This Subsection (6)(b) applies if:

(A) the receiver declines to seek reimbursement from the insured or from any available collateral;

(B) the receiver is unsuccessful in obtaining reimbursement from the insured or from any available collateral; or

(C) the receiver fails to take available commercially reasonable actions to collect a reimbursement owed.

(ii) The receiver shall notify an affected guaranty association if the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured or from any available collateral.

(iii) If a condition described in Subsection (6)(b)(i) exists, notwithstanding whether the affected guaranty association receives the notice required by Subsection (6)(b)(ii), an affected guaranty association:

(A) may, after notice to the receiver, collect a reimbursement due from the insured for the deductible claims the affected guaranty association has paid:

(I) on the same basis as the receiver; and

(II) with the same rights and remedies; and

(B) shall report any amounts collected under Subsection (6)(b)(iii)(A) from each insured to the receiver.

(iv) The receiver shall provide an affected guaranty association with available information needed to collect a reimbursement due from the insured.

(v) When an affected guaranty association undertakes to collect reimbursements from the insured, the affected guaranty association shall notify all other guaranty associations who have paid deductible claims on behalf of the same insured that this action is being taken.

(vi) An amount collected by the affected guaranty association pursuant to this Subsection (6)(b) may not be treated as a distribution under Section 31A-27a-703 or as an early access payment under Section 31A-27a-704.

(vii) An affected guaranty association may net an expense incurred in collecting a reimbursement against that reimbursement.

(c) The receiver shall provide any affected guaranty associations with periodic reports concerning the receiver's activities in discharging responsibilities under this section, which shall include an accounting for the receiver's deductible billing and collection activities.

(d) To the extent that an affected guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, the affected guaranty association has a claim for those amounts in the delinquency proceeding. Any claim by an affected guaranty association shall be reduced by reimbursed or unreimbursed expenses described in Subsection (8) incurred by the receiver.

(e) (i) If any collateral is held under a deductible policy at the time the receiver files an application to terminate the delinquency proceeding, and it appears that an additional deductible claim may be payable by an affected guaranty association under the deductible policy, the receiver shall:

(A) transfer to an affected guaranty association the portion of the collateral that is reasonably estimated to be necessary to pay the deductible claim; and

(B) release any remaining portion of the collateral to the insured.

(ii) An affected guaranty association shall handle any collateral transferred from the receiver as provided in this section.

(f) Nothing in this Subsection (6) limits any rights of the receiver or an affected guaranty association under applicable statutory law to obtain reimbursement from an insured for a claims payment made by the affected guaranty association under a policy of the insurer or for the affected guaranty association's related expenses.

(7) (a) The receiver shall periodically adjust the collateral being held using accepted actuarial principles and practices.

(b) The receiver may impose a discretionary safety margin for collateral maintained.

(c) The receiver may not be required to review collateral more than once a year.

(d) The receiver shall inform any affected guaranty association and the insured of any collateral reviews, including the basis for any proposed adjustment.

(8) The receiver may do the following in relation to reasonable expenses incurred in fulfilling the receiver's responsibilities under this section:

(a) deduct the expense from reimbursements;

(b) deduct the expense from the collateral; or

(c) recover the expense through billings to the insured.

(9) (a) A receiver shall meet the receiver's obligations under this section in a timely manner.

(b) If an affected guaranty association believes that a receiver is not meeting an obligation under this section in a timely manner, upon motion by an affected guaranty association, a receivership court may grant relief to the affected guaranty association if the receivership court finds that the receiver is not meeting an obligation under this section in a timely manner.

(10) This section modifies Subsection 31A-22-1010(2)(b) to the extent necessary to permit an insured to participate in the payment of the insurance claims and losses by reimbursement of a receiver or affected guaranty association as provided in this section.

Enacted by Chapter 309, 2007 General Session

31A-27a-701. Priority of distribution.

(1) (a) The priority of payment of distributions on unsecured claims shall be in accordance with the order in which each class of claim is set forth in this section except as provided in Section 31A-27a-702.

(b) All claims in each class shall be paid in full or adequate funds retained for the claim's payment before a member of the next class receives payment.

(c) All claims within a class shall be paid substantially the same percentage.

(d) Except as provided in Subsections (2)(a)(i)(E), (2)(k), and (2)(m), subclasses may not be established within a class.

(e) A claim by a shareholder, policyholder, or other creditor may not be permitted to circumvent the priority classes through the use of equitable remedies.

(2) The order of distribution of claims shall be as follows:

(a) a Class 1 claim, which:

(i) is a cost or expense of administration expressly approved or ratified by the liquidator, including the following:

(A) the actual and necessary costs of preserving or recovering the property of the insurer;

(B) reasonable compensation for all services rendered on behalf of the administrative supervisor or receiver;

(C) a necessary filing fee;

(D) the fees and mileage payable to a witness;

(E) an unsecured loan obtained by the receiver, which:

(I) unless its terms otherwise provide, has priority over all other costs of administration; and

(II) absent agreement to the contrary, shares pro rata with all other claims described in this Subsection (2)(a)(i)(E); and

(F) an expense approved by the rehabilitator of the insurer, if any, incurred in the course of the rehabilitation that is unpaid at the time of the entry of the order of liquidation; and

(ii) except as expressly approved by the receiver, excludes any expense arising from a duty to indemnify a director, officer, or employee of the insurer which expense, if allowed, is a Class 7 claim;

(b) a Class 2 claim, which:

(i) is a reasonable expense of a guaranty association, including overhead, salaries, or other general administrative expenses allocable to the receivership such as:

(A) an administrative or claims handling expense;

(B) an expense in connection with arrangements for ongoing coverage; and

(C) in the case of a property and casualty guaranty association, a loss adjustment expense, including:

(I) an adjusting or other expense; and

(II) a defense or cost containment expense; and

(ii) excludes an expense incurred in the performance of duties under Section 31A-28-112 or similar duties under the statute governing a similar organization in another state;

(c) a Class 3 claim, which:
(i) is:
(A) a claim under a policy of insurance including a third party claim;
(B) a claim under an annuity contract or funding agreement;
(C) a claim under a nonassessable policy for unearned premium;
(D) a claim of an obligee and, subject to the discretion of the receiver, a completion contractor under a surety bond or surety undertaking, except for:
(I) a bail bond;
(II) a mortgage guaranty;
(III) a financial guaranty; or
(IV) other form of insurance offering protection against investment risk or warranties;
(E) a claim by a principal under a surety bond or surety undertaking for wrongful dissipation of collateral by the insurer or its agents;
(F) an indemnity payment on:
(I) a covered claim;
(II) unearned premium; or
(III) a payment for the continuation of coverage made by an entity responsible for the payment of a claim or continuation of coverage of an insolvent health maintenance organization;
(G) a claim incurred during the extension of coverage provided for in Sections 31A-27a-402 and 31A-27a-403; or
(H) all other claims incurred in fulfilling the statutory obligations of a guaranty association not included in Class 2, including:
(I) an indemnity payment on covered claims; and
(II) in the case of a life and health guaranty association, a claim:
(Aa) as a creditor of the impaired or insolvent insurer for a payment of and liabilities incurred on behalf of a covered claim or covered obligation of the insurer; and
(Bb) for the funds needed to reinsure the obligations described under this Subsection (2)(c)(i)(H)(II) with a solvent insurer; and
(ii) notwithstanding any other provision of this chapter, excludes the following which shall be paid under Class 7, except as provided in this section:
(A) an obligation of the insolvent insurer arising out of a reinsurance contract;
(B) an obligation that is incurred pursuant to an occurrence policy or reported pursuant to a claims made policy after:
(I) the expiration date of the policy;
(II) the policy is replaced by the insured;
(III) the policy is canceled at the insured's request; or
(IV) the policy is canceled as provided in this chapter;
(C) an obligation to an insurer, insurance pool, or underwriting association and the insurer's, insurance pool's, or underwriting association's claim for contribution, indemnity, or subrogation, equitable or otherwise, except for direct claims under a policy where the insurer is the named insured;
(D) an amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy, which shall be paid as a claim in Class 9;
(E) a tort claim of any kind against the insurer;

(F) a claim against the insurer for bad faith or wrongful settlement practices; and

(G) a claim of a guaranty association for assessments not paid by the insurer, which claims shall be paid as claims in Class 7; and

(iii) notwithstanding Subsection (2)(c)(ii)(B), does not exclude an unearned premium claim on a policy, other than a reinsurance agreement;

(d) a Class 4 claim, which is a claim under a policy for mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risk or warranties;

(e) a Class 5 claim, which is a claim of the federal government not included in Class 3 or 4;

(f) a Class 6 claim, which is a debt due an employee for services or benefits:

(i) to the extent that the expense:

(A) does not exceed the lesser of:

(I) $5,000; or

(II) two months' salary; and

(B) represents payment for services performed within one year before the day on which the initial order of receivership is issued; and

(ii) which priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees;

(g) a Class 7 claim, which is a claim of an unsecured creditor not included in Classes 1 through 6, including:

(i) a claim under a reinsurance contract;

(ii) a claim of a guaranty association for an assessment not paid by the insurer; and

(iii) other claims excluded from Class 3 or 4, unless otherwise assigned to Classes 8 through 13;

(h) subject to Subsection (3), a Class 8 claim, which is:

(i) a claim of a state or local government, except a claim specifically classified elsewhere in this section; or

(ii) a claim for services rendered and expenses incurred in opposing a formal delinquency proceeding;

(i) a Class 9 claim, which is a claim for penalties, punitive damages, or forfeitures, unless expressly covered under the terms of a policy of insurance;

(j) a Class 10 claim, which is, except as provided in Subsections 31A-27a-601(2) and 31A-27a-601(3), a late filed claim that would otherwise be classified in Classes 3 through 9;

(k) subject to Subsection (4), a Class 11 claim, which is:

(i) a surplus note;

(ii) a capital note;

(iii) a contribution note;

(iv) a similar obligation;

(v) a premium refund on an assessable policy; or

(vi) any other claim specifically assigned to this class;

(l) a Class 12 claim, which is a claim for interest on an allowed claim of Classes 1 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the liquidator and approved by the receivership court; and

(m) subject to Subsection (4), a Class 13 claim, which is a claim of a shareholder or other owner arising out of:

(i) the shareholder's or owner's capacity as shareholder or owner or any other capacity; and

(ii) except as the claim may be qualified in Class 3, 4, 7, or 12.

(3) To prove a claim described in Class 8, the claimant shall show that:

(a) the insurer that is the subject of the delinquency proceeding incurred the fee or expense on the basis of the insurer's best knowledge, information, and belief:

(i) formed after reasonable inquiry indicating opposition is in the best interests of the insurer;

(ii) that is well grounded in fact; and

(iii) is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law; and

(b) opposition is not pursued for any improper purpose, such as to harass, to cause unnecessary delay, or to cause needless increase in the cost of the litigation.

(4) (a) A claim in Class 11 is subject to a subordination agreement related to other claims in Class 11 that exist before the entry of a liquidation order.

(b) A claim in Class 13 is subject to a subordination agreement, related to other claims in Class 13 that exist before the entry of a liquidation order.

Amended by Chapter 297, 2011 General Session

31A-27a-702. Health maintenance organization claims.

(1) In the liquidation of a health maintenance organization, a claim for uncovered expenditures has priority over a Class 3 claim as provided for in Section 31A-27a-701.

(2) A claim other than one described in Subsection (1) shall follow the priority of distribution outlined in Section 31A-27a-701.

Enacted by Chapter 309, 2007 General Session

31A-27a-703. Partial and final distributions of assets.

(1) (a) With the approval of the receivership court, a liquidator may declare and pay:

(i) one or more partial distributions on claims as those claims are allowed; and

(ii) a final distribution.

(b) All claims allowed within a priority class shall be paid at substantially the same percentage.

(c) A distribution under this section to a guaranty association is not an advance under Section 31A-27a-704.

(2) In determining the percentage of distributions to be paid on a claim, the liquidator may consider:

(a) the estimated value of the insurer's property, including estimated reinsurance recoverables in connection with the insurer's estimated liabilities for:

(i) unpaid losses and loss expenses; and

(ii) incurred but not reported losses and loss expenses; and

(b) the estimated value of the insurer's liabilities, including estimated liabilities for:

(i) unpaid losses and loss expenses; and

(ii) incurred but not reported losses and loss expenses.

(3) Distribution of property in kind may be made at valuations set by agreement:

(a) between the liquidator and the creditor; and

(b) as approved by the receivership court.

(4) (a) Notwithstanding Subsection (1) and Part 6, Claims, the liquidator may pay benefits under a workers' compensation policy after the day on which the liquidation order is entered if:

(i) there is an acceptance of liability by the insurer, and no bona fide dispute exists;

(ii) payment is commenced before the entry of the liquidation order; and

(iii) future or past indemnity or medical payments are due.

(b) A claim payment under this Subsection (4) may continue until the applicable guaranty association:

(i) assumes responsibility for the claim payments; or

(ii) determines the claim is not a covered claim under its guaranty association law.

(c) A claim payment or related expense made under this Subsection (4) may be treated as early access distribution under Section 31A-27a-704 in accordance with an agreement with the guaranty association responsible for the payment.

Enacted by Chapter 309, 2007 General Session

31A-27a-704. Early access disbursements.

(1) As used in this section, "distributable assets" means general assets of the liquidation estate less:

(a) amounts reserved, to the extent necessary and appropriate, for the entire Subsection 31A-27a-701(2)(a) expenses of the liquidation through and after the liquidation's closure; and

(b) to the extent necessary and appropriate, reserves for distributions on claims other than those of an affected guaranty association falling within the priority classes of claims established in Subsection 31A-27a-701(2)(c).

(2) (a) An early access payment to an affected guaranty association shall be made:

(i) as soon as possible after the day on which a liquidation order is entered;

(ii) as frequently as possible after the first early access payment, but at least annually if there are distributable assets available to be distributed to the affected guaranty association; and

(iii) in an amount consistent with this section.

(b) An amount advanced to an affected guaranty association pursuant to this section shall be accounted for as an advance against distributions to be made under Section 31A-27a-703.

(c) (i) Subject to Subsection (2)(c)(ii), if sufficient distributable assets are available, amounts advanced need not be limited to the claims and expenses paid to

date by the affected guaranty association.

(ii) Notwithstanding Subsection (2)(c)(i), the liquidator may not distribute distributable assets to an affected guaranty association in excess of the anticipated entire claims of the affected guaranty association falling within the priority classes of claims established in Subsections 31A-27a-701(2)(b) and 31A-27a-701(2)(c).

(3) (a) Within 180 days after the day on which an order of liquidation is entered by the receivership court, and at least annually after that date, the liquidator shall:

(i) apply to the receivership court for approval to make early access payments out of the general assets of the insurer to an affected guaranty association having an obligation arising in connection with the liquidation; or

(ii) report that the liquidator has determined that there are no distributable assets at that time based on financial reporting as required in Section 31A-27a-117.

(b) The liquidator may apply to the receivership court for approval to make early access payments more frequently than annually based on additional information or the recovery of material assets.

(4) Within 60 days after the day on which the receivership court approves an application under Subsection (3), the liquidator shall make an early access payment to an affected guaranty association as indicated in the approved application.

(5) (a) Notice of each application for early access payments, or of a report required pursuant to this section, shall be given in accordance with Section 31A-27a-107 to the affected guaranty associations.

(b) Notwithstanding Section 31A-27a-107, the liquidator shall provide the affected guaranty associations described in Subsection (5)(a) with at least 30 days actual notice of the filing of the application with a complete copy of the application before any action by the receivership court.

(c) An affected guaranty association may:

(i) request additional information from the liquidator, who may not unreasonably deny the request; and

(ii) object as provided in Section 31A-27a-107 to:

(A) any part of each application; or

(B) any report filed by the liquidator pursuant to this section.

(6) In each application regarding early access payments, the liquidator shall, based on the best information available to the liquidator at the time of the application, provide at a minimum:

(a) to the extent necessary and appropriate, the amount reserved for:

(i) the entire expenses of the liquidation through and after the liquidation's closure; and

(ii) distributions on claims falling within the priority classes of claims established in Subsections 31A-27a-701(2)(b) and (2)(c);

(b) the calculation of distributable assets;

(c) the amount and method of equitable allocation of early access payments to each affected guaranty association; and

(d) the most recent financial information filed with the receivership court by the liquidator.

(7) (a) Each affected guaranty association that receives a payment pursuant to this section agrees, upon depositing the payment in any account to its benefit, to return

to the liquidator any amount of these payments that may be required to pay:

(i) a claim of a secured creditor; or

(ii) a claim falling within the priority classes of claims established in Subsection 31A-27a-701(2)(a), (2)(b), or (2)(c).

(b) A bond may not be required of an affected guaranty association.

(8) Without the consent of an affected guaranty association or an order of the receivership court, the liquidator may not offset the amount to be disbursed to the affected guaranty association by the amount of any special deposit, any other statutory deposit, or any asset of the insolvent insurer held in that state unless the affected guaranty association actually receives the deposit or asset.

Enacted by Chapter 309, 2007 General Session

31A-27a-705. Unclaimed and withheld funds.

(1) (a) If any funds of the receivership estate remain unclaimed after the final distribution under Section 31A-27a-703, the funds shall be placed in a segregated unclaimed funds account held by the commissioner.

(b) If the owner of any of the funds described in Subsection (1)(a) presents proof of ownership satisfactory to the commissioner within two years after the day on which the delinquency proceeding terminates, the commissioner shall remit the funds to the owner.

(c) The interest earned on funds held in the unclaimed funds account may be used to pay any administrative costs related to the handling or return of unclaimed funds.

(2) (a) If any amounts held in the unclaimed funds account remain unclaimed for two years after the day on which the delinquency proceeding terminates, the commissioner may file a motion for an order directing the disposition of the funds in the court in which the delinquency proceeding was pending.

(b) Any costs incurred in connection with the motion made under this Subsection (2) may be paid from the unclaimed funds account.

(c) A motion under this Subsection (2) shall identify:

(i) the name of the insurer;

(ii) the names and last-known addresses of the one or more persons entitled to the unclaimed funds, if known; and

(iii) the amount of the funds.

(d) Notice of the motion shall be given as directed by the court.

(e) Upon a finding by the court that the funds have not been claimed within two years after the day on which the delinquency proceeding terminates:

(i) the court shall order that a claim for unclaimed funds, and any interest earned on the claim that has not been expended under Subsection (1), is abandoned; and

(ii) the funds shall be disbursed under one of the following methods, the amounts may be:

(A) deposited in the general receivership expense account under Subsection (3);

(B) transferred to the state treasurer and deposited into the General Fund; or

(C) (I) used to reopen the receivership in accordance with Section 31A-27a-803;

and

(II) distributed to the known claimants with approved claims.

(3) The commissioner may establish an account for the following purposes:

(a) to pay general expenses related to the administration of receiverships; or

(b) to advance funds to a receivership that does not have sufficient cash to pay its operating expenses.

(4) Any advance to a receivership estate under Subsection (3)(b) may be treated:

(a) as a claim under Section 31A-27a-701 as may be agreed at the time the advance is made; or

(b) in the absence of an agreement described in Subsection (4)(a), in a priority determined to be appropriate by the receivership court.

(5) If the commissioner determines at any time that the funds in the account created in Subsection (3) exceed the amount required, the commissioner may transfer the funds or any part of the funds to the state treasurer, and the transferred funds shall be deposited into the General Fund.

Enacted by Chapter 309, 2007 General Session

31A-27a-801. Condition on release from delinquency proceedings.

(1) Unless otherwise provided in a plan approved by the guaranty associations, an insurer that is subject to a rehabilitation proceeding may not take an action listed in Subsection (2) until all payments by all guaranty associations of or on account of the insurer's contractual obligations are repaid to the guaranty associations with:

(a) all expenses related to the payments by all guaranty associations of or on account of the insurer's contractual obligations; and

(b) interest on all the payments.

(2) Until an insurer that is subject to a rehabilitation proceeding complies with Subsection (1), the insurer may not:

(a) be permitted to:

(i) solicit or accept new business; or

(ii) request or accept the restoration of any suspended or revoked license or certificate of authority;

(b) be returned to the control of its shareholders or private management; or

(c) have any of its assets returned to the control of its shareholders or private management.

Enacted by Chapter 309, 2007 General Session

31A-27a-802. Discharge of liquidator and termination of liquidation proceedings.

(1) When all property justifying the expense of collection and distribution is collected and distributed under this chapter, the liquidator shall apply to the receivership court for an order discharging the liquidator and terminating the proceeding.

(2) The receivership court may grant the application and make any other orders, including orders to:

(a) transfer any remaining funds that are uneconomic to distribute; or
(b) pursuant to Subsection 31A-27a-703(3), assign an asset that remains unliquidated, including a claim or cause of action, as may be considered appropriate.

Enacted by Chapter 309, 2007 General Session

31A-27a-803. Reopening liquidation.
(1) After a liquidation proceeding is terminated and the liquidator discharged, the commissioner may at any time petition the court that was the receivership court to reopen the proceedings for good cause, including the discovery of additional property.
(2) If the court is satisfied that there is justification for reopening the proceedings, the court shall order the proceedings reopened.

Enacted by Chapter 309, 2007 General Session

31A-27a-804. Disposition of records during and after termination of liquidation.
(1) Whenever it appears to the receiver that records of the insurer in receivership are no longer useful, the receiver may recommend to the receivership court, and the receivership court shall direct what records shall be destroyed.
(2) (a) If the receiver determines that records should be maintained after the closing of the delinquency proceeding, the receiver may reserve property from the receivership estate for the maintenance of the records.
(b) Any amounts retained under this Subsection (2) are an administrative expense of the estate under Subsection 31A-27a-701(2)(a).
(c) Any records retained pursuant to this Subsection (2) shall be transferred to the custody of the commissioner, and the commissioner may retain or dispose of the records as appropriate, at the commissioner's discretion.
(d) Records of a delinquent insurer that are transferred to the commissioner:
(i) may not be considered a record of the department for any purpose; and
(ii) are not subject to Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 382, 2008 General Session

31A-27a-805. External audit of the receiver's books.
(1) As used in this section, "books" means:
(a) the business operations of the receiver;
(b) the accounting systems and procedures of the receiver; and
(c) the financial records of the receiver.
(2) (a) The receivership court may, as it considers desirable, order an audit to be made of the books of the receiver relating to any receivership established under this chapter.
(b) A report of each audit under this Subsection (1) shall be filed with:
(i) the commissioner; and
(ii) the receivership court.

(3) The books of the receivership shall be made available to the auditor at any time without notice.

(4) The expense of each audit shall be considered a cost of administration of the receivership.

Enacted by Chapter 309, 2007 General Session

31A-27a-901. Ancillary conservation of foreign insurers.

(1) The commissioner may initiate an action against a foreign insurer pursuant to Section 31A-27a-201 on any of the grounds stated in that section or on the basis that:

(a) any of the foreign insurer's property is sequestered, garnished, or seized by official action in its domiciliary state or in any other state;

(b) (i) the foreign insurer's certificate of authority to do business in this state is revoked or a certificate of authority is never issued; and

(ii) there is a resident of this state with an unpaid claim or in-force policy; or

(c) it is necessary to enforce a stay under Chapter 28, Guaranty Associations.

(2) If a domiciliary receiver is appointed, the commissioner may initiate an action against a foreign insurer under this section only with the consent of the domiciliary receiver.

(3) (a) An order entered pursuant to this section shall appoint the commissioner as conservator.

(b) The conservator's title to assets shall be limited to the insurer's property and records located in this state.

(4) (a) Notwithstanding Subsection 31A-27a-201(3), the conservator shall hold and conserve the assets located in this state until:

(i) the commissioner in the insurer's domiciliary state appoints its receiver; or

(ii) an order terminating conservation is entered under Subsection (7).

(b) Once a domiciliary receiver is appointed, the conservator shall turn over to the domiciliary receiver all property subject to an order under this section.

(5) The conservator may liquidate the property of the insurer that may be necessary to cover the costs incurred in the initiation or administration of a proceeding under this section.

(6) (a) The court in which an action under this section is pending may issue a finding of insolvency or an ancillary liquidation order.

(b) An ancillary liquidation order shall be entered for the limited purposes of:

(i) liquidating assets in this state to pay costs under Subsection (5); or

(ii) activating applicable guaranty associations in this state to pay valid claims that are not being paid by the insurer.

(7) The conservator may at any time petition the receivership court for an order terminating an order entered under this section.

Enacted by Chapter 309, 2007 General Session

31A-27a-902. Domiciliary receivers appointed in other states.

(1) (a) A domiciliary receiver appointed in another state is vested by operation of

law with title to, and may summarily take possession of, all property and records of the insurer in this state.

(b) Notwithstanding any other provision of law regarding special deposits, a special deposit held in this state for a guaranty association in this state as the only beneficiary shall be, upon the entry of an order of liquidation with a finding of insolvency, distributed to the guaranty association in this state as early access distributions, subject to Section 31A-27a-704, in relation to the lines of business for which the special deposit is made.

(c) The holder of a special deposit shall account to the domiciliary receiver for all distributions from the special deposit at the time of the distribution.

(d) The following shall be given full faith and credit in this state:

(i) a statutory provision of another state;

(ii) an order entered by a court of competent jurisdiction in relation to the appointment of a domiciliary receiver of an insurer; and

(iii) a related proceeding in another state.

(e) For purposes of this chapter, another state means any state other than this state.

(f) This state shall treat all foreign states as reciprocal states.

(2) The commissioner shall immediately transfer title to and possession of all property of the insurer under the commissioner's control to a domiciliary receiver:

(a) upon appointment of the domiciliary receiver in another state;

(b) unless otherwise agreed by the domiciliary receiver; and

(c) including all statutory general or special deposits other than special deposits where that state's guaranty association is the only beneficiary.

(3) (a) Except as provided in Subsection (1), the domiciliary receiver shall handle a special deposit or special deposit claim in accordance with the statutes pursuant to which the special deposit is required and applicable federal law.

(b) All amounts in excess of the estimated amount necessary to administer the special deposit and pay the unpaid special deposit claims shall be considered general assets of the estate.

(c) (i) Subject to Subsection (3)(c)(ii), if there is a deficiency in a special deposit so that a claim secured by the special deposit is not fully discharged from the special deposit, the claimant may share in the general assets of the insurer to the extent of the deficiency at the same priority as other claimants in the claimant's class of priority under Section 31A-27a-701.

(ii) The sharing described in Subsection (3)(c)(i) shall be deferred until the other claimants of the class are paid percentages of their claims equal to the percentage paid from the special deposit.

(iii) The intent of Subsection (3)(c)(ii) is to equalize to the extent provided in this Subsection (3) the advantage gained by the security provided by the special deposit.

Enacted by Chapter 309, 2007 General Session

31A-28-101. Title.

This part is known as the "Utah Life and Health Insurance Guaranty Association Act."

Amended by Chapter 185, 2002 General Session

31A-28-102. Purpose.

(1) The purpose of this part is to protect, subject to certain limitations, the persons specified in Subsection 31A-28-103(1) against failure in the performance of contractual obligations, under a life and accident and health insurance policy or annuity contract specified in Subsection 31A-28-103(2), because of the impairment or insolvency of the member insurer that issued the policy or contract.

(2) To provide the protection described in Subsection (1):

(a) the Utah Life and Health Insurance Guaranty Association, which currently exists, is continued to pay benefits and to continue coverages as limited by this part; and

(b) members of the association are subject to assessment to provide funds to carry out the purpose of this part.

Amended by Chapter 116, 2001 General Session
Amended by Chapter 161, 2001 General Session

31A-28-103. Coverage and limitations.

(1) (a) This part provides coverage for a policy or contract specified in Subsection (2) to a person who is:

(i) a beneficiary, assignee, or payee of a person covered by Subsection (1)(a)(ii) regardless of where that person resides, except for a nonresident certificate holder under a group policy or contract; or

(ii) an owner of or a certificate holder under a policy or contract, other than an unallocated annuity contract or structured settlement annuity, if the owner or certificate holder is:

(A) a resident of Utah; or

(B) not a resident of Utah, but only if:

(I) the insurer that issued the policy or contract is domiciled in this state;

(II) the state in which the person resides has an association similar to the association created by this part; and

(III) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the state at the time specified in the state's guaranty association's law.

(b) For an unallocated annuity contract specified in Subsection (2):

(i) Subsection (1)(a) does not apply; and

(ii) except as provided in Subsections (1)(d) and (1)(e), this part provides coverage for the unallocated annuity contract specified in Subsection (2) to a person who is:

(A) the owner of the unallocated annuity contract if the contract is issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(B) an owner of an unallocated annuity contract issued to or in connection with a government lottery if the owner is a resident.

(c) For a structured settlement annuity specified in Subsection (2):

(i) Subsection (1)(a) does not apply; and

(ii) except as provided in Subsections (1)(d) and (1)(e), this part provides coverage for the structured settlement annuity specified in Subsection (2) to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) is a resident, regardless of where the contract owner resides; or

(B) is not a resident, but only if one or more of the contract owners of the structured settlement annuity is a resident, or no contract owner of the structured settlement annuity is a resident, but:

(I) the insurer that issued the structured settlement annuity is domiciled in this state;

(II) the state in which the contract owner resides has an association similar to the association created by this part; and

(III) the payee, beneficiary, or the contract owner is not eligible for coverage by the association of the state in which the payee or contract owner resides.

(d) This part may not provide coverage for a policy or contract specified in Subsection (2) to:

(i) a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or

(ii) a person covered under Subsection (1)(b), if any coverage is provided to the person by the association of another state.

(e) (i) This part provides coverage for a policy or contract specified in Subsection (2) to a person who is a resident of this state and, in special circumstances, to a nonresident.

(ii) To avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person may not be provided coverage under this part.

(iii) In determining the application of this Subsection (1)(e) when a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one association.

(2) (a) (i) Except as limited by this part, this part provides coverage to a person specified in Subsection (1) for:

(A) a direct, nongroup life, accident and health, or annuity policy or contract;

(B) a supplemental contract to a policy or contract described in Subsection (2)(a)(i)(A);

(C) a certificate under a direct group policy or contract; and

(D) an unallocated annuity contract issued by a member insurer.

(ii) For purposes of Subsection (2)(a)(i), an annuity contract and a certificate under a group annuity contract includes:

(A) a guaranteed investment contract;

(B) a deposit administration contract;

(C) an unallocated funding agreement;

(D) an allocated funding agreement;

(E) a structured settlement annuity;
(F) an annuity issued to or in connection with a government lottery; and
(G) an immediate or deferred annuity contract.
(b) This part does not provide coverage for:
(i) a portion of a policy or contract:
(A) not guaranteed by the insurer; or
(B) under which the risk is borne by the policy or contract owner;
(ii) a policy or contract of reinsurance, unless:
(A) an assumption certificate is issued before the coverage date;
(B) the assumption certificate required by Subsection (2)(b)(ii)(A) is in effect pursuant to the reinsurance policy or contract; and
(C) the reinsurance contract is approved by the appropriate regulatory authorities;
(iii) a portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value, if the interest rate, crediting rate, or similar factor:
(A) is not excluded from coverage by Subsection (2)(b)(xi);
(B) averaged over the period of four years before the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged:
(I) for that same four-year period; or
(II) for the corresponding lesser period if the policy or contract was issued less than four years before the association became obligated; and
(C) exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available as determined on or after the earlier of the day on which the member insurer becomes:
(I) an impaired insurer under this part; or
(II) an insolvent insurer under this part;
(iv) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, accident and health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or other person under:
(A) a multiple employer welfare arrangement as defined in 29 U.S.C. Sec. 1144;
(B) a minimum premium group insurance plan;
(C) a stop-loss group insurance plan; or
(D) an administrative services only contract;
(v) a portion of a policy or contract to the extent that it provides:
(A) a dividend;
(B) an experience rating credit;
(C) voting rights; or
(D) payment of a fee or allowance to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
(vi) an unallocated annuity contract issued to or in connection with a benefit plan

protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payment with respect to the benefit plan;

(vii) a portion of an unallocated annuity contract that is not issued to or in connection with:

(A) a specific benefit plan of:

(I) employees;

(II) a union; or

(III) an association of natural persons; or

(B) a government lottery;

(viii) a portion of a policy or contract to the extent that the assessment required by Section 31A-28-109 that applies to the policy or contract is preempted by federal or state law;

(ix) an obligation that does not arise under the express written terms of the policy or contract issued by an insurer to the contract owner or policy owner, including:

(A) a claim based on marketing materials;

(B) a claim based on a side letter, rider, or other document that is issued by the insurer without meeting applicable policy form filing or approval requirements;

(C) a misrepresentation regarding a policy benefit;

(D) an extra-contractual claim;

(E) a claim for penalties; or

(F) a claim for consequential or incidental damages;

(x) a contract that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by a person that is:

(A) (I) the benefit plan; or

(II) the benefit plan's trustee; and

(B) not an affiliate of the member insurer;

(xi) a portion of a policy or contract to the extent it provides for interest or other changes in value:

(A) to be determined by the use of an index or other external reference stated in the policy or contract; and

(B) (I) that have not been credited to the policy or contract; or

(II) as to which the policy or contract owner's rights are subject to forfeiture as of the date the member insurer becomes an impaired or insolvent insurer under this part; and

(xii) a policy providing hospital, medical, prescription drug, or other health care benefit pursuant to United States Code, Title 42, Subchapter XVIII, Chapter 7, Part C or D, or federal regulations issued under Part C or D.

(3) Subject to Subsection (4), the benefits for which the association may become liable may not exceed the lesser of:

(a) the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(b) with respect to one life, regardless of the number of policies or contracts:

(i) for a life insurance policy:

(A) if the insured died before the coverage date, $500,000 of the death benefit;

(B) if the insurer received a valid request for cash surrender before the coverage date but has not paid the cash surrender value before the coverage date, $200,000 of cash surrender benefits; or

(C) if neither Subsection (3)(b)(i)(A) nor (B) apply, the covered portion of each benefit provided under the policy;

(ii) for an annuity contract, the covered portion of each benefit provided under the contract;

(iii) for an accident and health policy:

(A) classified as health insurance, $500,000; or

(B) not classified as health insurance, the covered portion of each benefit provided under the policy;

(c) for an individual, or a beneficiary of that individual if the individual is deceased, participating in a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code, covered by an unallocated annuity contract, in the aggregate, $250,000 in present value of annuity benefits, including:

(i) net cash surrender; and

(ii) net cash withdrawal values; or

(d) for a payee of a structured settlement annuity or a beneficiary of the payee if the payee is deceased, the limits set forth in Subsection (3)(b).

(4) Notwithstanding Subsections (3)(a) through (d), the association may not be obligated to cover more than:

(a) an aggregate of $500,000 in benefits for any one life under:

(i) Subsection (3)(b)(i)(A);

(ii) Subsection (3)(b)(i)(B);

(iii) Subsection (3)(b)(ii); and

(iv) Subsection (3)(b)(iii)(B);

(b) $5,000,000 in benefits for one owner of multiple nongroup policies of life insurance:

(i) whether the policy owner is an individual, firm, corporation, or other person;

(ii) whether the persons insured are officers, managers, employees, or other persons; and

(iii) regardless of the number of policies and contracts held by the owner; and

(c) $5,000,000 in benefits, regardless of the number of contracts held by the contract owner or plan sponsor, for:

(i) one contract owner provided coverage under Subsection (1)(b)(ii)(B); or

(ii) one plan sponsor whose plans own, directly or in trust, one or more unallocated annuity contracts not included in Subsection (3)(b)(ii).

(5) (a) Notwithstanding Subsection (4)(c) and except as provided in Subsection (5)(b), the association shall provide coverage if one or more unallocated annuity contracts are:

(i) covered contracts under this part;

(ii) owned by a trust or other entity for the benefit of two or more plan sponsors; and

(iii) the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in the state.

(b) Notwithstanding Subsection (5)(a) the association may not be obligated to

cover more than $5,000,000 in benefits with respect to the unallocated contracts described in Subsection (5)(a).

(6) (a) The limitations set forth in Subsections (3) and (4) are limitations on the benefits for which the association is obligated before taking into account:

(i) the association's subrogation and assignment rights; or

(ii) the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies.

(b) The costs of the association's obligations under this part may be met by the use of assets:

(i) attributable to covered policies, as described in Subsection 31A-28-114(3)(c); or

(ii) reimbursed to the association pursuant to the association's subrogation and assignment rights.

(c) On and after the date on which the association becomes obligated for a covered policy, the association may not be obligated to provide benefits to the extent that the benefits are based on an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value if the interest rate, crediting rate, or similar factor exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available on each date on which interest is credited or attributed to the covered policy.

(d) In performing its obligations to provide coverage under Section 31A-28-108, the association may not be required to guarantee, assume, reinsure, perform, or cause to be guaranteed, assumed, reinsured, or performed a contractual obligation of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract.

Amended by Chapter 292, 2010 General Session

31A-28-104. Construction.

This part shall be construed to effect the purposes under Section 31A-28-102.

Amended by Chapter 161, 2001 General Session

31A-28-105. Definitions.

As used in this part:

(1) "Association" means the Utah Life and Health Insurance Guaranty Association continued under Section 31A-28-106.

(2) (a) "Authorized assessment" or "authorized," when used in the context of assessments, means that the board of directors passed a resolution whereby an assessment will be called immediately or in the future from member insurers for an amount set forth in the resolution.

(b) An assessment is authorized when the resolution is passed.

(3) "Benefit plan" means a specific benefit plan of:

(a) employees;

(b) a union; or

(c) an association of natural persons.

(4) (a) "Called assessment" or "called," when used in the context of assessments, means that the association issued a notice to member insurers requiring that an authorized assessment be paid within the time frame set forth in the notice.

(b) All or part of an authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(5) "Cash surrender value" means the cash surrender value without reduction for an outstanding policy loan or surrender charge.

(6) "Contractual obligation" means an obligation under any of the following for which coverage is provided under Section 31A-28-103:

(a) a policy or contract;

(b) a certificate under a group policy or contract; or

(c) a portion of a policy or contract.

(7) "Coverage date" means the date on which the association becomes responsible for the obligations of a member insurer.

(8) "Covered policy" means any of the following for which coverage is provided in Section 31A-28-103:

(a) a policy or contract; or

(b) a portion of a policy or contract.

(9) (a) "Covered portion" means:

(i) for a covered policy that has a cash surrender value, a fraction calculated with:

(A) the numerator being the lesser of:

(I) (Aa) $200,000 for a life insurance policy; and

(Bb) $250,000 for a covered policy that is not a life insurance policy; or

(II) the cash surrender value of the policy; and

(B) the denominator being the cash surrender value of the policy; and

(ii) for a covered policy that does not have a cash surrender value, a fraction calculated with:

(A) the numerator being the lesser of:

(I) (Aa) $200,000 for a life insurance policy; or

(Bb) $250,000 for a covered policy that is not a life insurance policy; or

(II) the policy's minimum statutory reserve; and

(B) the denominator being the policy's minimum statutory reserve.

(b) The cash surrender value and the minimum statutory reserve are determined as of the coverage date in accordance with the exclusions in Subsection 31A-28-103(2)(b)(iii).

(10) "Extra-contractual claim" includes a claim relating to:

(a) bad faith in the payment of a claim;

(b) punitive or exemplary damages; or

(c) attorney fees and costs.

(11) "Impaired insurer" means a member insurer that is not an insolvent insurer and:

(a) is considered by the commissioner to be hazardous pursuant to this title; or

(b) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(12) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(13) (a) "Member insurer" means an insurer that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 31A-28-103.

(b) "Member insurer" includes an insurer whose license or certificate of authority in this state may have been:

(i) suspended;

(ii) revoked;

(iii) not renewed; or

(iv) voluntarily withdrawn.

(c) "Member insurer" does not include:

(i) a for-profit or nonprofit:

(A) hospital;

(B) hospital service organization; or

(C) medical service organization;

(ii) a health maintenance organization;

(iii) a fraternal benefit society;

(iv) a mandatory state pooling plan;

(v) a mutual assessment company or other person that operates on an assessment basis;

(vi) an insurance exchange;

(vii) an organization described in Subsection 31A-22-1305(2); or

(viii) an entity similar to an entity described in Subsections (13)(c)(i) through (vii).

(14) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor to Moody's Investors Service, Inc.

(15) (a) "Owner" of a policy or contract, "policy owner," or "contract owner" means a person who:

(i) is identified as the legal owner under the terms of the policy or contract; or

(ii) is otherwise vested with legal title to the policy or contract through a valid assignment:

(A) completed in accordance with the terms of the policy or contract; and

(B) properly recorded as the owner on the books of the insurer.

(b) "Owner," "policy owner," or "contract owner" does not include a person with only a beneficial interest in a policy or contract.

(16) "Person" means:

(a) an individual;

(b) a corporation;

(c) a limited liability company;

(d) a partnership;

(e) an association;

(f) a governmental body or entity;

(g) a trust; or

(h) a voluntary organization.

(17) "Plan sponsor" means:

(a) the employer, in the case of a benefit plan established or maintained by a single employer;

(b) the employee organization, in the case of a benefit plan established or maintained by an employee organization; or

(c) the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain a benefit plan, in the case of a benefit plan established or maintained by:

(i) two or more employers; or

(ii) jointly by:

(A) one or more employers; and

(B) one or more employee organizations.

(18) (a) "Premiums" means an amount or consideration received on covered policies or contracts, less:

(i) returned:

(A) premiums;

(B) considerations; and

(C) deposits; and

(ii) dividends and experience credits.

(b) (i) "Premiums" does not include an amount or consideration received for:

(A) a policy or contract for which coverage is not provided under Subsection 31A-28-103(2); or

(B) the portion of a policy or contract for which coverage is not provided under Subsection 31A-28-103(2).

(ii) Notwithstanding Subsection (18)(b)(i), an assessable premium may not be reduced on account of:

(A) Subsection 31A-28-103(2)(b)(iii) relating to interest limitations; and

(B) Subsection 31A-28-103(3) relating to limitations for:

(I) one individual;

(II) any one participant; and

(III) any one contract owner.

(c) "Premiums" does not include premiums in excess of $5,000,000:

(i) on an unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code; or

(ii) for multiple nongroup policies of life insurance owned by one owner:

(A) whether the policy owner is an individual, firm, corporation, or other person;

(B) whether the persons insured are officers, managers, employees, or other persons; and

(C) regardless of the number of policies or contracts held by the owner.

(19) (a) Except as provided in Subsection (19)(b), "principal place of business" of a plan sponsor or a person other than a natural person means the single state:

(i) in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise the function; and

(ii) determined by the association in its reasonable judgment by considering the following factors:

(A) the state in which the primary executive and administrative headquarters of the entity are located;

(B) the state in which the principal office of the chief executive officer of the entity is located;

(C) the state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(D) the state in which the executive or management committee of the board of directors, or similar governing person, of the entity conducts the majority of its meetings;

(E) the state from which the management of the overall operations of the entity is directed; and

(F) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors described in Subsections (19)(a)(ii)(A) through (E).

(b) Notwithstanding Subsection (19)(a), in the case of a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, the state where more than 50% of the participants are employed is considered to be the principal place of business of the plan sponsor.

(c) (i) The principal place of business of a plan sponsor of a benefit plan described in Subsection (3) is considered to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(ii) If for a benefit plan described in Subsection (3) there is not a specific or clear designation of a principal place of business under Subsection (19)(c)(i), the principal place of business is considered to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan.

(20) "Receiver" means, as the context requires:

(a) a rehabilitator;

(b) a liquidator;

(c) an ancillary receiver; or

(d) a conservator.

(21) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(22) (a) "Resident" means a person:

(i) to whom a contractual obligation is owed; and

(ii) who resides in this state on the earlier of the date a member insurer is an:

(A) impaired insurer; or

(B) insolvent insurer.

(b) A person may be a resident of only one state, which in the case of a person other than a natural person is where its principal place of business is located.

(c) A citizen of the United States that is either a resident of a foreign country or a resident of a United States possession, territory, or protectorate that does not have an association similar to the association created by this part, is considered a resident of the state of domicile of the insurer that issued the policy or contract.

(23) "State" means:
(a) a state;
(b) the District of Columbia;
(c) Puerto Rico; and
(d) a United States possession, territory, or protectorate.
(24) "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for personal injury suffered by the plaintiff or other claimant.
(25) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a policy or contract for:
(a) life;
(b) accident and health; or
(c) annuity.
(26) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Amended by Chapter 292, 2010 General Session

31A-28-106. Continuation of the association -- Association duties -- Allocation of assessments -- Not agency of state.

(1) (a) There is continued under this part the nonprofit legal entity known as the Utah Life and Health Insurance Guaranty Association created under former provisions of this title.
(b) All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state.
(c) The association shall:
(i) perform its functions under the plan of operation established and approved under Section 31A-28-110; and
(ii) exercise its powers through a board of directors established under Section 31A-28-107.
(d) The association shall allocate assessments among the following classes or subclasses:
(i) the life insurance and annuity class, which includes the following subclasses:
(A) the life insurance subclass;
(B) the annuity subclass:
(I) which includes annuity contracts owned by a governmental retirement plan, or its trustee, established under Section 401, 403(b), or 457, Internal Revenue Code; and
(II) otherwise excludes unallocated annuities; and
(C) the unallocated annuity subclass, which excludes contracts owned by a governmental retirement benefit plan, or its trustee, established under Sections 401, 403(b), or 457, Internal Revenue Code; and
(ii) the accident and health insurance class.
(2) (a) The association shall:

(i) come under the immediate supervision of the commissioner; and
(ii) be subject to the applicable provisions of the insurance laws of this state.
(b) Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.
(3) The association is not an agency of the state.

Amended by Chapter 320, 2006 General Session

31A-28-107. Board of directors.
(1) (a) The board of directors of the association shall consist of:
(i) at least five but not more than nine member insurers who:
(A) subject to Subsection (1)(e), serve terms as established in the plan of operation; and
(B) are selected by member insurers, subject to the approval of the commissioner; and
(ii) two public representatives appointed by the commissioner.
(b) (i) The commissioner shall make the appointment of a public representative coincide with the association's annual meeting at which the association's board of directors is elected.
(ii) A public representative may not be:
(A) an officer, director, or employee of an insurer; or
(B) a person engaged in the business of insurance.
(iii) Subject to Subsection (1)(e), a public representative shall serve a term of three years.
(c) When a vacancy occurs in the membership of the board of directors for any reason:
(i) if the vacancy is of a member insurer, a replacement may be elected for the unexpired term by a majority vote of the remaining board members, subject to the approval of the commissioner; and
(ii) if the vacancy is of a public representative, the commissioner shall appoint a replacement for the unexpired term.
(d) In approving a selection or in appointing a member to the board of directors, the commissioner shall consider, among other things, whether all member insurers are fairly represented.
(e) Notwithstanding Subsections (1)(a) and (b), the commissioner shall, at the time of election, reelection, appointment, or reappointment adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board of directors is selected during any two-year period.
(2) (a) A member of the board of directors may be reimbursed from the assets of the association for expenses incurred by the member as a member of the board of directors.
(b) A public representative appointed under Subsection (1)(a)(ii) may not receive compensation or benefits for the public representative's service, but in addition to reimbursement under Subsection (2)(a), a public representative may receive per diem and travel expenses established by the board with the approval of the commissioner.
(c) Except as provided in Subsections (2)(a) and (b), a member of the board of

directors may not be compensated by the association for the member's services.

Amended by Chapter 284, 2011 General Session

31A-28-108. Powers and duties of the association.

(1) (a) If a member insurer is an impaired insurer, subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, the association may provide the protections provided by this part.

(b) If the association makes the election described in Subsection (1)(a), the association may proceed under one or more of the options described in Subsection (3).

(2) If a member insurer is an insolvent insurer, the association shall provide the protections provided by this part by electing in its discretion to proceed under one or more of the options in Subsection (3).

(3) With respect to the covered portions of covered policies of an impaired or insolvent insurer, the association may:

(a) (i) (A) guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insurer; or

(B) assure payment of the contractual obligations of the insolvent insurer; and

(ii) provide the money, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(b) provide benefits and coverages in accordance with Subsection (4).

(4) (a) In accordance with Subsection (3)(b), the association may:

(i) 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 or contracts of the insurer, for claims incurred:

(A) with respect to group policies:

(I) not later than the earlier of the next renewal date under the policies or contracts or 45 days after the coverage date; and

(II) in no event less than 30 days after the coverage date; or

(B) with respect to nongroup policies or contracts:

(I) not later than the earlier of the next renewal date, if any, under the policies or contracts or one year from the coverage date; and

(II) in no event less than 30 days from the coverage date;

(ii) make diligent efforts to notify the following 30 days before any termination of the benefits that are provided under a policy or contract of the insurer:

(A) the known insureds or annuitants for nongroup policies and contracts;

(B) owners if other than an insured or annuitant; or

(C) group policy owners for group policies and contracts; and

(iii) with respect to nongroup life and accident and health insurance policies and annuities, make available substitute coverage on an individual basis, in accordance with Subsection (4)(b), to each known insured, annuitant, or owner and to each individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage on an individual basis in accordance with Subsection (4)(b), if the insured or annuitant had a right under law or the terminated policy or annuity contract to:

(A) convert coverage to individual coverage; or

(B) continue an individual policy in force until a specified age or for a specified time during which the insurer had:

(I) no right unilaterally to make changes in any provision of the policy; or

(II) a right only to make changes in premium by class.

(b) (i) In providing the substitute coverage required under Subsection (4)(a)(iii), the association may offer to:

(A) reissue the terminated coverage; or

(B) issue an alternative policy.

(ii) An alternative or reissued policy under Subsection (4)(b)(i):

(A) shall be offered without requiring evidence of insurability; and

(B) may not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(iii) The association may reinsure an alternative or reissued policy.

(c) (i) An alternative policy adopted by the association is subject to the approval of the commissioner.

(ii) The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(iii) An alternative policy:

(A) shall contain at least the minimum statutory provisions required in this state; and

(B) provide benefits that are not unreasonable in relation to the premium charged.

(iv) The association shall set the premium for an alternative policy in accordance with a table of rates that the association adopts. The premium shall reflect:

(A) the amount of insurance to be provided; and

(B) the age and class of risk of each insured.

(v) For an alternative policy issued under an individual policy of the impaired or insolvent insurer:

(A) age shall be determined in accordance with the original policy provisions; and

(B) class of risk is the class of risk under the original policy.

(vi) For an alternative policy issued to individuals insured under a group policy:

(A) age and class of risk shall be determined by the association in accordance with the alternative policy provisions and risk classification standards approved by the commissioner; and

(B) the premium may not reflect any changes in the health of the insured after the original policy was last underwritten.

(vii) An 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.

(d) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the association shall set the premium in accordance with the amount of insurance provided and the age and class of risk, subject to the approval of the commissioner or by a court of competent jurisdiction.

(e) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy ceases on

the date the coverage or policy is replaced by another similar policy by:

(i) the owner;

(ii) the insured; or

(iii) the association.

(f) (i) With respect to a claim unpaid as of the coverage date and a claim incurred during the period defined in Subsection (4)(a)(i), a provider of health care services, by accepting a payment from the association upon a claim of the provider against an insured whose health care insurer is an insolvent member insurer, agrees to forgive the insured of 20% of the debt which otherwise would be paid by the insurer had it not been insolvent, subject to a maximum of $8,000 being required to be forgiven by any one provider as to each claimant.

(ii) The obligations of a solvent insurer to pay all or part of the covered claim are not diminished by the forgiveness provided for in this section.

(5) When proceeding under Subsection (3)(b) 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 Subsection 31A-28-103(2)(b)(iii).

(6) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this part with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with this part.

(7) (a) Premium due after the coverage date with respect to the covered portion of a policy or contract of an impaired or insolvent insurer belongs to and is payable at the direction of the association. If a liquidator of an insolvent insurer requests the report, the association shall report to the liquidator the premium collected by the association.

(b) The association is liable to a policy or contract owner for unearned premiums due to the policy or contract owner arising after the coverage date with respect to the covered portion of the policy or contract.

(8) The protection provided by this part does not apply if any guaranty protection is provided to residents of this state by laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(9) In carrying out its duties under Subsection (2), and subject to approval by a court in this state, the association may:

(a) impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that:

(i) the amounts that 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

(ii) the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens to be in the public interest;

(b) 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; and

(c) if the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure:

(i) established by the receiver; and

(ii) approved by the receivership court.

(10) (a) A special deposit in this state held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, that is not turned over to the domiciliary receiver upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in any state shall be promptly paid to the association.

(b) Any amount paid under Subsection (10)(a) to the association less the amount retained by the association shall be treated as a distribution of estate assets pursuant to Sections 31A-27a-601, 31A-27a-602, and 31A-27a-701.

(11) If the association fails to act within a reasonable period of time as provided in this section, the commissioner has the powers and duties of the association under this part with respect to an impaired or insolvent insurer.

(12) The association may assist or advise the commissioner, upon the commissioner's request, concerning:

(a) rehabilitation;

(b) payment of claims;

(c) continuance of coverage; or

(d) the performance of other contractual obligations of any impaired or insolvent insurer.

(13) (a) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over:

(i) an impaired or insolvent insurer concerning which the association is or may become obligated under this part; or

(ii) any person or property against which the association may have rights through subrogation or otherwise.

(b) The standing referred to in Subsection (13)(a) extends to all matters germane to the powers and duties of the association, including:

(i) proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer; and

(ii) the determination of the policies or contracts and contractual obligations.

(c) The association has the right to appear or intervene before a court in another state with jurisdiction over:

(i) an impaired or insolvent insurer for which the association is or may become obligated; or

(ii) any person or property against which the association may have rights through subrogation of the insurer's policyowners.

(14) (a) A person receiving benefits under this part is considered to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this part, whether the benefits are payments of, or on account of:

(i) contractual obligations;

(ii) continuation of coverage; or

(iii) provision of substitute or alternative coverages.

(b) As a condition precedent to the receipt of any right or benefits conferred by this part upon that person, the association may require an assignment to it of the rights and causes of action described in Subsection (14)(a) by any:

(i) payee;

(ii) policy or contract owner;

(iii) beneficiary;

(iv) insured; or

(v) annuitant.

(c) The subrogation rights obtained by the association under this Subsection (14) 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.

(d) In addition to Subsections (14)(a) through (c), the association has the common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contract, including in the case of a structured settlement annuity any rights of the owner, beneficiary, or payee of the annuity to the extent of benefits received pursuant to this part against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment of the annuity.

(e) If a provision of this Subsection (14) is invalid or ineffective with respect to a person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion of the policies, covered by the association.

(f) If the association has provided benefits with respect to a covered policy and a person recovers amounts as to which the association has rights as described in this Subsection (14), the person shall pay to the association the portion of the recovery attributable to the covered policies.

(15) (a) In addition to the rights and powers elsewhere in this part, the association may:

(i) enter into a contract that is necessary or proper to carry out the provisions and purposes of this part;

(ii) sue or be sued, including taking any legal actions necessary or proper to:

(A) recover any unpaid assessments under Section 31A-28-109; and

(B) settle claims or potential claims against the association;

(iii) borrow money to effect the purposes of this part;

(iv) employ or retain the persons necessary or the appropriate staff members to:

(A) handle the financial transactions of the association; and

(B) perform other functions as become necessary or proper under this part;

(v) take necessary or appropriate legal action to avoid or recover payment of improper claims;

(vi) exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligation under this part;

(vii) request information from a person seeking coverage from the association to aid the association in determining the association's obligations under this part with respect to the person;

(viii) take other necessary or appropriate action to discharge the association's duties and obligations under this part or to exercise the association's powers under this part; and

(ix) act as a special deputy receiver if appointed by the commissioner.

(b) Any note or other evidence of indebtedness of the association under Subsection (15)(a)(iii) that is not in default:

(i) is a legal investment for a domestic insurer; and

(ii) may be carried as admitted assets.

(c) A person seeking coverage from the association shall promptly comply with a request for information by the association under Subsection (15)(a)(vii).

(16) 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.

(17) (a) At any time within 180 days after the coverage date, the association may elect to succeed to the rights and obligations of the member insurer that:

(i) accrue on or after the coverage date; and

(ii) relate to covered policies under any one or more indemnity reinsurance agreements:

(A) entered into by the member insurer as a ceding insurer and its reinsurer; and

(B) selected by the association.

(b) An election made pursuant to Subsection (17)(a) is effective as of the date of the order of liquidation.

(c) The association may make an election described in Subsection (17)(a) by notifying an affected reinsurer in writing, with verification of receipt, through:

(i) the association; or

(ii) a nationally recognized association representing state guaranty associations that is approved by the commissioner, that provides notice on behalf of the association.

(d) The association shall provide a copy of the notice described in Subsection (17)(c) to the receiver.

(e) (i) The receiver of an insolvent insurer and each reinsurer of the ceding member insurers shall make available as soon as possible after commencement of formal delinquency proceedings the information described in Subsection (17)(e)(ii) to:

(A) the association; or

(B) a nationally recognized association representing state guaranty associations that is approved by the commissioner, on behalf of the association.

(ii) This Subsection (17)(e) applies to:

(A) copies of in-force contracts of reinsurance and the related records relevant to the determination of whether the in-force contracts of reinsurance should be assumed;

(B) notices of any default under a reinsurance contract; or

(C) any known event or condition that with the passage of time could become a default under a reinsurance contract.

(f) If the association makes an election under Subsection (17)(a), the association shall comply with Subsections (17)(f)(i) through (vii) with respect to the agreements selected by the association.

(i) For a contract covered, in whole or in part, by the association, the association is responsible for:

(A) the unpaid premiums due under the agreements for periods both before and after the coverage date; and

(B) the performance of the other obligations to be performed after the coverage date.

(ii) The association may charge a contract covered in part by the association the costs for reinsurance in excess of the obligations of the association, through reasonable allocation methods.

(iii) The association shall provide notice and an accounting to the receiver of a charge made pursuant to Subsection (17)(f)(ii).

(iv) The association is entitled to any amounts payable by the reinsurer under the agreements with respect to a loss or event that:

(A) occurs after the coverage date; and

(B) relates to a contract covered by the association, in whole or in part.

(v) On receipt of any amounts under Subsection (17)(f)(iv), the association shall pay to the beneficiary under the policy or contract on account of which the amounts were paid an amount equal to the lesser of:

(A) the amount received by the association; and

(B) the excess of the amount received by the association over the benefits paid or payable by the association on account of the policy or contract less the retention of the insurer applicable to the loss or event.

(vi) (A) Within 30 days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to the items paid by either the member insurer, its receiver, or the indemnity reinsurer before the date of the association's election.

(B) Within five days of the completion of the calculation under Subsection (17)(f)(vi)(A):

(I) the reinsurer shall pay the receiver the amounts due for a loss or event before the coverage date, subject to any set-off for premiums unpaid for a period before the coverage date; and

(II) the association or the reinsurer shall pay any remaining balance due the other.

(C) A dispute over an amount due to either party shall be resolved:

(I) by arbitration pursuant to the terms of the affected reinsurance contract; or

(II) if the reinsurance contract contains no arbitration clause, as otherwise

provided by law.

(D) If the receiver receives an amount due the association pursuant to Subsection (17)(f)(iv), the receiver shall remit that amount to the association as promptly as practicable.

(vii) If the association, or the receiver on behalf of the association, within 60 days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer may not:

(A) terminate the reinsurance agreement for failure to pay premium, to the extent the reinsurance agreement relates to a policy or contract covered by the association, in whole or in part; and

(B) set off against amounts due the association an amount due:

(I) under another contract; or

(II) as an unpaid amount due from a person other than the association.

(g) (i) This Subsection (17)(g) applies during the period that:

(A) begins on the coverage date; and

(B) ends:

(I) on the election date; or

(II) if no election date occurs, 180 days after the coverage date.

(ii) During the period described in Subsection (17)(g)(i):

(A) neither the association nor the reinsurer have a right or obligation under a reinsurance contract that the association may assume under Subsection (17)(a), whether for a period before or after the coverage date; and

(B) the reinsurer, the receiver, and the association, to the extent practicable, shall provide each other data and records reasonably requested.

(iii) Notwithstanding Subsection (17)(g)(ii), once the association elects to assume a reinsurance contract, the parties' rights and obligations are governed by Subsections (17)(f)(i) through (vi).

(h) If the association does not elect to assume a reinsurance contract by the election date pursuant to Subsection (17)(a), the association has no right or obligation with respect to the reinsurance contract, whether for a period before or after the coverage date.

(i) An insurer other than the association succeeds to the rights and obligations of the association under Subsections (17)(a) through (f) effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in Subsections (17)(a) through (f) provided that:

(i) the association transfers its obligations to the other insurer;

(ii) the association and the other insurer agree to the transfer;

(iii) the indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

(iv) the obligations described in Subsection (17)(f)(v) may not apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer;

(v) the transferring party shall give notice in writing, with verification of receipt, to the affected reinsurer not less than 30 days before the effective date of the transfer; and

(vi) this Subsection (17)(i) may not apply if the association has previously

expressly determined in writing that the association will not exercise the election referred to in Subsections (17)(a) through (f).

(j) (i) This Subsection (17) supersedes the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the coverage date, to:

(A) the receiver of an insolvent member insurer; or

(B) another person.

(ii) The receiver is entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to a loss or event that occurs before the coverage date, subject to applicable setoff provisions.

(k) Except as otherwise expressly provided in Subsections (17)(a) through (j), this Subsection (17) does not:

(i) alter or modify the terms and conditions of a reinsurance agreement of the insolvent member insurer;

(ii) abrogate or limit a right any reinsurer to claim that it is entitled to rescind a reinsurance agreement;

(iii) give a policy owner or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance agreement;

(iv) limit or affect the association's rights as a creditor of the estate of an insolvent insurer against the assets of the estate; or

(v) apply to a reinsurance agreement that covers property or casualty risks.

(18) The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(19) If the association arranges or offers to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(20) (a) Venue in a suit against the association arising under this part is Salt Lake County.

(b) The association may not be required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

Amended by Chapter 292, 2010 General Session

31A-28-109. Assessments.

(1) (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 class or subclass, at the time and for the amounts that the board of directors finds necessary.

(b) Member insurer liability for an assessment is established as of the coverage date.

(c) Subject to Subsection (1)(d), a called assessment:

(i) is due not less than 30 days after prior written notice to the member insurer; and

(ii) shall accrue interest at 10% per annum on and after the due date.

(d) Notwithstanding Subsection (1)(c), the association may:

(i) assess the association's members as of the coverage date; and

(ii) defer the collection of the assessment described in Subsection (1)(d)(i).

(e) An assessment:

(i) has the force and effect of a judgment lien against the member insurer; and

(ii) may not be extinguished until paid.

(2) The two classes of assessment are described in Subsections (2)(a) and (2)(b).

(a) A Class A assessment shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. A Class A assessment may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) A Class B assessment shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Section 31A-28-108 with regard to an impaired or an insolvent insurer.

(3) (a) (i) The amount of a Class A assessment:

(A) shall be determined by the board of directors; and

(B) may be authorized and called on a pro rata or non-pro rata basis.

(ii) If the Class A assessment is pro rata, the board of directors may credit the assessment against future Class B assessments.

(iii) The total of the non-pro rata assessments may not exceed $300 per member insurer in any one calendar year.

(b) The amount of a Class B assessment shall be allocated for assessment purposes among subclasses pursuant to an allocation formula that may be based on:

(i) the premiums or reserves of the impaired or insolvent insurer; or

(ii) any other standard determined by the board of directors in the board of directors' sole discretion as being fair and reasonable under the circumstances.

(c) (i) A Class B assessment against a member insurer for the life insurance subclass, the annuity subclass, and the unallocated annuity subclass shall be in the proportion that the premiums received on business in this state by the member insurer on policies or contracts included in the subclass for the three most recent calendar years for which information is available preceding the year which includes the coverage date bears to the premiums received on business in this state for the same period by the assessed member insurers.

(ii) A Class B assessment against a member insurer for an accident and health insurance subclass shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts included in the subclass for the most recent calendar year for which information is available preceding the year in which the assessment is made bears to the premiums received on business in this state on policies or contracts included in the subclass for that calendar year by the assessed member insurers.

(d) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this part.

(e) Classification of assessments and premiums under Subsection (3)(b) and

computation of assessments under this Subsection (3) shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(f) The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the day on which the assessment is authorized.

(4) (a) 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.

(b) If an assessment against a member insurer is abated or deferred in whole or in part under Subsection (4)(a), the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(c) Once a condition that caused a deferral is removed or rectified, the member insurer shall pay the assessments that were deferred pursuant to a repayment plan approved by the association.

(5) (a) (i) Subject to Subsection (5)(b), the total of the assessments authorized by the association on a member insurer for each subclass may not in any one calendar year exceed 2% of that member's total average annual assessable premium in that subclass as defined in Subsection (3).

(ii) If two or more assessments are authorized in one calendar year with respect to one or more insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation in Subsection (5)(a)(i) shall be equal and limited to the highest of the total average annual assessable premiums of the different calendar year periods involved in the assessment or assessments.

(iii) If the maximum assessment together with the other assets of the association do not provide in one year an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon after as permitted by this part.

(b) 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.

(c) If the maximum assessment for the life insurance or annuity subclass in any one year does not provide an amount sufficient to carry out the responsibilities of the association, the board of directors shall assess the other of the subclasses of the life insurance and annuity class for the necessary additional amount:

(i) pursuant to Subsection (3)(b); and

(ii) subject to the maximum stated in Subsection (5)(a).

(6) (a) The board of directors may, by an equitable method established in the plan of operation, refund to member insurers in proportion to the contribution of each insurer to that subclass the amount by which the assets of the subclass exceed the amount the board of directors finds is necessary to carry out the obligations of the association with regard to that subclass, including assets accruing from:

(i) assignment;

(ii) subrogation;

(iii) net realized gains; and
(iv) income from investments.
(b) Notwithstanding Subsection (6)(a), a reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.
(7) A member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this part, may consider the amount reasonably necessary to meet its assessment obligations under this part.
(8) (a) The association shall issue to each insurer paying an assessment under this part, other than a Class A assessment, a certificate of contribution, in a form approved by the commissioner, for the amount of the assessment paid.
(b) The outstanding certificates described in Subsection (8)(a) shall be of equal dignity and priority without reference to amounts or dates of issue.
(c) (i) A certificate of contribution described in Subsection (8)(a) may be shown by the insurer in its financial statement as an asset in the amount of the certificate of contribution less the amount by which the insurer's premium taxes have already been reduced with respect to the certificate.
(ii) For good cause shown, the commissioner may order the insurer to show a different amount in its financial statement than the amount under Subsection (8)(c)(i).
(9) (a) The association may request information from a member insurer to aid in the exercise of the association's power under this part.
(b) A member insurer shall comply promptly with a request of the association under this Subsection (9).

Amended by Chapter 292, 2010 General Session

31A-28-110. Plan of operation.
(1) (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association.
(b) The plan of operation and any amendments become effective:
(i) upon the commissioner's written approval; or
(ii) after 30 days from the date the plan of operation or amendment is submitted to the commissioner if the commissioner has not disapproved the plan or amendment.
(c) (i) If the association fails to submit a suitable amendment to the plan, the commissioner, after notice and hearing, shall adopt reasonable rules that are necessary or advisable to effectuate the provisions of this part.
(ii) The rules described in Subsection (1)(c)(i) continue in force until:
(A) modified by the commissioner; or
(B) superseded by an amendment to the plan:
(I) submitted by the association; and
(II) approved by the commissioner.
(2) A member insurer shall comply with the plan of operation.
(3) The plan of operation shall, in addition to any other requirement in this part:
(a) establish procedures for handling the assets of the association;
(b) establish the amount and method of reimbursing members of the board of directors under Section 31A-28-107;

(c) establish regular places and times for meetings of the board of directors, including telephone conference calls;

(d) establish procedures for records to be kept of the financial transactions of:

(i) the association;

(ii) the association's agents; and

(iii) the board of directors;

(e) subject to Section 31A-28-107, establish the procedures to be followed for:

(i) selecting members to the board of directors; and

(ii) submitting the selected members to the commissioner for approval;

(f) establish any additional procedures for assessments under Section 31A-28-109;

(g) establish procedures under which a member insurer may be removed from the board of directors for cause, including when the member insurer becomes an impaired or insolvent insurer;

(h) require the board of directors to establish policies and procedures that address conflicts of interests; and

(i) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) (a) The plan of operation may provide that any or all powers and duties of the association, except those under Subsection 31A-28-108(14)(d) and Section 31A-28-109, are delegated to a corporation, association, or other organization that will perform functions similar to those of the association, or its equivalent, in two or more states.

(b) A corporation, association, or organization described in Subsection (4)(a) shall be:

(i) reimbursed for any payments made on behalf of the association; and

(ii) paid for its performance of any function of the association.

(c) A delegation under this Subsection (4):

(i) takes effect only with the approval of:

(A) the board of directors; and

(B) the commissioner; and

(ii) may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this part.

Amended by Chapter 292, 2010 General Session

31A-28-111. Duties and powers under this part.

In addition to the duties and powers enumerated elsewhere in this part, the persons described in this section have the duties and powers described in Subsections (1) through (6).

(1) The commissioner shall:

(a) upon request of the board of directors, provide the association with a statement of the premiums for each member insurer:

(i) in this state; and

(ii) any other appropriate state; and

(b) if 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.

(2) Notice to the impaired insurer under Subsection (1)(b) constitutes notice to the shareholders of the impaired insurer if the impaired insurer has shareholders.

(3) The failure of the insurer to promptly comply with the commissioner's demand under Subsection (1)(b) does not excuse the association from the performance of its powers and duties under this part.

(4) (a) After notice and hearing, the commissioner may suspend or revoke the certificate of authority to transact insurance in this state of a member insurer not domiciled in this state that fails to:

(i) pay an assessment when due; or

(ii) comply with the plan of operation.

(b) (i) As an alternative to suspending or revoking a certificate of authority under Subsection (4)(a), the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due.

(ii) A forfeiture described in Subsection (4)(b)(i):

(A) may not exceed 5% of the unpaid assessment per month; and

(B) may not be less than $100 per month.

(5) (a) A final action of the board of directors or the association may be appealed to the commissioner by any member insurer if appeal is taken within 60 days of the date the member insurer received notice of the final action being appealed.

(b) If a member insurer is appealing an assessment, the amount assessed shall be:

(i) paid to the association; and

(ii) made available to meet association obligations during the pendency of an appeal.

(c) If the appeal on the assessment described in Subsection (5)(b) is upheld, the amount paid in error or excess shall be returned to the member insurer.

(d) Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(6) The receiver of an impaired insurer shall notify the interested persons of the effect of this part.

Amended by Chapter 292, 2010 General Session

31A-28-112. Reports.

(1) The commissioner shall:

(a) report to the board of directors when:

(i) the commissioner takes an action set forth in Section 31A-27a-201;

(ii) an event described in Section 31A-17-603, 31A-17-604, or 31A-17-605 occurs; or

(iii) the commissioner receives a report from any other commissioner indicating that an action described in Subsection (1)(a)(i) has been taken in another state;

(b) include in the report to the board of directors required by Subsection (1)(a):

(i) the significant details of the action taken;

(ii) the significant details of an event described in Subsection (1)(a)(ii); or

(iii) the report received from another commissioner;

(c) promptly report to the board of directors when the commissioner has reasonable cause to believe from an examination of any member insurer, whether completed or in process, that the insurer may be an impaired or insolvent insurer; and

(d) furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners.

(2) (a) The board of directors may use the information contained in the ratios and listings described in Subsection (1)(d) in carrying out the board of directors' duties and responsibilities under this part.

(b) The board of directors shall keep the report and the information contained in the ratios and listings confidential until the commissioner or other lawful authority publishes the information.

(3) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(4) (a) The board of directors may make reports and recommendations to the commissioner upon any matter germane to:

(i) the solvency, liquidation, rehabilitation, or conservation of any member insurer; or

(ii) the solvency of any company seeking to do an insurance business in this state.

(b) The reports and recommendations of the board of directors described in Subsection (4)(a) are not public documents.

(5) The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(6) The board of directors may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(7) (a) At the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, the board of directors shall prepare a report to the commissioner containing the information the board of directors has in its possession bearing on the history and causes of the insolvency.

(b) In preparing a report on the history and causes of insolvency of a particular insurer, the board of directors may cooperate with:

(i) the board of directors of a guaranty association in another state; or

(ii) an organization described in Subsection 31A-28-108(16).

(c) The board of directors may adopt by reference any report prepared by:

(i) a guaranty association in another state; or

(ii) an organization described in Subsection 31A-28-108(16).

Amended by Chapter 292, 2010 General Session

31A-28-113. Credit for assessments paid.

(1) (a) A member insurer may offset against its premium tax liability to this state an assessment described in Subsection 31A-28-109(2)(b) to the extent of 20% of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid.

(b) To the extent that the offsets described in Subsection (1)(a) exceed premium tax liability, the offsets may be carried forward and used to offset premium tax liability in future years.

(c) If a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(2) (a) Money shall be paid by the insurers to the state in a manner required by the State Tax Commission if the money:

(i) is acquired by refund in accordance with Subsection 31A-28-109(6) from the association by member insurers; and

(ii) has been offset against premium taxes as provided in Subsection (1).

(b) The association shall notify the commissioner that the refunds described in Subsection (2)(a) have been made.

Amended by Chapter 342, 2011 General Session

31A-28-114. Miscellaneous provisions.

(1) 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.

(2) (a) The board of directors shall keep a record of a meeting of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 31A-28-108.

(b) A record of the association with respect to an impaired or insolvent insurer may not be disclosed before the earlier of:

(i) the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer;

(ii) the termination of the impairment or insolvency of the insurer; or

(iii) upon the order of a court of competent jurisdiction.

(c) Nothing in this Subsection (2) limits the duty of the association to render a report of its activities under Section 31A-28-115.

(3) (a) For the purpose of carrying out its obligations under this part, the association is considered to be a creditor of an 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 Subsection 31A-28-108(14).

(b) Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue the covered policies and pay the contractual obligations of the impaired or insolvent insurer as required by this part.

(c) As used in this Subsection (3), assets attributable to covered policies are that proportion of the assets which the reserves that should have been established for covered policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) (a) As a creditor of the impaired or insolvent insurer under Subsection (3)

and consistent with Section 31A-27a-701, the association and any other similar association are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse the association and any other similar association.

(b) If, within 180 days of a final determination of insolvency of an insurer by the receivership court, the receiver has not made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to the guaranty associations having obligations because of the insolvency, the association is entitled to make application to the receivership court for approval of the association's proposal for disbursement of these assets.

(5) (a) Before the termination of a liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including:

(i) the association;

(ii) the shareholders;

(iii) policyowners of the insolvent insurer; and

(iv) any other party with a bona fide interest in making an equitable distribution of the ownership rights of the insolvent insurer.

(b) In making a determination under Subsection (5)(a), the court shall consider the welfare of the policyowners of the continuing or successor insurer.

(c) A distribution to any stockholder of an impaired or insolvent insurer may not be made until and unless the total amount of valid claims of the association with interest has been fully recovered by the association for funds expended in carrying out its powers and duties under Section 31A-28-108 with respect to the insurer.

Amended by Chapter 292, 2010 General Session

31A-28-115. Examination of the association -- Annual report.

(1) The association shall be subject to examination and regulation by the commissioner.

(2) The board of directors shall submit to the commissioner each year, not later than 120 days after the association's fiscal year:

(a) a financial report in a form approved by the commissioner; and

(b) a report of its activities during the preceding fiscal year.

(3) At the request of a member insurer, the association shall provide the member insurer with a copy of a report submitted under Subsection (2).

Amended by Chapter 161, 2001 General Session

31A-28-116. Tax exemptions.

The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Repealed and Re-enacted by Chapter 211, 1991 General Session

31A-28-117. Immunity.

(1) For any action or omission committed in the performance of their powers and duties under this part, there is no liability on the part of, and no cause of action of any nature shall arise against:

(a) any member insurer;

(b) a member insurer's agents or employees;

(c) the association;

(d) the association's:

(i) agents or employees; or

(ii) members of the board of directors;

(e) representatives of persons described in Subsections (1)(a) through (d);

(f) the commissioner; or

(g) the commissioner's representatives.

(2) The immunity described in Subsection (1) extends to:

(a) the participation in any organization of one or more other state associations of similar purposes;

(b) an organization described in Subsection (2)(a); and

(c) the agents or employees of an organization described in Subsection (2)(a).

Amended by Chapter 161, 2001 General Session

31A-28-118. Stay of proceedings -- Reopening default judgments.

(1) A proceeding in which the insolvent insurer is a party in any court in this state shall be stayed 180 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.

(2) The association may apply to have a judgment under any decision, order, verdict, or finding based on default set aside by the same court that made the judgment. The association shall be permitted to defend against the suit on the merits.

Amended by Chapter 292, 2010 General Session

31A-28-119. Prohibited advertisement of the association -- Notice to owners of policies and contracts.

(1) (a) Except as provided in Subsection (1)(b), a person, including an insurer, agent, or affiliate of an insurer may not 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 a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over a radio station or television station, or in any other way, any advertisement, announcement, or statement written or oral, that uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance.

(b) Notwithstanding Subsection (1)(a), this section does not apply to:

(i) the association; or

(ii) another entity that does not sell or solicit insurance.

(2) (a) The association shall:

(i) have a summary document describing the general purposes and current

limitations of this part that complies with Subsection (3); and

(ii) submit the summary document described in Subsection (2)(a)(i) to the commissioner for approval.

(b) An insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is also delivered to the policy or contract owner before, or at the time of, delivery of the policy or contract.

(c) The summary document shall be available upon request by a policy owner.

(d) The distribution, delivery, or contents or interpretation of the summary document does not guarantee that:

(i) the policy or the contract is covered in the event of the impairment or insolvency of a member insurer; or

(ii) the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer.

(e) The summary document shall be revised by the association as amendments to this part may require.

(f) Failure to receive the summary document as required in Subsection (2)(b) does not give the owner of a policy or contract, certificate holder, or insured any greater rights than those stated in this part.

(3) (a) The summary document described in Subsection (2) shall contain a clear and conspicuous disclaimer on its face.

(b) The commissioner shall, by rule, establish the form and content of the disclaimer described in Subsection (3)(a), except that the disclaimer shall:

(i) state the name and address of:

(A) the association; and

(B) the department;

(ii) prominently warn a policy or contract owner that:

(A) the association may not cover the policy or contract; or

(B) if coverage is available, it is:

(I) subject to substantial limitations and exclusions; and

(II) conditioned on continued residence in the state;

(iii) state the types of policies or contracts for which the association will provide coverage;

(iv) state that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(v) state that the policy or contract owner should not rely on coverage under the association when selecting an insurer;

(vi) explain the rights available and procedures for filing a complaint to allege a violation of this part; and

(vii) provide other information as directed by the commissioner including sources for information about the financial condition of insurers provided that the information:

(A) is not proprietary; and

(B) is subject to disclosure under public records laws.

(4) (a) An insurer or agent may not deliver a policy or contract described in Subsection 31A-28-103(2)(a) and wholly excluded under Subsection 31A-28-103(2)(b)(i) 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 that clearly and conspicuously discloses that the policy or contract is not covered by the association.

(b) The commissioner shall by rule specify the form and content of the notice required by Subsection (4)(a).

(5) A member insurer shall retain evidence of compliance with Subsection (2) for the later of:

(a) three years; or

(b) until the conclusion of the next market conduct examination by the department of insurance where the member insurer is domiciled.

Amended by Chapter 292, 2010 General Session

31A-28-120. Prospective application.

Notwithstanding any prior or subsequent law, the provisions of this part that are in effect on the date on which the association first becomes obligated for the policies or contracts of an insolvent or impaired member govern the association's rights and obligations to the policyowners of the insolvent or impaired member.

Amended by Chapter 292, 2010 General Session

31A-28-202. Scope.

This part applies to protect resident policyowners and insureds under all types of direct insurance, except:

(1) life insurance;

(2) annuity;

(3) health insurance;

(4) disability insurance;

(5) mortgage guaranty insurance;

(6) financial guaranty, or other forms of insurance offering protection against investment risks;

(7) fidelity or surety bonds, or any other bonding obligation;

(8) credit insurance;

(9) vendor's single interest insurance;

(10) collateral protection insurance, or any similar insurance protecting the interests of a creditor in a creditor-debtor transaction;

(11) mechanical breakdown insurance, as defined in Section 31A-6a-101;

(12) insurance of a warranty or service contract as defined in Section 31A-6a-101;

(13) title insurance;

(14) ocean marine insurance;

(15) any transaction between a person and an insurer, or an affiliate of a person or insurer, that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

(16) any insurance provided by or guaranteed by government.

Amended by Chapter 116, 2001 General Session
Amended by Chapter 363, 2001 General Session

31A-28-203. Definitions.

As used in this part:

(1) "Affiliate" is as defined in Section 31A-1-301.

(2) "Association account" means the Utah Property and Casualty Insurance Guaranty Association Account created by Section 31A-28-205.

(3) (a) "Claimant" means:

(i) an insured making a first-party claim; or

(ii) a person instituting a liability claim.

(b) A person who is an affiliate of the insolvent insurer may not be a claimant.

(4) (a) "Covered claim" means an unpaid claim, including an unpaid claim under a personal lines policy for unearned premiums submitted by a claimant, if:

(i) the claim arises out of the coverage;

(ii) the claim is within the coverage;

(iii) the claim is not in excess of the applicable limits of an insurance policy to which this part applies;

(iv) the insurer who issued the policy becomes an insolvent insurer; and

(v) (A) the claimant or insured is a resident of this state at the time of the insured event; or

(B) the claim is a first-party claim for damage to property that is permanently located in this state.

(b) "Covered claim" does not include:

(i) any amount awarded as punitive or exemplary damages or any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise, nor does it include any supplementary payment obligation, including adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, and bond premiums, prior to the appointment of a liquidator;

(ii) any amount sought as a return of premium under a retrospective rating plan;

(iii) any first-party claim by an insured if:

(A) the insured's net worth exceeds $25,000,000 on December 31 of the year preceding the date the insurer becomes an insolvent insurer; and

(B) the insured's net worth includes the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis; or

(iv) any first-party claims by an insured that is an affiliate of the insolvent insurer.

(5) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(6) "Member insurer" means any person who:

(a) writes any kind of insurance to which this part applies under Section 31A-28-202, including the exchange of reciprocal or inter-insurance contracts; and

(b) is licensed to transact insurance in this state.

(7) (a) "Net direct written premiums" means direct gross premiums written in this state on insurance policies that this part applies to, less return premiums and dividends paid or credited to policyholders on the direct business.

(b) "Net direct written premiums" does not include premiums on contracts

between insurers or reinsurers.

(8) "Personal lines policy" means an insurance policy issued to an individual that:

(a) insures a motor vehicle used for personal purposes and not used in trade or business; or

(b) insures a residential dwelling.

(9) "Residence" means, for entities other than a natural person, the state where the principal place of business of a claimant, insured, or policyholder is located at the time of the insured event.

Amended by Chapter 308, 2002 General Session

31A-28-204. Unlawful statements.

(1) It is unlawful to make any statement, written or oral, regarding the coverages and protections provided by the association for the purpose of promoting the purchase of any form of insurance.

(2) It is unlawful to indicate or imply that the association is an agency of the state or that the existence of the association is in any way a guarantee by the state or any of its instrumentalities to insure the payment of claims.

(3) The commissioner shall prescribe rules to prevent:

(a) use of the association as an inducement for the sale of insurance;

(b) the dissemination of false or misleading information regarding the association and its limited guarantees; and

(c) the dissemination of information implying that the association is an agency of the state and that the state in any way insures the payment of claims.

(4) Any person who violates Subsection (1) or (2) is guilty of a class A misdemeanor. Any person who violates a rule under Subsection (3) is liable to the state for a civil penalty of not less than $250 or more than $1,000.

Amended by Chapter 241, 1991 General Session

31A-28-205. Creation of the association.

(1) (a) The Utah Property and Casualty Insurance Guaranty Association shall continue as a nonprofit legal entity.

(b) All member insurers of the association are, and remain, members of the association as a condition of their authority to transact insurance business in this state.

(c) The association shall:

(i) perform its functions under the plan of operation established and approved under Section 31A-28-209; and

(ii) exercise its powers through a board of directors established under Section 31A-28-206.

(d) For the purposes of administration and assessment, the association shall maintain an account known as the Property and Casualty Insurance Guaranty Association Account.

(e) (i) If as of May 6, 2002, the association has more than one account, the association shall consolidate all accounts into the Property and Casualty Insurance

Guaranty Association Account.

(ii) The Property and Casualty Insurance Guaranty Association Account:

(A) succeeds to all funds held by the association in an account existing on May 6, 2002; and

(B) is subject to any liability or obligation attributable to an account of the association existing on May 6, 2002.

(2) (a) An insurer shall cease to be a member insurer on the day following the termination or expiration of the insurer's license to transact the kinds of insurance to which this part applies.

(b) Notwithstanding Subsection (2)(a), the insurer shall remain liable as a member insurer for all obligations, including assessments levied:

(i) before the termination or expiration of the insurer's license; and

(ii) after the termination or expiration of the insurer's license but that relate to an insurer that became an insolvent insurer before the termination or expiration of the insurer's license.

(3) Meetings or records of the association shall be open to the public upon a majority vote of the board of directors of the association.

(4) The association is not an agency of the state.

Amended by Chapter 308, 2002 General Session

31A-28-206. Board of directors.

(1) (a) The board of directors of the association consists of not less than five nor more than nine members, serving terms of four years each.

(b) The members of the board shall be selected by member insurers, subject to the commissioner's approval. When a vacancy occurs in the membership for any reason, the replacement shall be elected for the unexpired term by a majority vote of the remaining board members, subject to the commissioner's approval.

(c) In approving selections or in appointing members to the board, the commissioner shall consider whether all member insurers are fairly represented.

(d) Notwithstanding Subsection (1)(a), the commissioner shall, at the time of election or reelection, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is selected every two years.

(2) A member of the board of directors may be reimbursed from the assets of the association for expenses the member incurs as a member of the board of directors.

Amended by Chapter 363, 2001 General Session

31A-28-207. Powers and duties of the association.

(1) (a) The association is obligated on the amount of the covered claims:

(i) existing prior to the order of liquidation; and

(ii) arising:

(A) within 30 days after the order of liquidation; or

(B) (I) before the policy expiration date if it is less than 30 days after the order of liquidation; or

(II) before the insured replaces the policy or causes its cancellation, if the insured does so within 30 days of the order of liquidation.

(b) The obligation under Subsection (1)(a) includes only that amount of each covered claim that is less than $300,000.

(c) A claim under a personal lines policy for unearned premiums shall include only those claims that exceed $100 in amount, subject to a maximum of $10,000 per policy.

(d) The association shall pay the full amount of any covered claim arising out of a workers' compensation policy. The association is not obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises.

(e) Any obligation of the association to defend an insured on a covered claim shall cease:

(i) upon payment by the association, as part of a settlement releasing the insured; or

(ii) on a judgment, of the lesser of:

(A) the association's covered claim obligation limit; or

(B) the applicable policy limit.

(f) The association:

(i) is considered as the insurer only to the extent of its obligation on the covered claims, subject to the limitations provided in this part;

(ii) has all the rights, duties, and obligations of the insolvent insurer as if the insurer had not yet become insolvent, including the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations; and

(iii) may not be considered the insolvent insurer for any purpose relating to whether the association is subject to personal jurisdiction in the courts of any state.

(g) (i) Notwithstanding any other provisions of this part, except in the case of a claim for benefits under workers' compensation coverage, any obligation of the association to or on behalf of a particular insured and its affiliates on covered claims shall cease when:

(A) a total amount of $10,000,000 has been paid to or on behalf of the insured and its affiliates on covered claims by the association or a similar association; and

(B) all payments on covered claims arise under one or more policies of a single insolvent insurer.

(ii) The association may establish a plan to allocate the amounts payable by the association in a manner the association considers equitable if the association determines that:

(A) there is more than one claimant asserting a covered claim against:

(I) the association;

(II) a similar association; or

(III) a property or casualty insurance security fund in another state; and

(B) all claims arise under the policy or policies of a single insolvent insurer.

(h) The association shall assess member insurers amounts necessary to pay:

(i) the obligations of the association under Subsection (1)(a), as limited by Subsections (1)(e) through (g), subsequent to the liquidation of an insolvent insurer;

(ii) the expenses of handling covered claims subsequent to the liquidation of an

insolvent insurer;

(iii) the cost of examinations under Section 31A-28-214; and

(iv) other expenses authorized by this part.

(i) (i) The association shall:

(A) investigate claims brought against the association; and

(B) adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims.

(ii) The association is not bound by a settlement, release, compromise, waiver, or judgment executed or entered into by the insolvent insurer:

(A) less than 12 months before the entry of an order of liquidation; or

(B) more than 12 months before the entry of an order of liquidation if the settlement, release, compromise, waiver, or judgment is:

(I) based on a claim that is not a covered claim; or

(II) the result of fraud, collusion, default, or failure to defend.

(iii) The association may assert all defenses available including defenses applicable to determining and enforcing the association's statutory rights and obligations to a claim.

(iv) The association may appoint and direct legal counsel retained under a liability insurance policy for the defense of a covered claim.

(j) (i) The association shall handle claims through:

(A) its employees;

(B) one or more insurers; or

(C) other persons designated as servicing facilities.

(ii) Designation of a servicing facility is subject to the approval of the commissioner, but this designation may be declined by a member insurer.

(k) The association shall:

(i) reimburse each servicing facility for:

(A) obligations of the association paid by the facility; and

(B) expenses incurred by the facility while handling claims on behalf of the association; and

(ii) pay the other expenses of the association as authorized by this title.

(2) The association may:

(a) employ or retain the persons, including private legal counsel, necessary to handle claims and perform other duties of the association;

(b) borrow funds necessary to implement the purposes of this part in accord with the plan of operation;

(c) sue or be sued;

(d) negotiate and become a party to the contracts necessary to carry out the purpose of this part;

(e) perform any other acts necessary or proper to accomplish the purposes of this chapter; or

(f) refund to the member insurers, in proportion to the contribution of each member insurer to the association account, the amount that the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that:

(i) the assets of the association in the association account exceed the liabilities

as estimated by the board of directors for the coming year; and

(ii) the excess assets are not needed for other purposes of this part.

(3) For a refund due to a member insurer for an assessment that has been offset against premium taxes, the association may pay the amount of the refund directly to the State Tax Commission.

(4) The courts of the state shall have exclusive jurisdiction over all actions brought against the association that relate to or arise out of this part.

(5) (a) Any person recovering under this part is considered to have assigned that person's rights under the policy to the association to the extent of that person's recovery from the association.

(b) Every insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent the person would have been required to cooperate with the insolvent insurer.

(c) Except as provided in Subsection (5)(e), the association has no cause of action against the insured of the insolvent insurer for any sums the association has paid out except those causes of action the insolvent insurer would have had if the sums had been paid by the insolvent insurer.

(d) When an insolvent insurer operates on a plan with assessment liability, payments of claims of the association do not reduce the liability for unpaid assessments of the insurer to:

(i) the receiver;

(ii) liquidator; or

(iii) statutory successor.

(e) The association may recover from the following persons the amount of any "covered claim" paid on behalf of that person pursuant to this part:

(i) any insured whose:

(A) net worth on December 31 of the year next preceding the date the insurer becomes insolvent, exceeds $25,000,000; and

(B) liability obligations to other persons are satisfied in whole or in part by payments made under this part; and

(ii) any person:

(A) who is an affiliate of the insolvent insurer; and

(B) whose liability obligations to other persons are satisfied in whole or in part by payments made under this part.

(f) (i) The receiver, liquidator, or statutory successor of an insolvent insurer is bound by:

(A) a determination of a covered claim eligibility under this part; and

(B) a settlement of a covered claim by the association or a similar organization in another state.

(ii) The court having jurisdiction shall grant settled claims a priority equal to that which the claimant would have been entitled to in the absence of this part, against the assets of the insolvent insurer.

(g) The association or any similar organization in another state shall:

(i) be recognized as a claimant in the liquidation of an insolvent insurer for any amounts paid on a covered claim obligation as determined under this part or a similar law in another state; and

(ii) receive dividends or distributions at the priority set forth in Section 31A-27a-701.

(h) (i) The association shall periodically file with the receiver or liquidator of the insolvent insurer:

(A) statements of the covered claims paid by the association; and

(B) estimates of anticipated claims on the association.

(ii) The filing under this Subsection (5)(h) preserves the rights of the association for claims against the assets of the insolvent insurer.

(i) The association need not pay any claim filed after the final date under Sections 31A-27a-406 and 31A-27a-601, or similar statutes of other states, for filing the same type of claim with the liquidator of the insolvent insurer.

Amended by Chapter 309, 2007 General Session

31A-28-208. Assessments.

(1) (a) To provide the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers at the time and in the amount the board finds necessary.

(b) An assessment under this section:

(i) is due not less than 30 days after written notice to the member insurers; and

(ii) accrues interest to the extent unpaid after the due date at the greater of:

(A) 10% per annum; or

(B) the then legal rate of interest provided in Section 15-1-1.

(2) An assessment is to be made in the amount necessary to carry out the powers and duties of the association under Section 31A-28-207 for an insolvent insurer.

(3) An assessment against a member insurer is in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance for which this part applies bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance for which this part applies.

(4) A member insurer may not be assessed in any year for an amount greater than 2% of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance for which this part applies.

(5) If the maximum assessment, together with the other assets of the association in the association account, do 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 as funds become available.

(6) 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.

(7) Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of the claims by the member insurer, if they are chargeable to the association account.

Amended by Chapter 308, 2002 General Session

31A-28-209. Plan of operation.

(1) (a) The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association.

(b) The plan of operation and amendments described in Subsection (1)(a) are effective upon approval in writing by the commissioner.

(c) Any amendments made under this section after July 1, 1986, shall be made within 180 days of the changed circumstance.

(2) The plan of operation shall continue in force until:

(a) modified by the commissioner; or

(b) superseded by a plan:

(i) submitted by the association; and

(ii) approved by the commissioner.

(3) All member insurers shall comply with the plan of operation.

(4) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(a) establish procedures for handling the assets of the association;

(b) establish the amount and method of reimbursing members of the board of directors under Section 31A-28-206;

(c) establish regular places and times for meetings of the board of directors;

(d) establish procedures for records to be kept of all financial transactions of the association, the association's agents, and the board of directors;

(e) establish the procedures on how selections for the board of directors shall be made and submitted to the commissioner;

(f) establish a procedure for the disposition of dividends or distributions from the estate of the insolvent insurer;

(g) establish any additional procedures for assessments under Section 31A-28-208; and

(h) contain any additional provisions that are necessary or proper for the execution of the powers and duties of the association.

(5) (a) The plan of operation may provide that any or all of the powers and duties of the association, except those under Sections 31A-28-207 and 31A-28-208, are delegated to one of the following that performs functions similar to the association:

(i) a corporation;

(ii) an association; or

(iii) organization other than one described in Subsections (5)(a)(i) and (ii).

(b) A corporation, association, or organization described in Subsection (5)(a) shall:

(i) be reimbursed for any payments made on behalf of the association; and

(ii) be paid for its performance of any function of the association.

(c) A delegation under this Subsection (5) takes effect only with the approval of:

(i) the board of directors; and

(ii) the commissioner.

Amended by Chapter 363, 2001 General Session

31A-28-210. Duties and powers of the commissioner.

(1) In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

(a) notify the association of the existence of an insolvent insurer not later than three days after the commissioner receives notice of the order of liquidation; and

(b) upon request of the board of directors, provide the association with a statement of the premiums in this state for each member insurer.

(2) (a) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails:

(i) to pay an assessment when due; or

(ii) to comply with the plan of operation or the rules adopted under this part.

(b) (i) As an alternative to an action described in Subsection (2)(a), the commissioner may levy a fine on any member insurer that fails to pay an assessment when due.

(ii) The fine permitted under this Subsection (2)(b) may not:

(A) exceed 5% of the unpaid assessment per month; or

(B) be less than $100 per month.

(c) The commissioner may revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Any final action or order of the commissioner under this part is subject to judicial review in a court of competent jurisdiction.

Amended by Chapter 363, 2001 General Session

31A-28-212. Credits for assessments paid.

(1) A member insurer may offset against its premium tax liability to this state an assessment described in Section 31A-28-208, but only up to 20% of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liabilities for the year it ceases doing business.

(2) Any sums acquired by a member insurer as a refund from the association which previously had been offset against premium taxes as provided in Subsection (1) shall be paid immediately by the member insurer to the State Tax Commission.

Amended by Chapter 204, 1986 General Session

31A-28-213. Miscellaneous provisions.

(1) (a) Any person who has a claim against an insurer, whether or not the insurer is a member insurer, under any provision in an insurance policy, other than a policy of an insolvent insurer that is also a covered claim, is required to first exhaust that person's right under that person's policy.

(b) Any amount payable on a covered claim under this part under an insurance

policy is reduced by the amount of any recovery under the insurance policy described in Subsection (1)(a).

(c) (i) Except as provided in Subsection (1)(c)(ii) a person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall first seek recovery from the association of the place of residence of the insured.

(ii) If the person's claim is:

(A) 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

(B) a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant.

(iii) Any recovery under this part shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

(2) This part may not 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.

(3) (a) 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 the association's powers and duties under Section 31A-28-207. Records of these negotiations or meetings shall be made public only:

(i) upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the insolvent insurer;

(ii) the termination of the insolvency of the insurer; or

(iii) the order of a court of competent jurisdiction.

(b) This Subsection (3) does not limit the duty of the association to render a report of its activities under Section 31A-28-214.

(4) For the purpose of carrying out its obligations under this part, the association is considered to be a creditor of the insolvent insurer, except to the extent of any amounts the association is entitled as subrogee under Section 31A-28-207.

(5) (a) Before the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including:

(i) the association;

(ii) the shareholders;

(iii) the policyowners of the insolvent insurer; and

(iv) any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer.

(b) In making the determination described in Subsection (5)(a), the court shall consider the welfare of the policyholders of the continuing or successor insurer.

(c) A distribution to stockholders, if any, of an insolvent insurer may not be made until the total amount of valid claims of the association with interest on those claims for funds expended in carrying out its powers and duties under Section 31A-28-207 regarding this insurer have been fully recovered by the association.

(6) A rehabilitator, liquidator, or conservator appointed under any section of this part may recover on behalf of the insurer for excessive distributions paid to affiliates, pursuant to Section 31A-27a-502.

Amended by Chapter 309, 2007 General Session

31A-28-214. Examination of the association -- Annual report.

(1) The association is subject to examination and regulation by the commissioner.

(2) The board of directors shall submit, to the commission by no later than April 30 of each year:

(a) a financial report for the preceding calendar year in a form approved by the commissioner; and

(b) a report of the association's activities during the preceding calendar year.

Amended by Chapter 363, 2001 General Session

31A-28-215. Tax exemptions.

The association is exempt from payment of all fees and taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Enacted by Chapter 242, 1985 General Session

31A-28-217. Immunity.

(1) There is 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 his representatives, for any action or omission by them in effecting this part.

(2) The state does not waive any defense under this part, including the defense of governmental immunity. The state is not liable for any action or omission of the association, its members, or their respective agents or employees. The state is not liable for any failure of the association to perform its duties or to fulfill its stated purpose under this part.

Amended by Chapter 97, 1988 General Session

31A-28-218. Stay of proceedings -- Reopening default judgments.

(1) Except for specific cases involving covered claims that are subject to waiver by the association, 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 until the last day fixed by the court for the filing of claims to permit proper defense by the association of all pending causes of action.

(2) For any covered claim arising from a judgment under any decision, order, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured:

(a) may apply to have the judgment set aside by the issuing court or administrator; and

(b) shall be permitted to defend against the claim on the merits.

Amended by Chapter 363, 2001 General Session

31A-28-220. Termination of association's operation.

(1) The commissioner shall by order terminate the operation of the association for any kind of insurance covered under this part when the commissioner finds that there is in effect a statutory or voluntary plan that:

(a) is a permanent plan that is adequately funded or where adequate funding is provided; or

(b) extends, or will extend to residents and policyholders, protection and benefits regarding insolvent insurers that are not substantially less favorable and effective to residents and policyholders than the protection and benefits provided regarding the kinds of insurance covered under this part.

(2) (a) The commissioner shall, by the order under Subsection (1), authorize discontinuance of future payments by insurers to the association regarding the kinds of insurance that are the subject of the order.

(b) Notwithstanding Subsection (2)(a), the assessments and payments shall continue, as necessary, to liquidate covered claims of insurers who are adjudged insolvent prior to the order and to pay the related expenses not covered by any other plan.

(3) (a) If the operation of the association is terminated under Subsection (1), the association shall, as soon as possible, distribute the balance of money and assets remaining, after discharging the functions of the association as to prior insurer insolvencies that were not covered by any other plan, together with related expenses, to the insurers that are then writing in this state policies of the kinds of insurance covered by this part, and that had made payments to the association.

(b) The reimbursement described in Subsection (3)(a) shall be:

(i) pro rata; and

(ii) based upon the aggregate of the payments made by the respective insurers during the period of five years next preceding the date of the order.

(c) For a reimbursement of an assessment that has been offset against premium taxes, the association may pay the amount of the reimbursement directly to the State Tax Commission.

(d) Upon completion of the distribution regarding all of the kinds of insurance covered by this part, this part shall terminate.

Amended by Chapter 363, 2001 General Session

31A-28-222. Application of amendments.

(1) The amendments in Laws of Utah 2001, Chapter 363, shall become effective on April 30, 2001 and apply to the association's obligations under policies of insolvent insurers as they exist on or after April 30, 2001.

(2) Notwithstanding Subsection (1), the amendments to Subsections 31A-28-203(3) and 31A-28-207(1)(a) in Laws of Utah 2001, Chapter 363, that add coverage for unearned premium claims shall apply only to insurers that become insolvent after April 30, 2001.

Amended by Chapter 250, 2008 General Session

31A-29-101. Short title.

This chapter is known as the "Comprehensive Health Insurance Pool Act."

Enacted by Chapter 232, 1990 General Session

31A-29-102. Purpose.

The purpose of the Comprehensive Health Insurance Pool Act is to provide access to health care insurance coverage to residents of Utah who are denied adequate health care insurance and are considered uninsurable.

Amended by Chapter 385, 2008 General Session

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

(b) "Creditable coverage" does not include a period of time in which there is a significant break in coverage, as defined in Section 31A-1-301.

(3) "Domicile" means the place where an individual has a fixed and permanent home and principal establishment:

(a) to which the individual, if absent, intends to return; and

(b) in which the individual, and the individual's family voluntarily reside, not for a special or temporary purpose, but with the intention of making a permanent home.

(4) "Enrollee" means an individual who has met the eligibility requirements of the pool and is covered by a pool policy under this chapter.

(5) "Health benefit plan":

(a) is defined in Section 31A-1-301; and

(b) does not include a plan that:

(i) (A) has a maximum actuarial value less than 100% of a health benefit plan described in Subsection (5)(c); or

(B) has a maximum annual limit of $100,000 or less; and

(ii) meets other criteria established by the board.

(c) For purposes of Subsection (5)(b)(i)(A) the health benefit plan shall:

(i) be a federally qualified high deductible health plan;

(ii) have a deductible that has the lowest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law; and

(iii) not exceed an annual out-of-pocket maximum equal to three times the amount of the deductible.

(6) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(7) "Health care insurance" is defined in Section 31A-1-301.

(8) "Health care provider" has the same meaning as provided in Section

78B-3-403, with the exception of "licensed athletic trainer."

(9) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization; or

(ii) incidental to furnishing medical care or hospitalization; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(10) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

(11) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(a) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(b) coverage through:

(i) a health maintenance organization;

(ii) a preferred provider prepayment;

(iii) group practice;

(iv) individual practice plan; or

(v) health care insurance;

(c) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(d) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(e) coverage by Medicare or other governmental benefit.

(12) "HIPAA" means the Health Insurance Portability and Accountability Act.

(13) "HIPAA eligible" means an individual who is eligible under the provisions of the Health Insurance Portability and Accountability Act.

(14) "Insurer" means:

(a) an insurance company authorized to transact accident and health insurance business in this state;

(b) a health maintenance organization; or

(c) a self-insurer not subject to federal preemption.

(15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., as amended.

(16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq., as amended.

(17) "Plan of operation" means the plan developed by the board in accordance with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under Section 31A-29-106.

(18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

(19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120.

(20) "Pool policy" means a health benefit plan policy issued under this chapter.

(21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

(22) (a) "Resident" or "residency" means a person who is domiciled in this state.

(b) A resident retains residency if that resident leaves this state:

(i) to serve in the armed forces of the United States; or

(ii) for religious or educational purposes.

(23) "Third party administrator" has the same meaning as provided in Section 31A-1-301.

Amended by Chapter 104, 2013 General Session

31A-29-104. Creation of pool -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Comprehensive Health Insurance Pool," a nonprofit entity within the Insurance Department.

(2) The pool shall be under the direction of a board of directors composed of 12 members.

(a) The governor shall appoint 10 of the directors with the consent of the Senate as follows:

(i) two representatives of health insurance companies or health service organizations;

(ii) one representative of a health maintenance organization;

(iii) one physician;

(iv) one representative of hospitals;

(v) one representative of the general public who is reasonably expected to qualify for coverage under the pool;

(vi) one parent or spouse of such an individual;

(vii) one representative of the general public;

(viii) one representative of employers; and

(ix) one licensed producer with an accident and health line of authority.

(b) The board shall also include:

(i) the commissioner or the commissioner's designee; and

(ii) the executive director of the Department of Health or the executive director's designee.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;
(b) Section 63A-3-107; and
(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.
(6) The board shall elect annually a chair and vice chair from its membership.
(7) Six board members are a quorum for the transaction of business.
(8) The action of a majority of the members of the quorum is the action of the board.

Amended by Chapter 286, 2010 General Session

31A-29-105. Contents of plan.

The plan of operation submitted by the board to the commissioner shall:
(1) demonstrate that any and all assumptions of risk or liability by the pool shall be based on sound financial and actuarial principles reviewed and established in advance by the board and approved by the commissioner;
(2) establish procedures in compliance with Title 51, Chapter 7, State Money Management Act, and accounting policies and procedures established by the Division of Finance, for handling and accounting for assets and money of the pool;
(3) establish regular times and places for meetings of the board;
(4) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;
(5) contain additional provisions necessary and proper for the execution of the powers and duties of the pool;
(6) establish procedures to pay claims under the pool;
(7) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred; and
(8) provide for the establishment of a mechanism to promote and publicize the existence of the plan, the eligibility requirements and procedures for enrollment in the plan, and to maintain public awareness of the plan.

Amended by Chapter 20, 1995 General Session

31A-29-106. Powers of board.

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care insurance business. In addition, the board shall have the specific authority to:
(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:
(i) similar pools of other states for the joint performance of common administrative functions; or
(ii) persons or other organizations for the performance of administrative functions;
(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;
(c) establish appropriate rates, rate schedules, rate adjustments, expense

allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

(d) issue policies of insurance in accordance with the requirements of this chapter;

(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool;

(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

(g) cause the pool to have an annual audit of its operations by the state auditor;

(h) coordinate with the Department of Health in seeking to obtain from the Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the enrollee;

(i) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;

(j) offer pool coverage through contracts with health maintenance organizations, preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;

(k) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

(l) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

(m) administer the Pool Fund;

(n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter;

(o) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products; and

(p) transition health care coverage for all individuals covered under the pool as part of the conversion to health insurance coverage, regardless of preexisting conditions, under PPACA.

(2) (a) The board shall prepare and submit an annual report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

(3) (a) The board shall on or before September 1, 2004, require the plan administrator or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under

Subsection 31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.

(b) The board shall redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.

Amended by Chapter 319, 2013 General Session

31A-29-107. Powers of commissioner.

(1) The commissioner shall, after notice and hearing, approve the plan of operation if the commissioner determines that the plan will assure the fair, reasonable, and equitable administration of the pool.

(2) The plan shall be effective upon the commissioner's written approval.

(3) If the board fails to submit a proposed plan of operation by January 1, 1991, or any time thereafter fails to submit proposed amendments to the plan of operation within a reasonable time after requested by the commissioner, the commissioner shall, after notice and hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

(4) Rules promulgated by the commissioner shall continue in force until modified by him or until superseded by a subsequent plan of operation submitted by the board and approved by the commissioner.

(5) The commissioner may designate an executive secretary from the department to provide administrative assistance to the board in carrying out its responsibilities.

Amended by Chapter 168, 2003 General Session

31A-29-108. Examination -- Financial report.

(1) The pool is subject to examination by the commissioner.

(2) By December 1 of each year, the board shall submit to the commissioner an audited financial report for the preceding fiscal year in a form approved by the commissioner.

Amended by Chapter 194, 2001 General Session

31A-29-109. Policy forms.

All policy forms issued by the pool shall conform in substance to forms developed by the board and shall be filed with the commissioner before they are issued.

Amended by Chapter 168, 2003 General Session

31A-29-110. Pool administrator -- Selection -- Powers.

(1) The board shall select a pool administrator in accordance with Title 63G, Chapter 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the board, which shall include:

(a) ability to manage medical expenses;

(b) proven ability to handle accident and health insurance;
(c) efficiency of claim paying procedures;
(d) marketing and underwriting;
(e) proven ability for managed care and quality assurance;
(f) provider contracting and discounts;
(g) pharmacy benefit management;
(h) an estimate of total charges for administering the pool; and
(i) ability to administer the pool in a cost-efficient manner.
(2) A pool administrator may be:
(a) a health insurer;
(b) a health maintenance organization;
(c) a third-party administrator; or
(d) any person or entity which has demonstrated ability to meet the criteria in Subsection (1).
(3) (a) The pool administrator shall serve for a period of three years, with two one-year extension options, subject to the terms, conditions, and limitations of the contract between the board and the administrator.
(b) At least one year prior to the expiration of the contract between the board and the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator.
(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of the period of service under Subsection (3)(a).
(4) The pool administrator is responsible for all operational functions of the pool and shall:
(a) have access to all nonpatient specific experience data, statistics, treatment criteria, and guidelines compiled or adopted by the Medicaid program, the Public Employees Health Plan, the Department of Health, or the Insurance Department, and which are not otherwise declared by statute to be confidential;
(b) perform all marketing, eligibility, enrollment, member agreements, and administrative claim payment functions relating to the pool;
(c) establish, administer, and operate a monthly premium billing procedure for collection of premiums from enrollees;
(d) perform all necessary functions to assure timely payment of benefits to enrollees, including:
(i) making information available relating to the proper manner of submitting a claim for benefits to the pool administrator and distributing forms upon which submission shall be made; and
(ii) evaluating the eligibility of each claim for payment by the pool;
(e) submit regular reports to the board regarding the operation of the pool, the frequency, content, and form of which reports shall be determined by the board;
(f) following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and submit a report of this information to the board, the commissioner, and the Division of Finance on a form prescribed by the commissioner; and
(g) be paid as provided in the plan of operation for expenses incurred in the performance of the pool administrator's services.

Amended by Chapter 347, 2012 General Session

31A-29-111. Eligibility -- Limitations.

(1) (a) Except as provided in Subsection (1)(b), an individual who is not HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium;

(ii) is a resident of this state; and

(iii) meets the health underwriting criteria under Subsection (5)(a).

(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual has terminated coverage in the pool, unless:

(A) 12 months have elapsed since the termination date; or

(B) the individual demonstrates that creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;

(iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(iv) the individual is an inmate of a public institution;

(v) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(vi) the individual's health condition does not meet the criteria established under Subsection (5);

(vii) the individual is eligible for coverage under an employer group that offers a health benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(viii) the individual is covered under any other health benefit plan;

(ix) except as provided in Subsections (3) and (6), at the time of application, the individual has not resided in Utah for at least 12 consecutive months preceding the date of application; or

(x) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

(2) (a) Except as provided in Subsection (2)(b), an individual who is HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium; and

(ii) is a resident of this state.

(b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(iii) the individual is covered under any other health benefit plan;

(iv) the individual is eligible for coverage under an employer group that offers a health benefit plan or self-insurance arrangements to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(vi) the individual is an inmate of a public institution; or

(vii) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

(3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose health care insurance coverage from a state high risk pool with similar coverage is terminated because of nonresidency in another state is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

(b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the termination date of the previous high risk pool coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:

(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and

(ii) if the other state's benefit limitation was not reached.

(4) (a) If an eligible individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be no later than the first day of the month following the date of submission of the completed insurance application to the carrier.

(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.

(5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:

(i) health condition; and

(ii) expected claims so that the expected claims are anticipated to remain within available funding.

(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a).

(c) If an individual is denied coverage by the pool under the criteria established in Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under Subsection 31A-30-108(3).

(6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose individual health care insurance coverage was

involuntarily terminated, is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii) and (x).

(b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the termination date of the previous individual health care insurance coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous individual coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived to the extent to which the waiting period was satisfied under the individual health insurance plan.

Amended by Chapter 158, 2012 General Session
Amended by Chapter 347, 2012 General Session

31A-29-112. Medicaid recipients.

(1) If authorized by federal statutes or rules, an individual receiving Medicaid benefits may continue to receive those benefits while satisfying the preexisting condition requirements established by Section 31A-29-113 and the terms of the pool policy issued under this chapter.

(2) If allowed by federal statute, federal regulation, state statute, or rule, the Department of Health shall allocate premiums paid to the pool by an individual receiving Medicaid benefits to that individual's spenddown for purposes of the Medicaid program.

(3) (a) If an individual continues to receive Medicaid benefits after the requirements for a preexisting condition are satisfied, the pool administrator may not issue a pool policy or allow that individual to receive any benefit from the pool.

(b) If an individual continues to receive Medicaid benefits when the requirements for a preexisting condition are satisfied, the pool administrator shall give any premiums collected by it during the preexisting conditions period to the Medicaid program.

(4) (a) If an enrollee becomes eligible to receive Medicaid benefits, the enrollee's coverage by the pool terminates as of the effective date of Medicaid coverage.

(b) The pool administrator shall:

(i) include a provision in the pool policy requiring an enrollee to provide written notice to the pool administration if the enrollee becomes covered by Medicaid; and

(ii) terminate an enrollee's coverage by the pool as of the effective date of the enrollee's Medicaid coverage when the pool administrator becomes aware that the enrollee is covered by Medicaid.

(5) If an individual terminates coverage under Medicaid and applies for coverage under a pool policy within 62 days after terminating the coverage, the individual may begin coverage under a pool policy as of the date that Medicaid coverage terminated, if an individual meets the other eligibility requirements of the chapter and pays the required premium.

(6) Notwithstanding Subsections 31A-29-111(1)(b)(i) and (2)(b)(i), an individual is eligible for coverage by the pool if the requirements of Section 31A-29-111 are met and if:

(a) the individual's eligibility for Medicaid requires a spenddown, as defined by rule, that exceeds the premium for a pool policy; or

(b) the individual is eligible for the Primary Care Network program administered by the Department of Health.

Amended by Chapter 253, 2012 General Session

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.

(5) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(6) (a) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective.

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded if:

(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law, within the six-month period ending on the effective date of plan coverage; and

(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) (a) A pool policy may contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

(9) (a) The pool will waive the preexisting condition exclusion described in Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the

pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.

(b) If this Subsection (9) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(10) Covered benefits available from the pool may not exceed a $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Amended by Chapter 319, 2013 General Session

31A-29-114. Deductibles -- Copayments.

(1) (a) A pool policy shall impose a deductible on a per calendar year basis.

(b) At least two deductible plans shall be offered.

(c) The deductible is applied to all of the eligible medical expenses as defined in Section 31A-29-113, incurred by the enrollee until the deductible has been satisfied. There are no benefits payable before the deductible has been satisfied.

(d) The pool may offer separate deductibles for prescription benefits.

(2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess of the mandatory deductible.

(b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool policy.

(3) The board shall establish maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee for each of the deductible plans offered under Subsection (1)(b).

(4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments under Subsection (3), the board may establish a coinsurance requirement to be imposed on eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.

(b) The circumstances in which the coinsurance authorized by this Subsection (4) may be imposed shall be designated in the pool policy.

(c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to exceed 5% of eligible medical expenses.

(5) The limits on maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee under this section may not include out-of-pocket payments for prescription benefits.

Amended by Chapter 95, 2006 General Session

31A-29-115. Cancellation -- Notice.

(1) (a) On the date of renewal, the pool may cancel an enrollee's policy if:

(i) the enrollee's health condition does not meet the criteria established in Subsection 31A-29-111(5);

(ii) the pool has provided written notice to the enrollee's last-known address no

less than 60 days before cancellation; and

(iii) at least one individual carrier has not reached the individual enrollment cap established in Section 31A-30-110.

(b) The pool shall issue a certificate of insurability to an enrollee whose policy is cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the requirements of Subsection 31A-29-111(5) are met.

(2) The pool may cancel an enrollee's policy at any time if:

(a) the pool has provided written notice to the enrollee's last-known address no less than 15 days before cancellation; and

(b) (i) the enrollee establishes a residency outside of Utah for three consecutive months;

(ii) there is nonpayment of premiums; or

(iii) the pool determines that the enrollee does not meet the eligibility requirements set forth in Section 31A-29-111, in which case:

(A) the policy may be retroactively terminated for the period of time in which the enrollee was not eligible;

(B) retroactive termination may not exceed three years; and

(C) the board's remedy under this Subsection (2)(b) shall be a cause of action against the enrollee for benefits paid during the period of ineligibility in accordance with Subsection 31A-29-119(3).

Amended by Chapter 2, 2004 General Session

31A-29-116. Notice of availability.

The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, governing notice of availability which is to be given by insurers to potential enrollees in the pool.

Amended by Chapter 382, 2008 General Session

31A-29-117. Premium rates.

(1) (a) Premium charges for coverage under the pool may not be unreasonable in relation to:

(i) the benefits provided;

(ii) the risk experience; and

(iii) the reasonable expenses provided in the coverage.

(b) Separate schedules of premium rates based on age and other appropriate demographic characteristics may apply for individual risks.

(2) Small employer carriers, as defined in Section 31A-30-103, shall annually inform the commissioner by February 1 of the carrier's:

(a) small employer index premium rates as of January 1 of the current and preceding year; and

(b) average percentage change in the index premium rate as of January 1, of the current and preceding year.

(3) (a) Premium rates may be adjusted by the board on a biannual basis, for an effective date of January 1 and July 1.

(b) In adjusting premium rates, the board shall:
(i) consider the average increase in small employer index rates for the five largest small employer carriers submitted under Subsection (2); and
(ii) be subject to Subsection (1).
(4) The board may establish a premium scale based on income. The highest rate may not exceed the expected claims and expenses for the individual.
(5) If an individual is HIPAA eligible, the maximum premium rate for that individual may not exceed the amount permitted under HIPAA.
(6) All rates and rate schedules shall be submitted by the board to the commissioner for approval.

Amended by Chapter 40, 2007 General Session

31A-29-119. Benefit reduction.
(1) The pool shall be the last payer of benefits whenever any other benefit is available.
(2) Benefits otherwise payable under pool coverage shall be reduced by:
(a) all amounts paid or payable through any other health benefit plan or any limited health benefit plan, including a self-insured plan;
(b) all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault; and
(c) any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law program.
(3) The board shall have a cause of action against an enrollee for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this Subsection (3).

Amended by Chapter 385, 2008 General Session

31A-29-120. Enterprise fund.
(1) There is created an enterprise fund known as the Comprehensive Health Insurance Pool Enterprise Fund.
(2) The following funds shall be credited to the pool fund:
(a) appropriations from the General Fund;
(b) pool policy premium payments; and
(c) all interest and dividends earned on the pool fund's assets.
(3) All money received by the pool fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.
(4) The pool fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.
(5) The pool fund shall comply with Title 63A, Utah Administrative Services Code.

Amended by Chapter 168, 2003 General Session

31A-29-121. Tax exemption.

The pool is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

Enacted by Chapter 232, 1990 General Session

31A-29-122. Immunity.

There is no liability on the part of and no cause of action of any nature may arise against any member of the board, the board's agents or employees, the executive director, the administrator or its agents or employees, or the commissioner for any action or omission by them in effecting the provisions of this chapter.

Amended by Chapter 168, 2003 General Session

31A-29-123. Exemption.

Other than where specifically stated above, the pool shall be exempt from all requirements contained in Title 31A.

Enacted by Chapter 232, 1990 General Session

31A-30-101. Title.

This chapter is known as the "Individual, Small Employer, and Group Health Insurance Act."

Amended by Chapter 108, 2004 General Session

31A-30-102. Purpose statement.

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

(a) a universal individual and small group application; and

(b) renewability of coverage;

(4) improve the overall fairness and efficiency of the individual and small group insurance market;

(5) provide increased access for individuals and small employers to health insurance; and

(6) provide an employer with the opportunity to establish a defined contribution arrangement for an employee to purchase a health benefit plan through the Internet portal created by Section 63M-1-2504.

Amended by Chapter 12, 2009 General Session

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Sections 31A-30-106 and 31A-30-106.1, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) (a) "Bona fide employer association" means an association of employers:

(i) that meets the requirements of Subsection 31A-22-701(2)(b);

(ii) in which the employers of the association, either directly or indirectly, exercise control over the plan;

(iii) that is organized:

(A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits; and

(B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and

(iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

(b) The commissioner shall consider the following with regard to determining whether an association of employers is a bona fide employer association under Subsection (4)(a):

(i) how association members are solicited;

(ii) who participates in the association;

(iii) the process by which the association was formed;

(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;

(v) the powers, rights and privileges of employer members; and

(vi) who actually controls and directs the activities and operations of the benefit programs.

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered

by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other

contributions associated with the health benefit plan.

(21) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(22) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

(23) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(24) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

(25) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g) and (h) for which coverage the applicant is applying.

(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Amended by Chapter 168, 2013 General Session

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers, except as provided in Subsection (3); or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of Sections 31A-30-106.5 and 31A-30-107.5.

(2) This chapter applies to a health benefit plan that provides coverage to small employers or individuals regardless of:

(a) whether the contract is issued to:

(i) an association, except as provided in Subsection (3);

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the situs of delivery of the policy or contract.

(3) This chapter does not apply to:

(a) short-term limited duration health insurance;

(b) federally funded or partially funded programs; or

(c) a bona fide employer association.

(4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

(i) carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier; and

(ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) Upon a finding of the commissioner, an affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if the ceding arrangements would result in less than 50% of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.

(d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to covered insureds in this state.

(5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the trust.

(b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a waiver if the commissioner finds that application with respect to the trust would:

(i) have a substantial adverse effect on the participants and beneficiaries of the trust; and

(ii) require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this Subsection (5) may not apply to an individual if the person participates in a Taft Hartley trust as an associate member of any employee organization.

(6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and 31A-30-111 apply to:

(a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit; and

(b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit.

(7) The commissioner may make rules requiring that the marketing practices be consistent with this chapter for:

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer;

(d) an insurance consultant; and

(e) a navigator.

Amended by Chapter 168, 2013 General Session
Amended by Chapter 341, 2013 General Session

31A-30-105. Establishment of classes of business.

Effective January 1, 2014, a covered carrier may establish up to four separate classes of business:

(1) one class of business for individual health benefit plans that are not grandfathered under PPACA;

(2) one class of business for small employer health benefit plans that are not grandfathered under PPACA;

(3) one class of business for individual health benefit plans that are grandfathered under PPACA; and

(4) one class of business for small employer health benefit plans that are grandfathered under PPACA.

Amended by Chapter 341, 2013 General Session

31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans for individuals under this chapter are subject to this section.

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) (i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to the individual under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate except as provided under Subsection (1)(b)(ii).

(ii) A carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not

exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan.

(d) (i) A carrier offering an individual health benefit plan shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical individuals that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the individuals assumed to select particular health benefit products.

(iii) A carrier offering an individual health benefit plan shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(f) A carrier offering a health benefit plan to an individual may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) geographic area; and

(iv) family composition.

(g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(A) implement this chapter; and

(B) assure that rating practices used by carriers who offer health benefit plans to individuals are consistent with the purposes of this chapter.

(ii) The rules described in Subsection (1)(g)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by carriers who offer health benefit plans to individuals are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by carriers who offer health benefit plans to individuals;

(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110(1).

(h) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 325% of that expected for a standard insurable individual with the same case characteristics.

(i) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) Each carrier subject to this section shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the carrier is in compliance with this chapter; and

(B) the rating methods of the carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the carrier at the carrier's principal place of business.

(c) A carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 284, 2011 General Session

31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for small employer health benefit plans under this chapter are subject to this section.

(2) (a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to an employer group under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

(3) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the small employer carrier's rate manual for the class of business, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d); and

(c) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined for the class of business from the small employer carrier's rate manual.

(4) (a) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(b) Rating adjustments and factors, including case characteristics, shall be applied uniformly and consistently to the rates charged for all employees and dependents of the small employer.

(c) Rating factors shall produce premiums for identical groups that:

(i) differ only by the amounts attributable to plan design; and

(ii) do not reflect differences due to the nature of the groups assumed to select particular health benefit products.

(d) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(5) A health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(6) The small employer carrier may not use case characteristics other than the following:

(a) age of the employee, in accordance with Subsection (7);

(b) geographic area;

(c) family composition in accordance with Subsection (9);

(d) for plans renewed or effective on or after July 1, 2011, gender of the

employee and spouse;

(e) for an individual age 65 and older, whether the employer policy is primary or secondary to Medicare; and

(f) a wellness program, in accordance with Subsection (12).

(7) Age limited to:

(a) the following age bands:

(i) less than 20;

(ii) 20-24;

(iii) 25-29;

(iv) 30-34;

(v) 35-39;

(vi) 40-44;

(vii) 45-49;

(viii) 50-54;

(ix) 55-59;

(x) 60-64; and

(xi) 65 and above; and

(b) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (9)(b):

(i) as developed by the commissioner by administrative rule; and

(ii) not to exceed an overall ratio as provided in Subsection (8).

(8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:

(i) 5:1 for plans renewed or effective before January 1, 2012; and

(ii) 6:1 for plans renewed or effective on or after January 1, 2012; and

(b) the age slope ratios for each age band may not overlap.

(9) Except as provided in Subsection 31A-30-207(2), family composition is limited to:

(a) an overall ratio of:

(i) 5:1 or less for plans renewed or effective before January 1, 2012; and

(ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and

(b) a tier rating structure that includes:

(i) four tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a child or children; and

(D) a family, consisting of an employee plus spouse, and a child or children;

(ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children; and

(E) employee plus spouse plus one or more children; or

(iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:

(A) employee only;

(B) employee plus spouse;
(C) employee plus one child;
(D) employee plus two or more children;
(E) employee plus spouse plus one child; and
(F) employee plus spouse plus two or more children.

(10) If a health benefit plan is a health benefit plan into which the small employer carrier is no longer enrolling new covered insureds, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the small employer carrier is actively enrolling new covered insureds.

(11) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:
(i) case characteristics;
(ii) claim experience;
(iii) health status; or
(iv) duration of coverage since issue.

(12) Notwithstanding Subsection (4)(b), a small employer carrier may:
(a) offer a wellness program to a small employer group if:
(i) the premium discount to the employer for the wellness program does not exceed 20% of the premium for the small employer group; and
(ii) the carrier offers the wellness program discount uniformly across all small employer groups;
(b) offer a premium discount as part of a wellness program to individual employees in a small employer group:
(i) to the extent allowed by federal law; and
(ii) if the employee discount based on the wellness program is offered uniformly across all small employer groups; and
(c) offer a combination of premium discounts for the employer and the employee, based on a wellness program, if:
(i) the employer discount complies with Subsection (12)(a); and
(ii) the employee discount complies with Subsection (12)(b).

(13) (a) Each small employer carrier shall maintain at the small employer carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the small employer carrier's rating methods and practices are:
(i) based upon commonly accepted actuarial assumptions; and
(ii) in accordance with sound actuarial principles.

(b) (i) Each small employer carrier shall file with the commissioner on or before April 1 of each year, in a form and manner and containing information as prescribed by the commissioner, an actuarial certification certifying that:
(A) the small employer carrier is in compliance with this chapter; and
(B) the rating methods of the small employer carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (13)(b)(i) shall be retained by the small employer carrier at the small employer carrier's principal place of business.

(c) A small employer carrier shall make the information and documentation described in this Subsection (13) available to the commissioner upon request.

(14) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(i) implement this chapter; and

(ii) assure that rating practices used by small employer carriers under this section and carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this chapter.

(b) The rules may:

(i) assure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans; and

(ii) prescribe the manner in which case characteristics may be used by small employer and individual carriers.

(15) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 279, 2012 General Session

31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.

(1) Section 31A-30-106 applies to conversion policies.

(2) Conversion policy premium rates may not exceed by more than 35% the index rate for small employers with similar case characteristics for any class of business in which the policy form has been filed.

(3) An insurer may not consider pregnancy of a covered insured in determining its conversion policy premium rates.

Amended by Chapter 284, 2011 General Session

31A-30-106.7. Surcharge for groups changing carriers.

(1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered carrier may impose upon a small group that changes coverage to that carrier from another carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could otherwise charge under Section 31A-30-106.

(b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

(i) the change in carriers occurs on the anniversary of the plan year, as defined in Section 31A-1-301;

(ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e); or

(iii) employees from an existing group form a new business.

(2) A covered carrier may not impose the surcharge described in Subsection (1)

if the offer to cover the group occurs at a time other than the anniversary of the plan year because:

(a) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) the offer to cover the group is not issued until after the anniversary date; or

(b) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) additional underwriting or rating information requested by the covered carrier is not received until after the anniversary date.

(3) If a covered carrier chooses to apply a surcharge under Subsection (1), the application of the surcharge and the criteria for incurring or avoiding the surcharge shall be clearly stated in the:

(a) written application materials provided to the applicant at the time of application; and

(b) written producer guidelines.

(4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to ensure compliance with this section.

Amended by Chapter 382, 2008 General Session

31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a small employer health benefit plan is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or
(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's minimum participation requirements.
(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:
(i) engages in an act or practice that constitutes fraud in connection with the coverage; or
(ii) makes an intentional misrepresentation of material fact in connection with the coverage.
(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
(i) 12 months after the date of discontinuance; and
(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.
(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.
(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.
(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:
(a) with respect to coverage provided to an employer member of the association; and
(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:
(i) an association;
(ii) a trust; or
(iii) a discretionary group.
(8) A covered carrier may modify a small employer health benefit plan only:
(a) at the time of coverage renewal; and
(b) if the modification is effective uniformly among all plans with that product.

Amended by Chapter 12, 2009 General Session

31A-30-107.1. Individual discontinuance and nonrenewal.
(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:
(i) with respect to all individuals or dependents; and
(ii) at the option of the individual.
(b) Subsection (1)(a) applies regardless of:
(i) whether the contract is issued through:
(A) a trust;
(B) an association;
(C) a discretionary group; or
(D) other similar grouping; or
(ii) the situs of delivery of the policy or contract.

(2) A health benefit plan may be discontinued or nonrenewed:
(a) for a network plan, if:
(i) the individual no longer lives, resides, or works in:
(A) the service area of the covered carrier; or
(B) the area for which the covered carrier is authorized to do business; and
(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or
(b) for coverage made available through an association, if:
(i) the individual's membership in the association ceases; and
(ii) the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.
(3) A health benefit plan may be discontinued if:
(a) a condition described in Subsection (2) exists;
(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;
(c) the individual:
(i) performs an act or practice that constitutes fraud in connection with the coverage; or
(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
(d) the covered carrier:
(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and
(ii) (A) provides notice of the discontinuance in writing:
(I) to each individual provided coverage; and
(II) at least 90 days before the date the coverage will be discontinued;
(B) provides notice of the discontinuation in writing:
(I) to the commissioner; and
(II) at least three working days prior to the date the notice is sent to the affected individuals;
(C) offers to each covered individual on a guaranteed issue basis the option to purchase all other individual health benefit products currently being offered by the covered carrier for individuals in that market; and
(D) acts uniformly without regard to any health status-related factor of a covered individual or dependent of a covered individual who may become eligible for coverage; or
(e) the covered carrier:
(i) elects to discontinue all of the covered carrier's health benefit plans in the individual market; and
(ii) (A) provides notice of the discontinuation in writing:
(I) to each covered individual; and
(II) at least 180 days before the date the coverage will be discontinued;
(B) provides notice of the discontinuation in writing:
(I) to the commissioner in each state in which an affected insured individual is known to reside; and
(II) at least 30 working days prior to the date the notice is sent to the affected

individuals;

(C) discontinues and nonrenews all health benefit plans the covered carrier issues or delivers for issuance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or a dependent of a covered individual who may become eligible for coverage.

Amended by Chapter 252, 2003 General Session

31A-30-107.3. Discontinuance and nonrenewal limitations and conditions.

(1) A carrier that elects to discontinue offering all individual health benefit plans under Subsection 31A-30-107.1(3)(e) is prohibited from writing new business in the individual market in this state for a period of five years beginning on the date of discontinuation of the last individual health benefit plan coverage that is discontinued.

(2) A carrier that elects to discontinue offering all small employer health benefit plans under Subsection 31A-30-107(3)(e) is prohibited from writing new business in the small group market in this state for a period of five years beginning on the date of discontinuation of the last small employer coverage that is discontinued.

(3) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier:

(i) may, except as prohibited by Section 31A-30-117, elect to discontinue offering new individual health benefit plans, except to HIPAA eligibles, but shall keep existing individual health benefit plans in effect, except those individual plans that are not renewed under the provisions of Subsection 31A-30-107(2) or 31A-30-107.1(2);

(ii) may elect to continue to offer new individual and small employer health benefit plans; or

(iii) may elect to discontinue all of the covered carrier's health benefit plans in the individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e).

(b) A carrier that makes an election under Subsection (3)(a)(i):

(i) is prohibited from writing new business:

(A) in the individual market in this state; and

(B) for a period of five years beginning on the date of discontinuation;

(ii) may continue to write new business in the small employer market; and

(iii) shall provide written notice of the election under Subsection (3)(a)(i) within two calendar days of the election to the Utah Insurance Department.

(c) The prohibition described in Subsection (3)(b)(i) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(d) A carrier that makes an election under Subsection (3)(a)(iii) is subject to the provisions of Subsection (1).

(4) If a carrier is doing business in one established geographic service area of the state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that geographic service area.

(5) If a small employer employs less than two eligible employees, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows as of the beginning of the plan year that the employer no longer has at least two current employees.

Amended by Chapter 341, 2013 General Session

31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion riders -- Limitation periods.

(1) A health benefit plan may impose a preexisting condition exclusion only if the provision complies with Subsection 31A-22-605.1(4).

(2) (a) In accordance with Subsection (2)(b), an individual carrier:

(i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to:

(A) a specific physical condition;

(B) a specific disease or disorder; and

(C) any specific or class of prescription drugs; and

(ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including drugs, when utilized for the treatment and care of the conditions, diseases, or disorders listed in Subsection (2)(b).

(b) (i) Except as provided in Section 31A-22-630 and Subsection (2)(b)(ii), the following may be the subject of a condition-specific exclusion rider:

(A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow, fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe, syndactylism, and treatment and prosthetic devices related to amputation;

(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius, interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, spermatocele, endometriosis;

(C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies, deviated nasal septum, and sinus related conditions, diseases, and disorders;

(D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases, and disorders;

(E) goiter and other thyroid related conditions, diseases, or disorders;

(F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus and other eye related conditions, diseases, and disorders;

(G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions, diseases, and disorders;

(H) Baker's cyst, ganglion cyst;

(I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC Doulourex, varicose veins, vestibular disorders;

(J) sleep disorders and speech disorders; and
(K) any specific or class of prescription drugs.
(ii) Subsection (2)(b)(i) does not apply:
(A) for the treatment of asthma; or
(B) when the condition is due to cancer.
(iii) A condition-specific exclusion rider:
(A) shall be limited to the excluded condition, disease, or disorder and any complications from that condition, disease, or disorder;
(B) may not extend to any secondary medical condition; and
(C) shall include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition, disease, or disorder."
(c) If an individual carrier issues a condition-specific exclusion rider, the condition-specific exclusion rider shall remain in effect for the duration of the policy at the individual carrier's option.
(d) An individual policy issued in accordance with this Subsection (2) is not subject to Subsection 31A-26-301.6(7).
(3) Notwithstanding the other provisions of this section, a health benefit plan may impose a limitation period if:
(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition, disease, or disorder that is excluded from coverage during the limitation period;
(b) the limitation period does not exceed 12 months;
(c) the limitation period is applied uniformly; and
(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b).

Amended by Chapter 297, 2011 General Session

31A-30-108. Eligibility for small employer and individual market.
(1) (a) Small employer carriers shall accept residents for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a).
(b) Individual carriers shall accept residents for individual coverage pursuant to:
(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and
(ii) Subsection (3).
(2) (a) Small employer carriers shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.
(b) Small employer carriers may:
(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:

(a) the individual is not covered or eligible for coverage:

(i) (A) as an employee of an employer;

(B) as a member of an association; or

(C) as a member of any other group; and

(ii) under:

(A) a health benefit plan; or

(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;

(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:

(i) the Medicare program established under Title XVIII of the Social Security Act;

(ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or

(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;

(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:

(i) Medicare supplement policy;

(ii) conversion option;

(iii) continuation or extension under COBRA; or

(iv) state extension;

(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and

(e) the individual is certified as ineligible for the Health Insurance Pool if:

(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or

(ii) the individual applies for coverage with any individual carrier within 45 days after:

(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.

(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.

(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium

is paid, the effective date of coverage shall be the day following the:

(i) cancellation of coverage under Subsection 31A-29-115(1); or

(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.

(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.

(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:

(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and

(ii) the commissioner finds that the carrier's issuance of new individual policies:

(A) is in the best interests of the state; and

(B) does not provide an unfair advantage to the carrier.

(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in Health Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).

(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the department.

(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:

(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and

(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:

(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and

(B) applies this section uniformly to all employers without regard to:

(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or

(II) any health status-related factor relating to an employee or dependent of an employee.

(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.

(ii) This Subsection (7)(b) does not:

(A) limit the small employer carrier's ability to renew coverage that is in force; or

(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.

(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.

Amended by Chapter 284, 2011 General Session

31A-30-110. Individual enrollment cap.

(1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.

(2) The commissioner shall raise the individual enrollment cap by .5% at the later of the following dates:

(a) six months from the last increase in the individual enrollment cap; or

(b) the date when CCI/TI is greater than .90, where:

(i) "CCI" is the total individual coverage count for all carriers certifying that their uninsurable percentage has reached the individual enrollment cap; and

(ii) "TI" is the total individual coverage count for all carriers.

(3) The commissioner may establish a minimum number of uninsurable individuals that a carrier entering the market who is subject to this chapter shall accept under the individual enrollment provisions of this chapter.

(4) Beginning July 1, 1997, an individual carrier may decline to accept individuals applying for individual enrollment under Subsection 31A-30-108(3), other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b), if:

(a) the uninsurable percentage for that carrier equals or exceeds the cap established in Subsection (1); and

(b) the covered carrier has certified on forms provided by the commissioner that its uninsurable percentage equals or exceeds the individual enrollment cap.

(5) The department may audit a carrier's records to verify whether the carrier's uninsurable classification meets industry standards for underwriting criteria as established by the commissioner in accordance with Subsection 31A-30-106(1)(h).

(6) (a) If the commissioner determines that individual enrollment is causing a substantial adverse effect on premiums, enrollment, or experience, the commissioner may suspend, limit, or delay further individual enrollment for up to 12 months.

(b) The commissioner shall adopt rules to establish a uniform methodology for calculating and reporting loss ratios for individual policies for determining whether the individual enrollment provisions of Section 31A-30-108 should be waived for an individual carrier experiencing significant and adverse financial impact as a result of complying with those provisions.

Amended by Chapter 284, 2011 General Session
Amended by Chapter 297, 2011 General Session

31A-30-111. Limitations on high risk enrollees.

(1) (a) The requirements of this chapter do not apply to any carrier that is currently in a state of supervision, insolvency, or liquidation.

(b) If a carrier demonstrates to the satisfaction of the commissioner that the requirements of this chapter would place the carrier in a state of supervision, insolvency, or liquidation the commissioner may waive or modify the requirements of Sections 31A-30-108 and 31A-30-110.

(2) (a) A modification or waiver by the commissioner under Subsection (1)(b) shall be effective for a period of not more than one year.

(b) At the end of the period described in Subsection (2)(a), a carrier is subject to Sections 31A-30-108 and 31A-30-110 unless the carrier demonstrates to the satisfaction of the commissioner the need for a modification or waiver in accordance with Subsection (1)(b).

(3) Notwithstanding the requirements of this chapter, a carrier may deny health benefit plan coverage in the small employer and individual market if the carrier demonstrates to the satisfaction of the commissioner that the carrier:

(a) does not have the financial reserves necessary to underwrite additional coverage;

(b) is applying this section uniformly to all small employers and individuals without regard to:

(i) any health status-related factor of the individuals; or

(ii) whether the individuals are eligible individuals.

Amended by Chapter 308, 2002 General Session

31A-30-112. Employee participation levels.

(1) (a) For purposes of this section, "participation" is as defined in Section 31A-1-301.

(b) Except as provided in Subsection (2) and Section 31A-30-206, a requirement used by a covered carrier in determining whether to provide coverage to a small employer, including a participation requirement and a minimum employer contribution requirement, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier.

(2) A covered carrier may not increase a participation requirement or a requirement for minimum employer contribution, applicable to a small employer, at any time after the small employer is accepted for coverage.

Amended by Chapter 341, 2013 General Session

31A-30-114. Disclosure.

(1) A covered carrier shall make the information described in Subsection (2) available:

(a) to:

(i) a small employer; or

(ii) an individual; and

(b) (i) at the time of solicitation; or

(ii) upon the request of:

(A) a small employer; or

(B) an individual;
(c) as part of the covered carrier's solicitation and sales materials.
(2) The following information is required to be disclosed or made available under Subsection (1):
(a) the provisions of the coverage concerning the covered carrier's right to change premium rates; and
(b) the factors that may effect changes in premium rates;
(c) the provisions of the coverage relating to renewability of coverage; and
(d) the provisions of the coverage relating to any preexisting condition exclusion.

Enacted by Chapter 308, 2002 General Session

31A-30-115. Actuarial review of health benefit plans.

(1) (a) The department shall conduct an actuarial review of rates submitted by a carrier that offers a small employer plan and a carrier that offers an individual plan under this chapter:
(i) to verify the validity of the rates, risk factors, and premiums of the plans; and
(ii) as the department determines is necessary to oversee market conduct.
(b) The actuarial review by the department shall be funded from a fee:
(i) established by the department in accordance with Section 63J-1-504; and
(ii) paid by a carrier offering a health benefit plan subject to this chapter.
(c) The department shall:
(i) report aggregate data from the actuarial review to the risk adjuster board created in Section 31A-42-201; and
(ii) contact carriers, if the department determines it is appropriate, to:
(A) inform a carrier of the department's findings regarding the rates of a particular carrier; and
(B) request a carrier to recalculate or verify base rates, rating factors, and premiums.
(d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).
(2) (a) There is created in the General Fund a restricted account known as the "Health Insurance Actuarial Review Restricted Account."
(b) The Health Insurance Actuarial Review Restricted Account shall consist of money received by the commissioner under this section.
(c) The commissioner shall administer the Health Insurance Actuarial Review Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the actuarial review conducted by the department under this section.

Amended by Chapter 319, 2013 General Session
Amended by Chapter 341, 2013 General Session

31A-30-116. Essential health benefits.

(1) For purposes of this section, the "Affordable Care Act" is as defined in Section 31A-2-212 and includes federal rules related to the offering of essential health

benefits.

(2) The state chooses to designate its own essential health benefits rather than accept a federal determination of the essential health benefits required to be offered in the individual and small group market for plans renewed or offered on or after January 1, 2014.

(3) (a) Subject to Subsections (3)(b) and (c), to the extent required by the Affordable Care Act, and after considering public testimony, the Legislature's Health System Reform Task Force shall recommend to the commissioner, no later than September 1, 2012, a benchmark plan for the state's essential health benefits based on:

(i) the largest plan by enrollment in any of the three largest small employer group insurance products in the state's small employer group market;

(ii) any of the largest three state employee health benefit plans by enrollment;

(iii) the largest insured commercial non-Medicaid health maintenance organization operating in the state; or

(iv) other benchmarks required or permitted by the Affordable Care Act.

(b) Notwithstanding the provisions of Subsection 63M-1-2505.5(2), based on the recommendation of the task force under Subsection (3)(a), and within 30 days of the task force recommendation, the commissioner shall adopt an emergency administrative rule that designates the essential health benefits that shall be included in a plan offered or renewed on or after January 1, 2014, in the small employer group and individual markets.

(c) The essential health benefit plan:

(i) shall not include a state mandate if the inclusion of the state mandate would require the state to contribute to premium subsidies under the Affordable Care Act; and

(ii) may add benefits in addition to the benefits included in a benchmark plan described in Subsection (3)(b) if the additional benefits are mandated under the Affordable Care Act.

Enacted by Chapter 279, 2012 General Session

31A-30-117. Patient Protection and Affordable Care Act -- Market transition.

(1) (a) After complying with the reporting requirements of Section 63M-1-2505.5, the commissioner may adopt administrative rules that change the rating and underwriting requirements of this chapter as necessary to transition the insurance market to meet federal qualified health plan standards and rating practices under PPACA.

(b) Administrative rules adopted by the commissioner under this section may include:

(i) the regulation of health benefit plans as described in Subsections 31A-2-212(5)(a) and (b); and

(ii) disclosure of records and information required by PPACA and state law.

(c) (i) The commissioner shall establish by administrative rule one statewide open enrollment period that applies to the individual insurance market that is not on the PPACA certified individual exchange.

(ii) The statewide open enrollment period:

(A) may be shorter, but no longer than the open enrollment period established for the individual insurance market offered in the PPACA certified exchange; and

(B) may not be extended beyond the dates of the open enrollment period established for the individual insurance market offered in the PPACA certified exchange.

(2) A carrier that offers health benefit plans in the individual market that is not part of the individual PPACA certified exchange:

(a) shall open enrollment:

(i) during the statewide open enrollment period established in Subsection (1)(c); and

(ii) at other times, for qualifying events, as determined by administrative rule adopted by the commissioner; and

(b) may open enrollment at any time.

(3) (a) The commissioner shall identify a new mandated benefit that is in excess of the essential health benefits required by PPACA.

(b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c) directly to the qualified health plan issuer on behalf of an individual who receives an advance premium tax credit under PPACA.

(c) The state shall quantify the cost attributable to each additional mandated benefit specified in Subsection (3)(a) based on a qualified health plan issuer's calculation of the cost associated with the mandated benefit, which shall be:

(i) calculated in accordance with generally accepted actuarial principles and methodologies;

(ii) conducted by a member of the American Academy of Actuaries; and

(iii) reported to the commissioner and to the individual exchange operating in the state.

(d) The commissioner may require a proponent of a new mandated benefit under Subsection (3)(a) to provide the commissioner with a cost analysis conducted in accordance with Subsection (3)(c). The commissioner may use the cost information provided under this Subsection (3)(d) to establish estimates of the cost to the state for premium subsidies under Subsection (3)(b).

Enacted by Chapter 341, 2013 General Session

31A-30-201. Title.

This part is known as "Defined Contribution Arrangements."

Enacted by Chapter 12, 2009 General Session

31A-30-202. Definitions.

For purposes of this part:

(1) "Defined benefit plan" means an employer group health benefit plan in which:

(a) the employer selects the health benefit plan or plans from a single insurer;

(b) employees are not provided a choice of health benefit plans on the Health Insurance Exchange; and

(c) the employer is subject to contribution requirements in Section 31A-30-112.

(2) "Defined contribution arrangement":

(a) means a defined contribution arrangement employer group health benefit plan that:

(i) complies with this part; and

(ii) is sold through the Health Insurance Exchange in accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act; and

(b) beginning January 1, 2011, includes an employer choice of either a defined contribution arrangement health benefit plan or a defined benefit plan offered through the Health Insurance Exchange.

(3) "Health reimbursement arrangement" means an employer provided health reimbursement arrangement in which reimbursements for medical care expenses are excluded from an employee's gross income under the Internal Revenue Code.

(4) "Producer" is as defined in Subsection 31A-23a-501(4)(a).

(5) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies under Section 125, Internal Revenue Code, which permits an employee to contribute pre-tax dollars to a health benefit plan.

(6) "Small employer" is defined in Section 31A-1-301.

Amended by Chapter 68, 2010 General Session

31A-30-202.6. Dental and vision plans on the defined contribution arrangement market.

(1) Beginning January 1, 2014, a carrier may offer dental and vision plans in the defined contribution arrangement market.

(2) (a) A carrier that offers a dental or vision plan in the defined contribution arrangement market is not required to offer the same dental or vision plans outside the defined contribution arrangement market and does not have to use the same rating and underwriting practices in and out of the defined contribution arrangement market.

(b) If a carrier offers a dental or vision plan in the defined contribution arrangement market, the carrier shall allow an employee of a small employer group to enroll in a dental and vision plan in accordance with Subsection (3).

(3) (a) A small employer group shall participate in a defined contribution arrangement and meet participation requirements for the defined contribution arrangement before the employer may elect to offer its employees dental or vision plans under Subsection (3)(b).

(b) A small employer who meets the requirements of Subsection (3)(a) may elect to offer its employees:

(i) a dental plan offered in the defined contribution arrangement market;

(ii) a vision plan offered in the defined contribution arrangement market; or

(iii) both a vision plan and a dental plan offered in the defined contribution arrangement market.

(4) An employee whose employer has offered its employees a defined contribution medical plan and met participation requirements under Subsection (3)(a)

may elect to enroll, or not enroll, in the dental and vision plan selected by the employer.

(5) An employer's small group must meet participation requirements established by the commissioner by administrative rule for each dental or vision plan selected by an employer under Subsection (3).

Enacted by Chapter 341, 2013 General Session

31A-30-203. Eligibility for defined contribution arrangement market -- Enrollment.

(1) (a) An eligible small employer may choose to participate in:

(i) the defined contribution arrangement market in the Health Insurance Exchange under this part; or

(ii) the traditional defined benefit market under Part 1, Individual and Small Employer Group.

(b) A small employer may choose to offer its employees one of the following through the defined contribution arrangement market in the Health Insurance Exchange:

(i) a defined contribution arrangement health benefit plan; or

(ii) a defined benefit plan.

(c) Defined contribution arrangement health benefit plans are employer group health plans individually selected by an employee of an employer.

(2) (a) Participating insurers shall offer to accept all eligible employees of an employer described in Subsection (1), and their dependents, at the same level of benefits as anyone else who has the same health benefit plan in the defined contribution arrangement market on the Health Insurance Exchange.

(b) A participating insurer may:

(i) request an employer to submit a copy of the employer's quarterly wage list to determine whether the employees for whom coverage is provided or requested are bona fide employees of the employer; and

(ii) deny or terminate coverage if the employer refuses to provide documentation requested under Subsection (2)(b)(i).

Amended by Chapter 400, 2011 General Session

31A-30-204. Employer election -- Defined benefit -- Defined contribution arrangements -- Responsibilities.

(1) (a) An employer participating in the defined contribution arrangement market on the Health Insurance Exchange shall make an initial election to offer its employees either a defined benefit plan or a defined contribution arrangement health benefit plan.

(b) If an employer elects to offer a defined benefit plan:

(i) the employer or the employer's producer shall enroll the employer in the Health Insurance Exchange;

(ii) the employees shall submit the uniform application required for the Health Insurance Exchange; and

(iii) the employer shall select the defined benefit plan in accordance with Section 31A-30-208.

(c) When an employer makes an election under Subsections (1)(a) and (b):

(i) the employer may not offer its employees a defined contribution arrangement health benefit plan; and

(ii) the employees may not select a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

(d) If an employer elects to offer its employees a defined contribution arrangement health benefit plan, the employer shall comply with the provisions of Subsections (2) through (5).

(2) (a) (i) An employer that chooses to participate in a defined contribution arrangement health benefit plan may not offer to an employee a health benefit plan that is not a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

(ii) Subsection (2)(a)(i) does not prohibit the offer of supplemental or limited benefit policies such as dental or vision coverage, or other types of federally qualified savings accounts for health care expenses.

(b) (i) To the extent permitted by Sections 31A-1-301, 31A-30-112, and 31A-30-206, and the risk adjustment plan adopted under Section 31A-42-204, the employer reserves the right to determine:

(A) the criteria for employee eligibility, enrollment, and participation in the employer's health benefit plan; and

(B) the amount of the employer's contribution to that plan.

(ii) The determinations made under Subsection (2)(b) may only be changed during periods of open enrollment.

(3) An employer that chooses to establish a defined contribution arrangement health benefit plan to provide a health benefit plan for its employees shall:

(a) establish a mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the defined contribution arrangement market on the Health Insurance Exchange created in Section 63M-1-2504, which may include:

(i) a health reimbursement arrangement;

(ii) a Section 125 Cafeteria plan; or

(iii) another plan or arrangement similar to Subsection (3)(a)(i) or (ii) which is excluded or deducted from gross income under the Internal Revenue Code;

(b) before the employee's health benefit plan selection period:

(i) inform each employee of the health benefit plan the employer has selected as the default health benefit plan for the employer group;

(ii) offer each employee a choice of any of the defined contribution arrangement health benefit plans available through the defined contribution arrangement market on the Health Insurance Exchange; and

(iii) notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, before the employee's selection period ends:

(A) selects a different defined contribution arrangement health benefit plan available in the Health Insurance Exchange;

(B) provides proof of coverage from another health benefit plan; or

(C) specifically declines coverage in a health benefit plan.

(4) An employer shall enroll an employee in the default defined contribution

arrangement health benefit plan selected by the employer if the employee does not make one of the choices described in Subsection (3)(b)(iii) before the end of the employee selection period, which may not be less than 14 calendar days.

(5) The employer's notice to the employee under Subsection (3)(b)(iii) shall inform the employee that the failure to act under Subsections (3)(b)(iii)(A) through (C) is considered an affirmative election under pre-tax payroll deductions for the employer to begin payroll deductions for health benefit plan premiums.

Amended by Chapter 68, 2010 General Session

31A-30-206. Minimum participation and contribution levels -- Premium payments.

An insurer who offers a health benefit plan for which an employer has established a defined contribution arrangement under the provisions of this part:

(1) may not:

(a) establish an employer minimum contribution level for the health benefit plan premium under Section 31A-30-112, or any other law; or

(b) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to maintain a minimum employer contribution level;

(2) shall accept premium payments for an enrollee from multiple sources through the Internet portal, including:

(a) government assistance programs;

(b) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by any employer of the enrollee;

(c) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by an employer of a spouse or dependent of the enrollee; and

(d) contributions from private sources of premium assistance; and

(3) may require, as a condition of coverage, a minimum participation level for eligible employees of an employer, which for purposes of the defined contribution arrangement market may not exceed 75% participation.

Amended by Chapter 297, 2011 General Session

31A-30-207. Rating and underwriting restrictions for health plans in the defined contribution arrangement market.

(1) Except as provided in Subsection (2), rating and underwriting restrictions for defined contribution arrangement health benefit plans offered in the Health Insurance Exchange shall be in accordance with Section 31A-30-106.1, and the plan adopted under Chapter 42, Defined Contribution Risk Adjuster Act.

(2) Notwithstanding the provisions of Subsections 31A-30-106.1(9)(b)(ii) and (iii), a carrier offering a defined contribution arrangement in the Health Insurance Exchange under this part:

(a) shall calculate rates based on a family tier rating structure that includes four tiers in compliance with Subsection 31A-30-106.1(9)(b)(i); and

(b) may not calculate rates based on a family tier rating structure that includes five or six tiers as described in Subsection 31A-30-106(9)(b)(ii) or (iii).

(3) All insurers who participate in the defined contribution market shall:

(a) participate in the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

(b) provide the risk adjuster board with:

(i) an employer group's risk factor; and

(ii) carrier enrollment data; and

(c) submit rates to the exchange that are net of commissions.

(4) When an employer group enters the defined contribution arrangement market and the employer group has a health plan with an insurer who is participating in the defined contribution arrangement market, the risk factor applied to the employer group when it enters the defined contribution arrangement market may not be greater than the employer group's renewal risk factor for the same group of covered employees and the same effective date, as determined by the employer group's insurer.

Amended by Chapter 5, 2011 Special Session 2

31A-30-208. Enrollment for defined contribution arrangements.

(1) An insurer offering a health benefit plan in the defined contribution arrangement market:

(a) shall allow an employer to enroll in a small employer defined contribution arrangement plan; and

(b) shall otherwise comply with the requirements of this part, Chapter 42, Defined Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

(2) (a) An insurer may enter or exit the defined contribution arrangement market on January 1 of each year.

(b) An insurer may offer new or modify existing products in the defined contribution arrangement market:

(i) on January 1 of each year;

(ii) when required by changes in other law; and

(iii) at other times as established by the risk adjuster board created in Section 31A-42-201.

(c) An insurer shall give the department, the Health Insurance Exchange, and the risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a) or (b).

Amended by Chapter 319, 2013 General Session
Amended by Chapter 341, 2013 General Session

31A-30-209. Appointment of insurance producers to Health Insurance Exchange.

(1) A producer may be listed on the Health Insurance Exchange as a producer for the defined contribution arrangement market in accordance with Section

63M-1-2504, if the producer is designated as an appointed agent for the defined contribution arrangement market in accordance with Subsection (2).

(2) A producer whose license under this title authorizes the producer to sell defined contribution arrangement health benefit plans may be appointed to the defined contribution arrangement market on the Health Insurance Exchange by the Insurance Department and may sell any product on the Health Insurance Exchange, if the producer:

(a) submits an application to the Insurance Department to be appointed as a producer for the defined contribution arrangement market on the Health Insurance Exchange;

(b) is an appointed agent in accordance with Subsection (3), for products offered in the defined contribution arrangement market of the Health Insurance Exchange, with the carriers that offer a defined contribution arrangement health benefit plan on the Health Insurance Exchange; and

(c) has completed continuing education for the defined contribution arrangement market that:

(i) is required by administrative rule adopted by the commissioner; and

(ii) provides training on premium assistance programs.

(3) A carrier shall appoint a producer to sell the carrier's products in the defined contribution arrangement market of the Health Insurance Exchange, within 30 days of the notice required in Subsection (3)(b), if:

(a) the producer is currently appointed by a majority of the carriers in the Health Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange; and

(b) the producer informs the carrier that the producer is:

(i) applying to be appointed to the defined contribution arrangement market in the Health Insurance Exchange;

(ii) appointed by a majority of the carriers in the defined contribution arrangement market in the Health Insurance Exchange;

(iii) willing to complete training regarding the carrier's products offered on the defined contribution arrangement market in the Health Insurance Exchange; and

(iv) willing to sign the contracts and business associate's agreements that the carrier requires for appointed producers in the Health Insurance Exchange.

Amended by Chapter 400, 2011 General Session

31A-30-210. State contract requirements -- Employer default plans.

(1) This section applies to an employer who is required to offer its employees a health benefit plan as a condition of qualifying for a state contract under:

(a) Section 17B-2a-818.5;

(b) Section 19-1-206;

(c) Subsection 63A-5-205(3);

(d) Section 63C-9-403;

(e) Section 72-6-107.5; and

(f) Section 79-2-404.

(2) An employer described in Subsection (1) shall, when selecting the default

plan required in Section 31A-30-204, select a default plan that is "qualified health insurance coverage" as defined in the sections listed in Subsections (1)(a) through (f).

Enacted by Chapter 229, 2010 General Session

31A-30-211. Insurer disclosure.

(1) The Health Insurance Exchange shall provide an employer's producer with the group's risk factor used to calculate the employer group's premium at the time of:

(a) the initial offering of a health benefit plan; and

(b) the renewal of a health benefit plan.

(2) For health benefit plans that renew on or after March 1, 2012:

(a) a carrier shall provide an employer and the employer's producer with premium renewal rates at least 60 days prior to the group's renewal date for a plan offered under Part 1, Individual and Small Employer Group; and

(b) the Health Insurance Exchange shall provide an employer and the employer's producer with premium renewal rates at least 60 days prior to the group's renewal date for a plan offered under Part 2, Defined Contribution Arrangements.

(3) An insurer does not have to provide additional notice of premium renewal rates to the employer or the employer's producer if the Health Insurance Exchange provides notice in accordance with Subsection (2)(b).

Amended by Chapter 5, 2011 Special Session 2

31A-31-101. Title.

This chapter may be cited as the "Insurance Fraud Act."

Enacted by Chapter 243, 1994 General Session

31A-31-102. Definitions.

As used in this chapter:

(1) "Authorized agency" means:

(a) the attorney general;

(b) the state fire marshal;

(c) any state law enforcement agency;

(d) any criminal investigative department or agency of the United States;

(e) a district attorney;

(f) the prosecuting attorney of any municipality or county;

(g) the department; or

(h) the disciplinary section of an agency licensing a service provider.

(2) "Financial loss" includes:

(a) out-of-pocket expenses;

(b) reasonable attorney fees;

(c) repair and replacement costs; or

(d) claims payments.

(3) "Insurer" means any person or aggregation of persons:

(a) doing insurance business, as defined in Section 31A-1-301; or

(b) subject to the supervision of the commissioner under:
(i) this title; or
(ii) any equivalent insurance supervisory official of another state.
(4) "Knowingly" has the same meaning as in Subsection 76-2-103(2).
(5) "Person" means an individual, firm, company, corporation, association, limited liability company, partnership, organization, society, business trust, service provider, or any other legal entity.
(6) (a) "Runner" means a person who procures clients at the direction of, or in cooperation with a person who intends to:
(i) perform or obtain a service or benefit under a contract of insurance; or
(ii) assert a claim against an insured.
(b) "Runner" includes:
(i) a capper; or
(ii) a steerer.
(7) "Service provider" means:
(a) an individual licensed to practice law;
(b) an individual licensed or certified by the state under:
(i) this title;
(ii) Title 41, Chapter 3, Motor Vehicle Business Regulation Act;
(iii) Title 58, Occupations and Professions; or
(iv) Title 61, Securities Division - Real Estate Division;
(c) an individual licensed in another jurisdiction in a manner similar to a license described in Subsection (7)(a) or (b);
(d) an individual practicing any nonmedical treatment rendered in accordance with a recognized religious method of healing; or
(e) a hospital, health care facility, or person whose services are compensated directly or indirectly by insurance.
(8) "Statement" includes any:
(a) (i) notice;
(ii) statement;
(iii) proof of loss;
(iv) bill of lading;
(v) receipt for payment;
(vi) invoice;
(vii) account;
(viii) estimate of property damage;
(ix) bill for services;
(x) diagnosis;
(xi) prescription;
(xii) hospital or doctor record;
(xiii) x-ray;
(xiv) test result; or
(xv) other evidence of loss, injury, or expense; or
(b) item listed in Subsection (8)(a) that is a computer-generated document.

Amended by Chapter 104, 2004 General Session

31A-31-103. Fraudulent insurance act.

(1) A person commits a fraudulent insurance act if that person with intent to deceive or defraud:

(a) knowingly presents or causes to be presented to an insurer any oral or written statement or representation knowing that the statement or representation contains false, incomplete, or misleading information concerning any fact material to an application for the issuance or renewal of an insurance policy, certificate, or contract;

(b) knowingly presents or causes to be presented to an insurer any oral or written statement or representation:

(i) (A) as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, certificate, or contract; or

(B) in connection with any civil claim asserted for recovery of damages for personal or bodily injuries or property damage; and

(ii) knowing that the statement or representation contains false, incomplete, or misleading information concerning any fact or thing material to the claim;

(c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance act;

(d) assists, abets, solicits, or conspires with another to commit a fraudulent insurance act;

(e) knowingly supplies false or fraudulent material information in any document or statement required by the department;

(f) knowingly fails to forward a premium to an insurer in violation of Section 31A-23a-411.1; or

(g) knowingly employs, uses, or acts as a runner for the purpose of committing a fraudulent insurance act.

(2) A service provider commits a fraudulent insurance act if that service provider with intent to deceive or defraud:

(a) knowingly submits or causes to be submitted a bill or request for payment:

(i) containing charges or costs for an item or service that are substantially in excess of customary charges or costs for the item or service; or

(ii) containing itemized or delineated fees for what would customarily be considered a single procedure or service;

(b) knowingly furnishes or causes to be furnished an item or service to a person:

(i) substantially in excess of the needs of the person; or

(ii) of a quality that fails to meet professionally recognized standards;

(c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance act; or

(d) assists, abets, solicits, or conspires with another to commit a fraudulent insurance act.

(3) An insurer commits a fraudulent insurance act if that insurer with intent to deceive or defraud:

(a) knowingly withholds information or provides false or misleading information with respect to an application, coverage, benefits, or claims under a policy or certificate;

(b) assists, abets, solicits, or conspires with another to commit a fraudulent insurance act;

(c) knowingly accepts a benefit from the proceeds derived from a fraudulent

insurance act; or

(d) knowingly supplies false or fraudulent material information in any document or statement required by the department.

(4) An insurer or service provider is not liable for any fraudulent insurance act committed by an employee without the authority of the insurer or service provider unless the insurer or service provider knew or should have known of the fraudulent insurance act.

Amended by Chapter 104, 2004 General Session

31A-31-104. Disclosure of information.

(1) (a) Subject to Subsection (2), upon written request by an insurer to an authorized agency, the authorized agency may release to the insurer information or evidence that is relevant to any suspected insurance fraud.

(b) Upon written request by an authorized agency to an insurer, the insurer or an agent authorized by the insurer to act on the insurer's behalf shall release to the authorized agency information or evidence that is relevant to any suspected insurance fraud.

(2) (a) Any information or evidence furnished to an authorized agency under this section may be classified as a protected record in accordance with Subsection 63G-2-305(10).

(b) Any information or evidence furnished to an insurer under this section is not subject to discovery in a civil proceeding unless, after reasonable notice to any insurer, agent, or any authorized agency that has an interest in the information and subsequent hearing, a court determines that the public interest and any ongoing criminal investigation will not be jeopardized by the disclosure.

(c) An insurer shall report to the department agency terminations based upon a violation of this chapter.

Amended by Chapter 445, 2013 General Session

31A-31-105. Immunity.

(1) (a) A person, insurer, or authorized agency is immune from civil action, civil penalty, or damages when in good faith that person, insurer, or authorized agency:

(i) cooperates with an agency described in Subsection (1)(b);

(ii) furnishes evidence to an agency described in Subsection (1)(b);

(iii) provides information regarding a suspected fraudulent insurance act to an agency described in Subsection (1)(b);

(iv) receives information regarding a suspected fraudulent insurance act from an agency described in Subsection (1)(b); or

(v) submits a required report to the department under Section 31A-31-110.

(b) An agency referred to in Subsection (1)(a) is one or more of the following:

(i) the department or a division of the department;

(ii) a federal, state, or government agency established to detect and prevent insurance fraud;

(iii) a nonprofit organization established to detect and prevent insurance fraud;

or

(iv) an agent, employee, or designee of an agency listed in this Subsection (1)(b).

(2) An insurer, or person employed by an insurer, is immune from civil action, civil penalty, or damages when in good faith the insurer or person employed by an insurer provides or shares information with another insurer or insurer's employee in a good faith effort to discover or prevent a fraudulent insurance act or other criminal conduct.

(3) A person, insurer, or authorized agency is immune from civil action, civil penalty, or damages if that person, insurer, or authorized agency complies in good faith with a court order to provide evidence or testimony requested by an agency described in Subsection (1)(b).

(4) This section does not abrogate or modify a common law or statutory right, privilege, or immunity enjoyed by a person.

(5) Notwithstanding any other provision in this section, a person, insurer, or service provider is not immune from civil action, civil penalty or damages under this section if that person commits the fraudulent insurance act that is the subject of the information.

Amended by Chapter 253, 2012 General Session

31A-31-106. Disciplinary action.

(1) If, after giving notice and a hearing conducted pursuant to Title 63G, Chapter 4, Administrative Procedures Act, the commissioner finds by a preponderance of the evidence that a person licensed under Title 31A has committed a fraudulent insurance act, the commissioner may suspend or revoke the license issued under Title 31A.

(2) If the appropriate licensing authority finds by a preponderance of the evidence that a service provider violated Section 31A-31-103, the service provider is subject to revocation or suspension of the service provider's license.

(3) The commissioner may notify the appropriate licensing authority of conduct by a service provider that the commissioner believes may constitute a fraudulent insurance act.

Amended by Chapter 382, 2008 General Session

31A-31-107. Workers' compensation insurance fraud.

In any action involving workers' compensation insurance, Section 34A-2-110 supersedes this chapter.

Amended by Chapter 375, 1997 General Session

31A-31-108. Assessment of insurers.

(1) For purposes of this section:

(a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define:

(i) "annuity consideration";

(ii) "membership fees";
(iii) "other fees";
(iv) "deposit-type contract funds"; and
(v) "other considerations in Utah."
(b) "Insurance fraud provisions" means:
(i) this chapter;
(ii) Section 34A-2-110; and
(iii) Section 76-6-521.
(c) "Utah consideration" means:
(i) the total premiums written for Utah risks;
(ii) annuity consideration;
(iii) membership fees collected by the insurer;
(iv) other fees collected by the insurer;
(v) deposit-type contract funds; and
(vi) other considerations in Utah.
(d) "Utah risks" means insurance coverage on the lives, health, or against the liability of persons residing in Utah, or on property located in Utah, other than property temporarily in transit through Utah.
(2) To implement insurance fraud provisions, the commissioner may assess an admitted insurer and a nonadmitted insurer transacting insurance under Chapter 15, Parts 1, Unauthorized Insurers and Surplus Lines, and 2, Risk Retention Groups Act, an annual fee as follows:
(a) $200 for an insurer for which the sum of the Utah consideration is less than or equal to $1,000,000;
(b) $450 for an insurer for which the sum of the Utah consideration is greater than $1,000,000 but is less than or equal to $2,500,000;
(c) $800 for an insurer for which the sum of the Utah consideration is greater than $2,500,000 but is less than or equal to $5,000,000;
(d) $1,600 for an insurer for which the sum of the Utah consideration is greater than $5,000,000 but less than or equal to $10,000,000;
(e) $6,100 for an insurer for which the sum of the Utah consideration is greater than $10,000,000 but less than $50,000,000; and
(f) $15,000 for an insurer for which the sum of the Utah consideration equals or exceeds $50,000,000.
(3) Money received by the state under this section shall be deposited into the Insurance Fraud Investigation Restricted Account created in Subsection (4).
(4) (a) There is created in the General Fund a restricted account known as the "Insurance Fraud Investigation Restricted Account."
(b) The Insurance Fraud Investigation Restricted Account shall consist of the money received by the commissioner under this section and Subsections 31A-31-109(1)(a)(ii), (1)(b), (2)(b)(i), (2)(c), and (3)(a). Money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a) shall be deposited in the Insurance Fraud Victim Restitution Fund pursuant to Section 31A-31-108.5.
(c) The commissioner shall administer the Insurance Fraud Investigation Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Insurance Fraud Investigation Restricted

Account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of insurance fraud provisions.

Amended by Chapter 319, 2013 General Session

31A-31-108.5. Insurance Fraud Victim Restitution Fund.

(1) There is created an expendable special revenue fund known as the "Insurance Fraud Victim Restitution Fund."

(2) The Insurance Fraud Victim Restitution Fund shall consist of money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a).

(3) The commissioner shall administer the Insurance Fraud Victim Restitution Fund for the sole benefit of insurance fraud victims.

Enacted by Chapter 319, 2013 General Session

31A-31-109. Civil penalties.

(1) In addition to other penalties provided by law, a person who violates this chapter:

(a) is subject to the following civil penalties:

(i) the person shall make full restitution; and

(ii) the person shall pay the costs of enforcement of this chapter for the case in which the person is found to have violated this chapter:

(A) as determined by the one or more authorized agencies involved; and

(B) including costs of:

(I) investigators;

(II) attorneys; and

(III) other public employees; and

(b) in the discretion of the court, may be required to pay to the state a civil penalty not to exceed three times that amount of value improperly sought or received from the fraudulent insurance act.

(2) (a) Money paid under Subsection (1)(a)(i) shall be paid to the person damaged by the fraudulent insurance act.

(b) Money paid under Subsection (1)(a)(ii) shall be paid to each applicable authorized agency in the following order:

(i) to the Insurance Fraud Investigation Restricted Account created in Section 31A-31-108 for the costs of enforcement incurred by the commissioner;

(ii) to the General Fund for the costs of enforcement incurred by a state agency other than the commissioner;

(iii) to the applicable political subdivision for the costs of enforcement incurred by the political subdivision; and

(iv) to the applicable criminal investigative department or agency of the United States for the costs of enforcement incurred by the department or agency.

(c) Money paid under Subsection (1)(b) shall be paid into the General Fund.

(3) (a) A civil penalty assessed under Subsection (1) shall be awarded by the court as part of its judgment in both criminal and civil actions.

(b) A criminal action need not be brought against a person in order for that

person to be civilly liable under this section.

Amended by Chapter 284, 2011 General Session

31A-31-110. Mandatory reporting of fraudulent insurance acts.

(1) (a) A person shall report a fraudulent insurance act to the department if:

(i) the person has a good faith belief on the basis of a preponderance of the evidence that a fraudulent insurance act is being, will be, or has been committed by a person other than the person making the report; and

(ii) the person is:

(A) an insurer; or

(B) in relation to the business of title insurance, an auditor that is employed by a title insurer.

(b) The report required by this Subsection (1) shall:

(i) be in writing;

(ii) provide information in detail relating to:

(A) the fraudulent insurance act; and

(B) the perpetrator of the fraudulent insurance act; and

(iii) (A) state whether the person required to report under Subsection (1)(a) also reported the fraudulent insurance act in writing to:

(I) the attorney general;

(II) a state law enforcement agency;

(III) a criminal investigative department or agency of the United States;

(IV) a district attorney; or

(V) the prosecuting attorney of a municipality or county; and

(B) if the person reported the fraudulent insurance act as provided in Subsection (1)(b)(iii)(A), state the agency to which the person reported the fraudulent insurance act.

(c) A person required to submit a written report under this Subsection (1) shall submit the written report to the department by no later than 90 days from the day on which the person required to report the fraudulent insurance act has a good faith belief on the basis of a preponderance of the evidence that the fraudulent insurance act is being, will be, or has been committed.

(2) An action brought under Section 31A-2-201, 31A-2-308, or 31A-31-109, for failure to comply with Subsection (1) shall be commenced within four years from the date on which a person described in Subsection (1):

(a) has a good faith belief on the basis of a preponderance of the evidence that a fraudulent insurance act is being, will be, or has been committed; and

(b) willfully fails to report the fraudulent insurance act.

(3) The department may by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide a process by which a person described in Subsection (1)(a)(ii)(B) may comply with the requirements of Subsection (1) by reporting a fraudulent insurance act to the insurer with whom the person is employed, except that the rule shall provide that if the person reports the fraudulent insurance act to the insurer, the insurer is required to report the fraudulent insurance act to the department.

(4) A person described in Subsection (1)(a)(ii) who in good faith makes a report

under this section, in accordance with Section 31A-31-105, is immune from civil action, civil penalty, or damages for making that report.

Amended by Chapter 150, 2008 General Session

31A-31-111. Health discount program fraud.

(1) In addition to any other fraudulent acts prohibited by this chapter, a person commits a fraudulent insurance act if that person with intent to deceive or defraud:

(a) accepts fees, dues, charges, or other consideration for providing a health discount program as defined in Section 31A-8a-102 without having health care providers under contract who have agreed to provide the discounts promised to enrollees; or

(b) operates a health discount program without complying with the provisions of Section 31A-8a-201.

(2) In addition to any other civil penalties or remedies provided by law, a person who violates this section is guilty of a third degree felony.

Enacted by Chapter 58, 2005 General Session

31A-32a-101. Title and scope.

(1) This chapter is known as the "Medical Care Savings Account Act."

(2) (a) This chapter applies only to a medical care savings account established for the purpose of seeking a tax credit under Section 59-10-1021.

(b) This chapter does not apply to a medical care savings account with respect to which a tax credit is not claimed under Section 59-10-1021.

Amended by Chapter 389, 2008 General Session

31A-32a-102. Definitions.

As used in this chapter:

(1) "Account administrator" means any of the following:

(a) a depository institution as defined in Section 7-1-103;

(b) a trust company as defined in Section 7-1-103;

(c) an insurance company authorized to do business in this state under this title;

(d) a third party administrator licensed under Section 31A-25-203; and

(e) an employer if the employer has a self-insured health plan under ERISA.

(2) "Account holder" means the resident individual who establishes a medical care savings account or for whose benefit a medical care savings account is established.

(3) "Deductible" means the total deductible for an employee and all the dependents of that employee for a calendar year.

(4) "Dependent" means the same as "dependent" under Section 31A-30-103.

(5) "Eligible medical expense" means an expense paid by the taxpayer for:

(a) medical care described in Section 213(d), Internal Revenue Code;

(b) the purchase of a health coverage policy, certificate, or contract, including a qualified higher deductible health plan; or

(c) premiums on long-term care insurance policies as defined in Section 31A-1-301.

(6) "Employee" means the individual for whose benefit or for the benefit of whose dependents a medical care savings account is established. Employee includes a self-employed individual.

(7) "ERISA" means the Employee Retirement Income Security Act of 1974, Public Law 93-406, 88 Stat. 829.

(8) "Higher deductible" means a deductible of not less than $1,000.

(9) "Medical care savings account" or "account" means a trust account established at a depository institution in this state pursuant to a medical care savings account program to pay the eligible medical expenses of:

(a) an employee or account holder; and

(b) the dependents of the employee or account holder.

(10) "Medical care savings account program" or "program" means one of the following programs:

(a) a program established by an employer in which the employer:

(i) purchases a qualified higher deductible health plan for the benefit of an employee and the employee's dependents; and

(ii) contributes on behalf of an employee into a medical care savings account; or

(b) a program established by an account holder in which the account holder:

(i) purchases a qualified higher deductible health plan for the benefit of the account holder and the account holder's dependents; and

(ii) contributes an amount to the medical care savings account.

(11) "Qualified higher deductible health plan" means a health coverage policy, certificate, or contract that:

(a) provides for payments for covered benefits that exceed the higher deductible; and

(b) is purchased by:

(i) an employer for the benefit of an employee for whom the employer makes deposits into a medical care savings account; or

(ii) an account holder.

Amended by Chapter 116, 2001 General Session

31A-32a-103. Establishing medical care savings accounts.

(1) For a taxable year beginning on or after January 1, 1995:

(a) an employer, except as otherwise provided by contract or a collective bargaining agreement, may offer a medical care savings account program to the employer's employees; or

(b) a resident individual may establish a medical care savings account program for the individual or for the individual's dependents.

(2) (a) A contribution into an account made by an employer on behalf of an employee, or made by an individual account holder may not exceed the greater of:

(i) $2,000 in any taxable year; or

(ii) an amount of money equal to the sum of all eligible medical expenses paid by the employee or account holder for that taxable year on behalf of the employee,

account holder, or the employee's or account holder's spouse or dependents.

(b) For purposes of Subsection (2)(a)(ii), eligible medical expenses are limited to expenses in the taxable year that an insurance carrier has applied to the employee's or account holder's deductible.

(3) An employer that offers a medical care savings account program shall, before making any contributions:

(a) inform all employees in writing of the fact that these contributions may not be deductible under the federal tax laws; and

(b) obtain from the employee a written election to participate in the medical care savings account program.

(4) Except as provided in Sections 31A-32a-105 and 59-10-114, principal contributed to and interest earned on a medical care savings account and money reimbursed to an employee or account holder for eligible medical expenses are exempt from taxation.

(5) (a) An employer may select a single account administrator for all of the employer's employee's medical care savings accounts.

(b) If a single account administrator is not selected, an employer may contribute directly to the account holder's individual medical care savings account.

Amended by Chapter 389, 2008 General Session

31A-32a-104. Administration of medical care savings account.

(1) An account administrator shall administer the medical care savings account from which the payment of claims is made and has a fiduciary duty to the person for whose benefit the account administrator administers an account.

(2) (a) Except as provided in Subsection 31A-32a-105(1), the account administrator shall use the funds held in a medical care savings account solely for the purpose of paying or reimbursing the employee or account holder for eligible medical expenses of the employee or account holder or of the employee's or account holder's dependents.

(b) The commissioner shall adopt rules concerning the coordination of benefits between a medical care savings account and medical expenses payable from automobile insurance policies, workers' compensation insurance policies, or other health care insurance policies or contracts.

(3) The employee or account holder may submit documentation of eligible medical expenses paid by the employee or account holder in the taxable year to the account administrator, and the account administrator shall reimburse the employee or account holder from the employee's or account holder's account for eligible medical expenses.

(4) If an employer makes contributions to a medical care savings account program on a periodic installment basis, the employer may advance to an employee an amount necessary to cover eligible medical expenses incurred that exceed the amount in the employee's medical care savings account at the time the expense is incurred if the employee agrees to repay the advance.

Amended by Chapter 389, 2008 General Session

31A-32a-105. Withdrawals -- Termination -- Transfers.

(1) Subject to Subsection (3), if the employee or account holder withdraws money for any purpose other than a medical expense at any time in which the balance in the account is below $4,000:

(a) the amount of the withdrawal shall be added to adjusted gross income in accordance with Section 59-10-114; and

(b) the administrator shall withhold from the amount of the withdrawal, and on behalf of the employee or account holder shall pay a penalty to the State Tax Commission equal to 10% of the amount of the withdrawal.

(2) If an employee or account holder withdraws money from the employee's or account holder's medical care savings account for any purpose other than a medical expense, but the withdrawal occurs when the balance in the medical care savings account is over $4,000, and the withdrawal will not result in the account balance dropping below $4,000, the amount of the withdrawal:

(a) is not subject to the penalties described in Subsection (1)(b); and

(b) shall be added to adjusted gross income in accordance with Section 59-10-114.

(3) The amount of a disbursement of any assets of a medical care savings account pursuant to a filing for protection under 11 U.S.C. Sec. 101 to 1330, by an employee, account holder, or person for whose benefit the account was established:

(a) is not considered a withdrawal for purposes of this section; and

(b) shall be added to adjusted gross income in accordance with Section 59-10-114.

(4) (a) Upon the death of the employee or account holder, the account administrator shall distribute the principal and accumulated interest of the medical care savings account to the estate of the employee or account holder.

(b) A distribution under this Subsection (4) is not subject to the penalties described in Subsection (1)(b).

(5) (a) If an employee is no longer employed by an employer that participates in a medical care savings account program, and if the employee's account is administered by the employer's account administrator, the money in the medical care savings account may be used for the benefit of the employee or the employee's dependents in accordance with this chapter, and may not be added to adjusted gross income under Section 59-10-114 if the employee, not more than 60 days after the employee's final day of employment:

(i) transfers the account to a new account administrator; or

(ii) (A) requests in writing to the former employer's account administrator that the account remain with that administrator; and

(B) the account administrator agrees to retain the account.

(b) Not more than 30 days after the expiration of the 60 days described in Subsection (5)(a), if an account administrator has not accepted the former employee's account, the employer shall mail a check to the former employee at the employee's last-known address equal to the amount in the account on that day.

(c) The amount mailed to the employee under Subsection (5)(b) shall be added to adjusted gross income in accordance with Section 59-10-114, but is not subject to the penalties under Subsection (1)(b).

(d) If an employee becomes employed with a different employer that participates in a medical care savings account program, the employee may transfer the employee's medical care savings account to that new employer's account administrator.

(e) If an account holder becomes an employee of an employer that participates in a medical care savings account program, the account holder may transfer the account holder's account to the employer's account administrator.

Amended by Chapter 389, 2008 General Session

31A-32a-106. Regulation of account administrators -- Administration of addition to adjusted gross income and tax credit -- Rulemaking authority.

(1) The department shall regulate account administrators and may adopt rules necessary to administer this chapter.

(2) The State Tax Commission may adopt rules necessary to monitor and implement the:

(a) amounts required to be added to adjusted gross income in accordance with Sections 31A-32a-105 and 59-10-114; or

(b) amount claimed as a tax credit in accordance with Section 59-10-1021.

Amended by Chapter 389, 2008 General Session

31A-32a-107. Penalties for noncompliance with tax provisions.

(1) An account administrator who fails to comply with a provision described in Subsection (2) is subject to:

(a) the civil penalties provided in Section 59-1-401; and

(b) interest at the rate and in the manner provided in Section 59-1-402.

(2) The following provisions apply to Subsection (1):

(a) a provision of this chapter relating to:

(i) an addition to income made in accordance with Section 59-10-114; or

(ii) a tax credit allowed by Section 59-10-1021; or

(b) a provision of Title 59, Chapter 10, Individual Income Tax Act, relating to:

(i) an addition to income made in accordance with Section 59-10-114; or

(ii) a tax credit allowed by Section 59-10-1021.

Amended by Chapter 389, 2008 General Session

31A-33-101. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the Workers' Compensation Fund.

(2) "Chief executive officer" means the chief executive officer appointed by the board.

(3) "Director" means a member of the board.

(4) "Fund" and "Workers' Compensation Fund" mean the nonprofit, quasi-public corporation established by this chapter.

(5) "Injury Fund" means the premiums, reserves, investment income, and any other funds administered by the Workers' Compensation Fund as provided in this

chapter.

(6) "Joint enterprise" means a joint business activity either for-profit or not-for-profit:

(a) by which two or more persons provide insurance, products, or services; and

(b) that is established by contract between the persons providing the insurance, products, or services.

(7) (a) "Workers' compensation products and services" means:

(i) medical or lost time claims management;

(ii) utilization review;

(iii) rehabilitation counseling or training;

(iv) fraud detection for workers' compensation claims;

(v) loss prevention or safety consultation;

(vi) data or information reporting or processing involving workers' compensation; and

(vii) liability insurance claims management if the claims management is related to or arising out of:

(A) the sale of workers' compensation products and services described in Subsections (7)(a)(i) through (vi) by:

(I) the Workers' Compensation Fund; or

(II) a subsidiary of the fund; or

(B) workers' compensation insurance coverage through:

(I) the Workers' Compensation Fund; or

(II) a subsidiary of the fund in accordance with Section 31A-33-103.5.

(b) "Workers' compensation products and services" does not include the bearing of any insurance risk associated with insurance coverage.

Amended by Chapter 222, 2000 General Session

31A-33-102. Establishment of the Workers' Compensation Fund and the Injury Fund.

(1) (a) There is created a nonprofit, quasi-public corporation to be known as the Workers' Compensation Fund created by this chapter.

(b) The purpose of the fund is to:

(i) insure Utah employers against liability for compensation based on job-related accidental injuries and occupational diseases; and

(ii) assure payment of this compensation to Utah employees who are entitled to it under Title 34A, Chapters 2, Workers' Compensation Act, and 3, Utah Occupational Disease Act.

(2) (a) There is created an Injury Fund, which shall be maintained by the Workers' Compensation Fund.

(b) The Injury Fund shall consist of all assets acquired from premiums and penalties paid into the Injury Fund and interest and dividends earned on those assets.

(c) The Injury Fund is the sole source of money to:

(i) pay losses sustained on account of the insurance provided; and

(ii) pay salaries and other expenses of the Workers' Compensation Fund in accordance with this chapter.

Amended by Chapter 222, 2000 General Session

31A-33-103. Legal nature of Workers' Compensation Fund.

(1) The Workers' Compensation Fund is:

(a) a nonprofit, self-supporting, quasi-public corporation; and

(b) a legal entity, that may sue and be sued in its own name.

(2) All of the business and affairs of the corporation shall be conducted in the name of the Workers' Compensation Fund or if conducted through a subsidiary, such other corporate names that comply with state law.

Amended by Chapter 222, 2000 General Session

31A-33-103.5. Powers of Fund -- Limitations.

(1) The fund may form or acquire subsidiaries or enter into a joint enterprise:

(a) in accordance with Section 31A-33-107; and

(b) except as limited by this section and applicable insurance rules and statutes.

(2) Subject to applicable insurance rules and statutes, the fund may only offer:

(a) workers' compensation insurance in Utah;

(b) workers' compensation insurance in a state other than Utah to the extent necessary to:

(i) accomplish its purpose under Subsection 31A-33-102(1)(b); and

(ii) provide workers' compensation or occupational disease insurance coverage to Utah employers and their employees engaged in interstate commerce; and

(c) workers' compensation products and services in Utah or other states.

(3) Subject to applicable insurance rules and statutes, a subsidiary of the fund may:

(a) offer workers' compensation insurance coverage only:

(i) in a state other than Utah; and

(ii) (A) to insure the following against liability for compensation based on job-related accidental injuries and occupational diseases:

(I) an employer, as defined in Section 34A-2-103, that has a majority of its employees, as defined in Section 34A-2-104, hired or regularly employed in Utah;

(II) an employer, as defined in Section 34A-2-103, whose principal administrative office is located in Utah;

(III) a subsidiary or affiliate of an employer described in Subsection (3)(a)(ii)(A)(I) or (II); or

(IV) an employer, as defined in Section 34A-2-103, whose purchase of insurance arises solely out of the purchase of workers' compensation products and services from the fund or a fund subsidiary; or

(B) for a state fund organization that is not an admitted insurer in the other state:

(I) on a fee for service basis; and

(II) without bearing any insurance risk; and

(b) offer workers' compensation products and services in Utah and other states.

(4) The fund shall write workers' compensation insurance in accordance with Section 31A-22-1001.

(5) (a) The fund may enter into a joint enterprise that offers workers' compensation insurance and other coverage only in the state, provided:

(i) the joint enterprise offers only property or liability insurance in addition to workers' compensation insurance;

(ii) the fund may not bear any insurance risk associated with the insurance coverage other than risk associated with workers' compensation insurance; and

(iii) the offer of other insurance shall be part of an insurance program that includes workers' compensation insurance coverage that is provided by the fund.

(b) The fund or a subsidiary of the fund may not offer, or enter into a joint enterprise that offers, or otherwise participate in the offering of accident and health insurance.

Amended by Chapter 33, 2001 General Session
Amended by Chapter 116, 2001 General Session

31A-33-104. Workers' Compensation Fund exempted.

(1) The Workers' Compensation Fund is exempt from the provisions of:

(a) Title 52, Chapter 4, Open and Public Meetings Act;

(b) Title 63G, Chapter 2, Government Records Access and Management Act; and

(c) Title 63A, Utah Administrative Services Code.

(2) The board may specifically exempt the Workers' Compensation Fund from any provisions of:

(a) Title 67, Chapter 19, Utah State Personnel Management Act; and

(b) Title 63G, Chapter 6a, Utah Procurement Code.

(3) The provisions of Title 63G, Chapter 4, Administrative Procedures Act, do not govern the initial determination of any person's eligibility for benefits under Title 34A, Chapter 2, Workers' Compensation Act, and Title 34A, Chapter 3, Utah Occupational Disease Act.

Amended by Chapter 347, 2012 General Session

31A-33-105. Price of insurance -- Liability of state.

(1) The Workers' Compensation Fund shall provide workers' compensation insurance at an actuarially sound price, which the board shall determine.

(2) The state:

(a) is not liable for the expenses, liabilities, or debts of:

(i) the Workers' Compensation Fund;

(ii) a subsidiary of the fund; or

(iii) a joint enterprise in which the fund participates; and

(b) may not use any assets of the Injury Fund for any purpose.

Amended by Chapter 107, 1998 General Session

31A-33-106. Board of directors -- Status of the fund in relationship to the state.

(1) There is created a board of directors of the Workers' Compensation Fund.

(2) The board shall consist of seven directors.

(3) Subject to Subsection (8), one director:

(a) (i) shall be the executive director of the Department of Administrative Services or the executive director's designee; and

(ii) acts as the representative of the state as a policyholder of the Workers' Compensation Fund; or

(b) is a public director appointed in accordance with Subsection (8)(b).

(4) One director shall be the chief executive officer of the fund.

(5) (a) In accordance with a plan that meets the requirements of this section, the governor, with the consent of the Senate, shall appoint five public directors as follows:

(i) three directors who are owners, officers, or employees of policyholders other than the state, each of whom is an owner, officer, or employee of a policyholder that has been insured by the Workers' Compensation Fund for at least one year before the appointment of the director representing the policyholder; and

(ii) two directors from the public in general.

(b) The plan described in Subsection (5)(a) shall comply with Section 31A-5-409 to the extent that Section 31A-5-409 does not conflict with this section.

(6) No two directors may represent or be employed by the same policyholder.

(7) At least four directors appointed by the governor shall have had previous experience in:

(a) the actuarial profession;

(b) accounting;

(c) investments;

(d) risk management;

(e) occupational safety;

(f) casualty insurance; or

(g) the legal profession.

(8) (a) Any director who represents a policyholder that fails to maintain workers' compensation insurance through the Workers' Compensation Fund shall immediately resign from the board, including the executive director of the Department of Administrative Services or the executive director's designee if the state is no longer insured by the Workers' Compensation Fund pursuant to Section 34A-2-203.

(b) (i) If the state is no longer insured by the Workers' Compensation Fund pursuant to Section 34A-2-203, the governor with the consent of the Senate, shall appoint a public director to replace the executive director of the Department of Administrative Services or the executive director's designee.

(ii) The public director appointed under this Subsection (8)(b) shall:

(A) be an owner, officer, or employee of a policyholder that has been insured by the Workers' Compensation Fund for at least one year before the appointment of the director representing the policyholder;

(B) have previous experience described in Subsection (7); or

(C) be the director of the Governor's Office of Economic Development.

(c) Once the executive director of the Department of Administrative Services or the executive director's designee is not a member of the board under Subsection (3), the state shall have a member on the board to represent the state as a policyholder

only if the member is appointed in accordance with Subsection (5) or (8)(b).

(9) A person may not be a director if that person:

(a) has any interest as a stockholder, employee, attorney, or contractor of a competing insurance carrier providing workers' compensation insurance in Utah;

(b) fails to meet or comply with the conflict of interest policies established by the board; or

(c) is not bondable.

(10) After notice and a hearing, the governor may remove any director for cause which includes:

(a) neglect of duty; or

(b) malfeasance.

(11) (a) Except as required by Subsection (11)(b), the term of office of the directors appointed by the governor shall be four years, beginning July 1 of the year of appointment.

(b) Notwithstanding the requirements of Subsection (11)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that no more than two terms expire in a calendar year.

(12) Each director shall hold office until the director's successor is appointed and qualified.

(13) When a vacancy occurs in the membership of the board for any reason, the replacement shall be appointed for the unexpired term.

(14) The board shall annually elect a chair and other officers as needed from its membership.

(15) (a) The board shall meet at least quarterly at a time and place designated by the chair.

(b) The chair:

(i) may call board meetings more frequently than quarterly; and

(ii) shall call additional board meetings if requested to do so by a majority of the board.

(16) Four directors are a quorum for the purpose of transacting all business of the board.

(17) Each decision of the board requires the affirmative vote of at least four directors for approval.

(18) (a) (i) A director may receive compensation and be reimbursed for reasonable expenses incurred in the performance of the director's official duties:

(A) as determined by the board of directors; and

(B) if the aggregate of compensation paid to all directors of the Workers' Compensation Fund in a calendar year is less than or equal to the amount described in Subsection (18)(a)(ii).

(ii) (A) For the period beginning May 1, 2007 and ending December 31, 2007, the amount described in Subsection (18)(a)(i)(B) is $75,000 except that any compensation paid to a director of the Workers' Compensation Fund on or after January 1, 2007 but on or before April 30, 2007 shall be included in determining whether the aggregate amount described in Subsection (18)(a)(i)(B) is exceeded.

(B) For calendar years beginning on or after January 1, 2008, the amount described in Subsection (18)(a)(i)(B) is the sum of the amount under this Subsection

(18)(a) for the previous year and an amount equal to the greater of:

(I) an amount calculated by multiplying the amount under this Subsection (18)(a) for the previous year by the actual percent change during the previous calendar year in the consumer price index; and

(II) 0.

(C) For purposes of this Subsection (18), the consumer price index shall be calculated as provided in Sections 1(f)(4) and 1(f)(5), Internal Revenue Code.

(b) Directors may decline to receive compensation and expenses for their service.

(c) The Worker's Compensation Fund shall pay compensation to and reimburse reasonable expenses of directors as permitted by this section:

(i) from the Injury Fund; and

(ii) upon vouchers drawn in the same manner as the Workers' Compensation Fund pays its normal operating expenses.

(d) The following shall serve on the board without payment of compensation, but may be reimbursed for reasonable expenses in accordance with Subsection (18)(a):

(i) the executive director of the Department of Administrative Services, or the executive director's designee;

(ii) the chief executive officer of the Workers' Compensation Fund; and

(iii) the director of the Governor's Office of Economic Development if appointed under Subsection (8).

(e) The Workers' Compensation Fund shall annually report to the commissioner compensation and expenses paid to the directors on the board.

(19) The requirement that the governor, with the consent of the Senate, appoint the directors of the Workers' Compensation Fund specified in Subsection (5) or (8), does not:

(a) remove from the board of directors the managerial, financial, or operational control of the Workers' Compensation Fund;

(b) give to the state or the governor managerial, financial, or operational control of the Workers' Compensation Fund;

(c) consistent with Section 31A-33-105, cause the state to be liable for any:

(i) obligation of the Workers' Compensation Fund; or

(ii) expense, liability, or debt described in Section 31A-33-105;

(d) alter the legal status of the Workers' Compensation Fund as:

(i) a nonprofit, self-supporting, quasi-public corporation; and

(ii) an insurer:

(A) regulated under this title;

(B) that is structured to operate in perpetuity; and

(C) domiciled in the state; or

(e) alter the requirement that the Workers' Compensation Fund provide workers' compensation:

(i) for the purposes set forth in Section 31A-33-102;

(ii) consistent with Section 34A-2-201; and

(iii) as provided in Section 31A-22-1001.

Amended by Chapter 74, 2007 General Session

31A-33-107. Duties of board -- Creation of subsidiaries -- Entering into joint enterprises.

(1) The board shall:

(a) appoint a chief executive officer to administer the Workers' Compensation Fund;

(b) receive and act upon financial, management, and actuarial reports covering the operations of the Workers' Compensation Fund;

(c) ensure that the Workers' Compensation Fund is administered according to law;

(d) examine and approve an annual operating budget for the Workers' Compensation Fund;

(e) serve as investment trustees and fiduciaries of the Injury Fund;

(f) receive and act upon recommendations of the chief executive officer;

(g) develop broad policy for the long-term operation of the Workers' Compensation Fund, consistent with its mission and fiduciary responsibility;

(h) subject to Chapter 19a, Part 4, Workers' Compensation Rates, approve any rating plans that would modify a policyholder's premium;

(i) subject to Chapter 19a, Part 4, Workers' Compensation Rates, approve the amount of deviation, if any, from standard insurance rates;

(j) approve the amount of the dividends, if any, to be returned to policyholders;

(k) adopt a procurement policy consistent with the provisions of Title 63G, Chapter 6a, Utah Procurement Code;

(l) develop and publish an annual report to policyholders, the governor, the Legislature, and interested parties that describes the financial condition of the Injury Fund, including a statement of expenses and income and what measures were taken or will be necessary to keep the Injury Fund actuarially sound;

(m) establish a fiscal year;

(n) determine and establish an actuarially sound price for insurance offered by the fund;

(o) establish conflict of interest requirements that govern the board, officers, and employees;

(p) establish compensation and reasonable expenses to be paid to directors on the board subject to the requirements of Section 31A-33-106, so that the board may not approve compensation that exceeds the amount described in Subsection 31A-33-106(18)(a)(i)(B); and

(q) perform all other acts necessary for the policymaking and oversight of the Workers' Compensation Fund.

(2) Subject to board review and its responsibilities under Subsection (1)(e), the board may delegate authority to make daily investment decisions.

(3) The fund may form or acquire a subsidiary or enter into a joint enterprise:

(a) only if that action is approved by the board; and

(b) subject to the limitations in Section 31A-33-103.5.

Amended by Chapter 347, 2012 General Session

31A-33-108. Powers and duties of chief executive officer.

(1) The chief executive officer shall:

(a) administer all operations of the Workers' Compensation Fund under the direction of the board;

(b) recommend to the board any necessary or desirable changes in the workers' compensation law;

(c) recommend to the board an annual administrative budget covering the operations of the Workers' Compensation Fund and, upon approval, submit the administrative budget, financial status, and actuarial condition of the fund to the governor and the Legislature for their examination;

(d) direct and control all expenditures of the approved budget;

(e) from time to time, upon the recommendation of a consulting actuary, recommend to the board rating plans, the amount of deviation, if any, from standard rates, and the amount of dividends, if any, to be returned to policyholders;

(f) invest the Injury Fund's assets under the guidance of the board and in accordance with Chapter 18;

(g) recommend general policies and procedures to the board to guide the operations of the fund;

(h) formulate and administer a system of personnel administration and employee compensation that uses merit principles of personnel management, includes employee benefits and grievance procedures consistent with those applicable to state agencies, and includes inservice training programs;

(i) prepare and administer fiscal, payroll, accounting, data processing, and procurement procedures for the operation of the Workers' Compensation Fund;

(j) conduct studies of the workers' compensation insurance business, including the preparation of recommendations and reports;

(k) develop uniform procedures for the management of the Workers' Compensation Fund;

(l) maintain contacts with governmental and other public or private groups having an interest in workers' compensation insurance;

(m) within the limitations of the budget, employ necessary staff personnel and consultants, including actuaries, attorneys, medical examiners, adjusters, investment counselors, accountants, and clerical and other assistants to accomplish the purpose of the Workers' Compensation Fund;

(n) maintain appropriate levels of property, casualty, and liability insurance as approved by the board to protect the fund, its directors, officers, employees, and assets; and

(o) develop self-insurance programs as approved by the board to protect the fund, its directors, officers, employees, and assets to supersede or supplement insurance maintained under Subsection (1)(n).

(2) The chief executive officer may:

(a) enter into contracts of workers' compensation and occupational disease insurance, which may include employer's liability insurance to cover the exposure of a policyholder to his Utah employees and their dependents for liability claims, including the cost of defense in the event of suit, for claims based upon bodily injury to the policyholder's Utah employees;

(b) reinsure any risk or part of any risk;

(c) cause to be inspected and audited the payrolls of policyholders or employers applying to the Workers' Compensation Fund for insurance;

(d) establish procedures for adjusting claims against the Workers' Compensation Fund that comply with Title 34A, Chapters 2 and 3, and determine the persons to whom and through whom the payments of compensation are to be made;

(e) contract with physicians, surgeons, hospitals, and other health care providers for medical and surgical treatment and the care and nursing of injured persons entitled to benefits from the Workers' Compensation Fund;

(f) require policyholders to maintain an adequate deposit to provide security for periods of coverage for which premiums have not been paid;

(g) contract with self-insured entities for the administration of workers' compensation claims and safety consultation services; and

(h) with the approval of the board, adopt the calendar year or any other reporting period to report claims and payments made or reserves established on claims that are necessary to accommodate the reporting requirements of the Labor Commission, department, State Tax Commission, or National Council on Compensation Insurance.

Amended by Chapter 252, 2003 General Session

31A-33-109. Liability limited.

(1) No officer or employee of the Workers' Compensation Fund is liable in a private capacity for any act performed or obligation entered into when done in good faith, without intent to defraud, and in an official capacity in connection with the administration, management, or conduct of the Workers' Compensation Fund or affairs relating to it.

(2) Subject to the director's fiduciary responsibility as established by Section 31A-33-106, no director of the Workers' Compensation Fund is liable in a private capacity for any act performed or obligation entered into when done in good faith, without intent to defraud, and in an official capacity in connection with the administration, management, or conduct of the Workers' Compensation Fund or affairs relating to it.

Renumbered and Amended by Chapter 240, 1996 General Session

31A-33-110. Audits and examinations required.

(1) (a) The Workers' Compensation Fund shall annually obtain an audit:

(i) conducted in accordance with:

(A) generally accepted auditing standards; and

(B) government auditing standards; and

(ii) by a national firm of certified public accountants.

(b) The fund shall provide the audit performed under Subsection (1)(a) to the state auditor within 30 days of its completion.

(2) (a) The insurance commissioner shall examine the Injury Fund according to the purposes and procedures provided in Sections 31A-2-203 through 31A-2-205 at least once every five years.

(b) The chief executive officer shall pay the necessary expense of this

examination from the Injury Fund.

Amended by Chapter 204, 1997 General Session

31A-33-111. Adoption of rates.

(1) The Workers' Compensation Fund shall adopt the rates approved by the insurance commissioner under Chapter 19a, Part 4, Workers' Compensation Rates.

(2) The chief executive officer, with the approval of the board, may file with the insurance commissioner a resolution to deviate from the rates approved by the insurance commissioner in order to provide workers' compensation insurance at the lowest possible cost to policyholders consistent with maintaining the actuarial soundness of the Injury Fund.

Amended by Chapter 130, 1999 General Session

31A-33-112. Withdrawal of policyholders.

Any policyholder may, upon complying with Section 31A-22-1002, withdraw from the Workers' Compensation Fund by providing an advance written notice of his intent to cancel. The policyholder shall remain liable for any unpaid premium for periods of coverage prior to cancellation.

Renumbered and Amended by Chapter 240, 1996 General Session

31A-33-113. Cancellation of policies.

The Workers' Compensation Fund may cancel a policy as provided in Section 31A-22-1002.

Amended by Chapter 116, 2001 General Session

31A-33-114. Premium assessment.

The Workers' Compensation Fund is liable for the premium assessment provided by Subsection 59-9-101(2) to the same extent as private workers' compensation insurance companies.

Renumbered and Amended by Chapter 240, 1996 General Session

31A-33-115. Interest and costs of collecting delinquent premium.

If the Workers' Compensation Fund commences a legal action for collection of delinquent premium, it is entitled, in addition to the unpaid premium, to interest on the unpaid premium at the same rate as is then being charged by the United States Internal Revenue Service for delinquent taxes from the due date of the unpaid premium, and for all costs of collection including reasonable attorneys' fees and court costs. The remedies of the Workers' Compensation Fund under this section do not affect or diminish, and may be exercised in addition to, its right to cancel policies under Sections 31A-33-112 and 31A-33-113.

Renumbered and Amended by Chapter 240, 1996 General Session

31A-33-116. Dividends.

The board may declare a dividend to policyholders if it determines that a surplus exists in the Injury Fund at the end of a fiscal period after the payment of all claims, administrative costs, and the establishment of appropriate reserves for future liabilities. In making this determination, the board shall require a certified audit and actuarial report of the financial condition of the Injury Fund. The board shall establish uniform eligibility requirements for such dividends. In determining the amount of dividend to be paid to policyholders, the board may establish a procedure which takes into consideration the claims loss experience of policyholders as an incentive to encourage safe working conditions for employees. The Workers' Compensation Fund may use dividends to offset amounts due or owing by policyholders or former policyholders.

Renumbered and Amended by Chapter 240, 1996 General Session

31A-33-117. Availability of employers' reports.

The Labor Commission shall make the employers' annual reports provided for in Section 34A-2-206 available to the Workers' Compensation Fund, to the same extent the reports would be available to private insurers.

Amended by Chapter 375, 1997 General Session

31A-33-118. Scope of chapter.

The placement of this chapter in this title may not be construed to change the Workers' Compensation Fund's legal nature or purpose as set forth in this chapter.

Amended by Chapter 107, 1998 General Session

31A-34-101. Title.

This chapter is known as the "Voluntary Health Insurance Purchasing Alliance Act."

Enacted by Chapter 143, 1996 General Session

31A-34-102. Purpose and intent -- Legislative findings.

(1) The purpose of this chapter is to improve the delivery of health care coverage for employer groups and individual applicants through the establishment of private competing purchasing entities to be known as health insurance purchasing alliances.

(2) The Legislature finds that the establishment of voluntary health insurance purchasing alliances will likely improve cost, quality, and access to health insurance services.

(3) To facilitate health insurance purchasing alliances and to ensure a fair allocation of risk among contracted insurers, the Legislature finds that cooperation among contracted insurers and health insurance purchasing alliances is necessary in

the development of coordinated actuarial models and in the coordination of underwriting and marketing methodologies.

(4) This chapter establishes state supervision and control over the activities of health insurance purchasing alliances. By this chapter, the Legislature substitutes state regulation and control for competition among contracted insurers with respect to the coordinated development and implementation of actuarial models and underwriting and marketing methodologies used in conjunction with health insurance made available through a health insurance purchasing alliance licensed under this chapter. To the extent regulated and controlled under this chapter, alliances and contracted insurers are immune from actions that might arise under state or federal antitrust laws.

Enacted by Chapter 143, 1996 General Session

31A-34-103. Definitions.

As used in this chapter:

(1) "Alliance," "health insurance purchasing alliance," or "health insurance purchasing co-operative" means a nonrisk bearing nonprofit corporation or trust which makes health insurance available to its members and enrollees from multiple unaffiliated insurers through the use of coordinated actuarial models, coordinated underwriting, or coordinated marketing methodologies.

(2) "Board" means a health insurance purchasing alliance's board of directors or trustees.

(3) "Contracted insurer" means an insurer that contracts with a health insurance purchasing alliance to provide coverage to enrollees under a health benefit plan.

(4) "Enrollee" means an individual who is covered in a health benefit plan made available through a health insurance purchasing alliance and offered by a contracted insurer.

(5) "Health insurance purchasing association" means a nonprofit corporation organized pursuant to Section 31A-34-105 by employers for the purpose of jointly purchasing health insurance.

(6) "Member" means a person who purchases health insurance through a health insurance purchasing alliance.

Enacted by Chapter 143, 1996 General Session

31A-34-104. Alliance -- Required license.

(1) A person shall be licensed as an alliance pursuant to this chapter to directly or indirectly make available or otherwise arrange for health insurance through multiple unaffiliated insurers through the use of coordinated actuarial models, coordinated underwriting, or coordinated marketing methodologies.

(2) (a) A person may not hold itself out as a health insurance purchasing alliance, purchasing alliance, health insurance purchasing cooperative, purchasing cooperative, or otherwise use a similar name unless licensed by the commissioner as an alliance.

(b) Notwithstanding Subsection (2)(a), a person may hold itself out as a voluntary health insurance purchasing association without being licensed by the

commissioner as provided in Section 31A-34-105.

(3) To apply for licensure as an alliance, a person shall complete an application in a form designated by the commissioner and file it with the commissioner, together with the applicable filing fees determined by the commissioner under Section 63J-1-504.

Amended by Chapter 297, 2011 General Session

31A-34-105. Association requirements.

(1) A nonprofit corporation organized under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, may only hold itself out as a voluntary health insurance purchasing association if it:

(a) is organized by participating employers;

(b) is governed and controlled by participating employers;

(c) does not bear risk; and

(d) has filed with the commissioner:

(i) its articles of incorporation and bylaws; and

(ii) a completed form provided by the department.

(2) A voluntary health insurance purchasing association is not an alliance under this chapter, is not exempt from state or federal antitrust laws, and is therefore not subject to the regulation of this chapter, except as provided in this section.

Amended by Chapter 300, 2000 General Session

31A-34-106. Jurisdiction of the commissioner.

(1) The commissioner shall facilitate the creation and operation of alliances to ensure a fair allocation of risk among contracted insurers and proper state oversight and to provide consumer protection to members, enrollees, and the public through the active supervision and regulation of alliances with regard to:

(a) marketing through:

(i) standards for the development and approval of coordinated actuarial models and coordinated underwriting and marketing methodologies that promote efficiencies of scale while preserving market competition;

(ii) limitations on the cooperation permitted among contracted insurers, the circumstances under which such cooperation may occur, and the nature of the information that may be shared for purposes of developing coordinated actuarial models as well as coordinated underwriting and marketing methodologies;

(iii) reporting requirements; and

(iv) limitations on unfair marketing methods and practices;

(b) the financial stability of alliances and their contracted insurers regarding:

(i) financial solvency;

(ii) maintenance of trust accounts;

(iii) risk sharing methods; and

(iv) other matters relating to financial reporting and solvency; and

(c) the articles of incorporation and bylaws of alliances.

(2) An alliance shall submit proposed actuarial models and underwriting and

marketing methodologies to the commissioner for review, modification, if necessary, and approval prior to use.

(3) Financial and performance examinations of an alliance shall be conducted in accordance with the provisions of Sections 31A-2-203, 31A-2-203.5, and 31A-2-204. The alliance shall reimburse the Insurance Department for the reasonable costs of such audits or examinations under Section 31A-2-205.

Enacted by Chapter 143, 1996 General Session

31A-34-107. Directors, trustees, and officers.

(1) To ensure representation of consumer interests, at least 25% of the board shall be enrollees, chosen under a plan proposed by the alliance and approved by the commissioner.

(2) Those who sit as directors or trustees on the board or as officers or principals of the corporation or trust shall be trustworthy and collectively have the competence and experience to carry out the activities of the alliance.

Amended by Chapter 297, 2011 General Session

31A-34-108. Powers of and restrictions on alliances.

(1) An alliance may only exercise the powers necessary to:

(a) make health insurance available to its members and enrollees from multiple unaffiliated insurers through the use of coordinated actuarial models, coordinated underwriting, or coordinated marketing methodologies; and

(b) subject to Subsection (3)(d), make available to its members other related insurance products and services, including dental, vision, and life insurance.

(2) In addition to the powers granted to a nonprofit corporation in Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, or to the powers of a trust under common law, the powers of an alliance include:

(a) setting reasonable fees and conditions for membership, which may vary by group size, to reflect reasonable and necessary costs incurred in administering the alliance;

(b) providing or contracting for premium collection services consistent with the requirements of Title 31A, Chapter 25; or

(c) contracting with qualified independent third parties for any service necessary to carry out the powers and duties authorized or required by this chapter.

(3) Notwithstanding Subsection (1), an alliance may not:

(a) purchase health care services;

(b) assume risk for the cost or provision of health services;

(c) contract with health care providers for the provision of health care services to enrollees; or

(d) condition alliance membership on the purchase or subscription of a product or service other than health insurance.

Amended by Chapter 300, 2000 General Session

31A-34-109. Operation of alliances.

An alliance shall:

(1) be operated by its board;

(2) contract with at least three insurers unaffiliated with each other to ensure that enrollees have a choice from among a reasonable number of competing insurers and types of health benefit plans. The commissioner may, by order, modify this requirement to allow an alliance to contract with only two unaffiliated insurers if the commissioner finds that modification of this requirement may enhance competitive cost, quality, or access in the pricing and delivery of health insurance and that such modification does not prejudice the interests of potential members or enrollees;

(3) develop standard enrollment procedures;

(4) prepare and distribute educational materials, plan descriptions, and comparison sheets describing contracted insurers and the health benefit plans available through the alliance to prospective members;

(5) receive, review, and act, as appropriate, on grievances by members and enrollees;

(6) establish administrative and accounting procedures for operating the alliance and for providing services to members and enrollees;

(7) prepare an annual report for the commissioner on the operations of the alliance no later than March 1, which shall include an accounting of all revenues received by the alliance, internal and independent audits, and other related information as the commissioner may require;

(8) establish procedures for billing and collecting premiums from members;

(9) establish procedures that allow an enrollee to transfer at least once each year to another health benefit plan that is comparable in benefits and is available through the alliance;

(10) deposit and maintain all money received and collected for the operation of the alliance in trust with the clear understanding that the alliance, its board, employees, and agents have a fiduciary duty to safeguard the money it receives, pursue funds that are owed, pay outstanding obligations, and account fully to alliance members and the commissioner; and

(11) establish marketing standards to be used by contracted insurers.

Enacted by Chapter 143, 1996 General Session

31A-34-110. Contracts with member employers and contracted insurers.

(1) Contracts between an alliance and members shall provide that the alliance is the contract holder of the health benefit plan policy on behalf of members and enrollees.

(2) Contracts between an alliance and a contracted insurer shall specify how premiums will be transferred, what penalties and grace periods will be, and how examination costs will be allocated to contracted insurers.

(3) Subject only to Sections 31A-8-105.5 and 31A-8-501, and until July 1, 2004, health benefit plans offered exclusively in an alliance under this chapter may limit reimbursement to providers on the panel of a contracted insurer if the commissioner finds that the aggregate of alliance contracts available to its members provide a broad

and substantial choice of providers, encompassing the vast majority of doctors and hospitals in the state.

Amended by Chapter 108, 2001 General Session

31A-34-111. Alliance evaluation.

Each alliance shall make a detailed annual report to the commissioner no later than March 1 containing at least the following:

(1) the progress achieved in assuring affordable health care coverage to eligible employees of members;

(2) the benefits, if any, to its members and enrollees of purchasing health insurance through the alliance; and

(3) changes in the law or procedure that would increase overall efficiency, reduce costs, or improve fairness.

Enacted by Chapter 143, 1996 General Session

31A-35-101. Title.

This chapter is known as the "Bail Bond Act."

Amended by Chapter 173, 2004 General Session

31A-35-102. Definitions.

As used in this chapter:

(1) "Bail bond" means a bond for a specified monetary amount that is:

(a) executed by a bail bond producer licensed in accordance with Section 31A-35-401; and

(b) issued to a court, magistrate, or authorized officer as security for the subsequent court appearance of the defendant upon the defendant's release from actual custody pending the appearance.

(2) "Bail bond producer" means an individual who:

(a) is appointed by:

(i) a surety insurer that issues bail bonds; or

(ii) a bail bond surety company licensed under this chapter;

(b) is appointed to execute or countersign undertakings of bail in connection with judicial proceedings; and

(c) receives or is promised money or other things of value for engaging in an act described in Subsection (2)(b).

(3) "Bail bond surety" means a person that:

(a) (i) is a bail bond surety company licensed under this chapter; or

(ii) a surety insurer; and

(b) issues bonds to secure:

(i) the release of a person from incarceration; and

(ii) the appearance of that person at court hearings.

(4) "Bail bond surety company" means any sole proprietor or entity who:

(a) (i) is the agent of a surety insurer that issues a bail bond in connection with

judicial proceedings;

(ii) pledges the assets of a letter of credit from a Utah depository institution for a bail bond in connection with judicial proceedings; or

(iii) pledges personal or real property, or both, as security for a bail bond in connection with judicial proceedings; and

(b) receives or is promised money or other things of value for a service described in Subsection (4)(a).

(5) "Bail enforcement agent" means an individual who:

(a) is employed or contracted with to:

(i) enforce the terms and conditions of a defendant's release on bail in a civil or criminal proceeding;

(ii) apprehend a defendant or surrender a defendant to custody; or

(iii) both Subsections (5)(a)(i) and (ii); and

(b) receives or is promised money or other things of value for the services described in Subsection (5)(a).

(6) "Board" means the Bail Bond Surety Oversight Board created in Section 31A-35-201.

(7) "Certificate" means a certificate of authority issued under this chapter to allow an insurer to operate as a surety insurer.

(8) "Indemnitor" means an entity or natural person who enters into an agreement with a bail bond surety to hold the bail bond surety harmless from loss incurred as a result of executing a bail bond.

(9) "Liquid assets" means financial holdings that can be converted into cash in a timely manner without the loss of principal.

(10) "Principal" means an individual or corporation whose performance is guaranteed by bond.

(11) "Surety insurer" means an insurer that:

(a) is licensed under Chapter 4, 5, or 14;

(b) receives a certificate under this title; and

(c) issues bail bonds.

(12) "Utah depository institution" is a depository institution, as defined in Section 7-1-103, that:

(a) has Utah as its home state; or

(b) operates a branch in Utah.

Amended by Chapter 298, 2003 General Session

31A-35-103. Exemption from other sections of this title.

Bail bond surety companies are exempted from:

(1) Chapter 3, Department Funding, Fees, and Taxes, except Section 31A-3-103;

(2) Chapter 4, Insurance in General, except Sections 31A-4-102, 31A-4-103, 31A-4-104, and 31A-4-107;

(3) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except Section 31A-5-103, and

(4) Chapters 6, 6a, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 24, 25, 26,

27, 27a, 28, 29, 30, 31, 32, 33, and 34.

Amended by Chapter 309, 2007 General Session

31A-35-104. Rulemaking authority.

The commissioner shall by rule establish specific licensure and certification guidelines and standards of conduct for the business of bail bond surety insurance under this chapter.

Amended by Chapter 259, 2000 General Session

31A-35-201. Bail Bond Surety Oversight Board.

(1) There is created a Bail Bond Surety Oversight Board within the department, consisting of:

(a) the following seven voting members to be appointed by the commissioner:

(i) one representative each from four licensed bail bond surety companies;

(ii) two members of the general public who do not have any financial interest in or professional affiliation with any bail bond surety company; and

(iii) one attorney in good standing licensed to practice law in Utah; and

(b) a nonvoting member who is a staff member of the insurance department appointed by the commissioner.

(2) (a) The appointments are for terms of four years. A board member may not serve more than two consecutive terms.

(b) The insurance commissioner shall, at the time of appointment or reappointment of a board member described in Subsection (1)(a), adjust the length of terms to ensure that the terms of board members are staggered so approximately half of the board is appointed every two years.

(3) A board member serves until:

(a) removed by the insurance commissioner;

(b) the member's resignation; or

(c) for a member described in Subsection (1)(a), the expiration of the member's term and the appointment of a successor.

(4) When a vacancy occurs in the membership of a board member described in Subsection (1)(a) for any reason, the replacement shall be appointed for the remainder of the unexpired term.

(5) The board shall annually elect one of its members as chair.

(6) Four voting members constitute a quorum for the transaction of business.

(7) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

(8) (a) The commissioner, with a majority vote of the board, may remove any member of the board described in Subsection (1)(a) for misconduct, incompetency, or neglect of duty.

(b) The board shall conduct a hearing if requested by the board member described in Subsection (1)(a) that is to be removed.

(9) Members of the board are immune from suit with respect to all acts done and actions taken in good faith in carrying out the purposes of this chapter.

Amended by Chapter 286, 2010 General Session

31A-35-202. Board responsibilities.

(1) The board shall:

(a) meet:

(i) at least quarterly; and

(ii) at the call of the chair;

(b) make written recommendations to the commissioner for rules governing the following aspects of the bail bond surety insurance business:

(i) qualifications, applications, and fees for obtaining:

(A) a license required by this Section 31A-35-401; or

(B) a certificate;

(ii) limits on the aggregate amounts of bail bonds;

(iii) unprofessional conduct;

(iv) procedures for hearing and resolving allegations of unprofessional conduct; and

(v) sanctions for unprofessional conduct;

(c) screen:

(i) bail bond surety company license applications; and

(ii) persons applying for a bail bond surety company license; and

(d) recommend to the commissioner action regarding the granting, renewing, suspending, revoking, and reinstating of bail bond surety company license.

(2) The board may:

(a) conduct investigations of allegations of unprofessional conduct on the part of persons or bail bond sureties involved in the business of bail bond surety insurance; and

(b) provide the results of the investigations described in Subsection (2)(a) to the commissioner with recommendations for:

(i) action; and

(ii) any appropriate sanctions.

Amended by Chapter 284, 2011 General Session

31A-35-301. The commissioner's authority.

(1) The commissioner shall:

(a) make rules as necessary for the administration of this chapter;

(b) with information as provided by the board, issue or deny licensure under this chapter;

(c) take action regarding a license, including suspension or revocation; and

(d) maintain and publish a current list of licensed bail bond surety companies and producers.

(2) The commissioner may establish fees for the issuance, renewal, and reinstatement of a bail bond surety company license in accordance with Section 63J-1-504.

Amended by Chapter 183, 2009 General Session

31A-35-401. Requirement for license or certificate of authority -- Process -- Fees -- Limitations.

(1) (a) A person may not engage in the bail bond surety insurance business unless that person:

(i) is a bail bond surety company licensed under this chapter;

(ii) is a surety insurer that is granted a certificate under this section in the same manner as other insurers doing business in this state are granted certificates of authority under this title; or

(iii) is a bail bond producer licensed in accordance with this section.

(b) A bail bond surety company shall be licensed under this chapter as an agency.

(c) A bail bond producer shall be licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, as a limited lines producer.

(2) A person applying for a bail bond surety company license under this chapter shall submit to the commissioner:

(a) a completed application form as prescribed by the commissioner;

(b) a fee as determined by the commissioner in accordance with Section 31A-3-103; and

(c) any additional information required by rule.

(3) A fee required under this section is not refundable.

(4) A fee collected from a bail bond surety company shall be deposited in a restricted account created in Section 31A-35-407.

(5) (a) A bail bond surety company shall be domiciled in Utah.

(b) A bail bond producer shall be a resident of Utah.

(c) A foreign surety insurer that is granted a certificate to issue bail bonds may only issue bail bonds through a bail bond surety company licensed under this chapter.

Amended by Chapter 10, 2010 General Session

31A-35-401.5. Additional licensure requirements for a bail bond surety company.

(1) A person applying for licensure as a bail bond surety or agency for the first time shall, in addition to the requirements of Section 31A-35-401, provide proof that at least one principal of the bail bond surety or agency will have a minimum of 2,000 hours of experience working as an employee of a bail bond surety company as a licensed bail bond agent.

(2) The applicant shall provide proof of the experience claimed under Subsection (1), including providing:

(a) the exact details of the character and nature of the experience on a form

provided by the department;

(b) a statement by each employer verifying the number of hours the applicant worked for the employer; and

(c) (i) federal income reporting forms that account for the wages for hours claimed or documented approval of the claimed hours by the insurance commissioner; and

(ii) the total of 2,000 hours may be proved in part by federal income reporting forms and in part by approval by the insurance commissioner.

(3) The burden of proving the hours of experience as required in this section is upon the applicant.

Amended by Chapter 253, 2012 General Session

31A-35-402. Authority related to bail bonds.

(1) A bail bond surety company may only issue bail bonds.

(2) In accordance with Section 31A-23a-205, a bail bond producer may not execute or issue a bail bond in this state without holding a current appointment from a bail bond surety or current designation from a bail bond company.

(3) A bail bond surety may not allow any person who is not a bail bond producer to engage in the bail bond surety business on the bail bond surety's behalf, except for individuals:

(a) employed solely for the performance of clerical, stenographic, investigative, or other administrative duties that do not require a license as:

(i) a bail bond surety company; or

(ii) a bail bond producer; and

(b) whose compensation is not related to or contingent upon the number of bonds written.

Amended by Chapter 298, 2003 General Session

31A-35-403. Exemptions to licensing requirements.

This chapter does not affect the negotiation through a licensed producer for, or the execution or delivery of, an undertaking of bail executed by an insurer for its insured under a policy of automobile insurance or of liability insurance upon the automobile of the insured.

Amended by Chapter 298, 2003 General Session

31A-35-404. Minimum financial requirements for bail bond surety company license.

(1) (a) A bail bond surety company that pledges the assets of a letter of credit from a Utah depository institution in connection with a judicial proceeding shall maintain an irrevocable letter of credit with a minimum face value of $300,000 assigned to the state from a Utah depository institution.

(b) Notwithstanding Subsection (1)(a), a bail bond surety company described in Subsection (1)(a) that is licensed under this chapter as of December 31, 1999, shall

maintain an irrevocable letter of credit with a minimum face value of $250,000 assigned to the state from a Utah depository institution.

(2) (a) A bail bond surety company that pledges personal or real property, or both, as security for a bail bond in connection with a judicial proceeding shall maintain:

(i) (A) a current financial statement:

(I) reviewed by a certified public accountant; and

(II) showing a net worth of at least $300,000, at least $100,000 of which is in liquid assets; or

(B) notwithstanding Subsection (2)(a)(i), if the bail bond surety company is licensed under this chapter as of December 31, 1999, a current financial statement:

(I) reviewed by a certified public accountant; and

(II) showing a net worth of at least $250,000, at least $50,000 of which is in liquid assets;

(ii) a copy of the applicant's federal income tax return for the preceding two years; and

(iii) for each parcel of real property owned by the applicant and included in net worth calculations:

(A) a title letter; and

(B) an appraisal dated not more than two years prior to the date of application.

(b) For purposes of this Subsection (2), only real or personal property located in Utah may be included in the net worth of the bail bond surety company.

(3) A bail bond surety company shall maintain a qualifying power of attorney issued by a surety insurer:

(a) if the bail bond surety company is the agent of the surety insurer; and

(b) the surety insurer:

(i) issues bail bonds;

(ii) is in good standing in its state of domicile; and

(iii) is granted a certificate to write bail bonds in Utah.

(4) The commissioner may revoke the license of a bail bond surety company that fails to maintain the minimum financial requirements required under this section.

(5) The commissioner may set by rule the limits on the aggregate amounts of bail bonds issued by a bail bond surety company.

Amended by Chapter 259, 2000 General Session

31A-35-405. Issuance of license -- Denial -- Right of appeal.

(1) Upon a determination by the board that a person applying for a bail bond surety company license meets the requirements for issuance of a license under this chapter, the commissioner shall issue to that person a bail bond surety company license.

(2) (a) If the commissioner denies an application for a bail bond surety company license under this chapter, the commissioner shall provide prompt written notification to the person applying for licensure:

(i) stating the grounds for denial; and

(ii) notifying the person applying for licensure as a bail bond surety company that:

(A) the person is entitled to a hearing if that person wants to contest the denial; and

(B) if the person wants a hearing, the person shall submit the request in writing to the commissioner within 15 days after the issuance of the denial.

(b) The department shall schedule a hearing described in Subsection (2)(a) no later than 60 days after the commissioner's receipt of the request.

(c) The department shall hear the appeal, and may:

(i) return the case to the commissioner for reconsideration;

(ii) modify the commissioner's decision; or

(iii) reverse the commissioner's decision.

(3) A decision under this section is subject to review under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 349, 2009 General Session

31A-35-406. Renewal and reinstatement.

(1) (a) A license under this chapter expires annually on August 14. To renew its license under this chapter, on or before July 15 a bail bond surety company shall:

(i) complete and submit a renewal application to the department; and

(ii) pay the department the applicable renewal fee established in accordance with Section 31A-3-103.

(b) A bail bond surety company shall renew its license under this chapter annually as established by department rule, regardless of when the license is issued.

(2) A bail bond surety company may apply for reinstatement of an expired bail bond surety company license within one year following the expiration of the license under Subsection (1) by:

(a) submitting the renewal application required by Subsection (1); and

(b) paying a license reinstatement fee established in accordance with Section 31A-3-103.

(3) If a bail bond surety company license has been expired for more than one year, the person applying for reinstatement of the bail bond surety license shall:

(a) submit a new application form to the commissioner; and

(b) pay the application fee established in accordance with Section 31A-3-103.

(4) If a bail bond surety company license is suspended, the applicant may not submit an application for a bail bond surety company license until after the end of the period of suspension.

(5) A fee collected under this section shall be deposited in the restricted account created in Section 31A-35-407.

Amended by Chapter 284, 2011 General Session

31A-35-407. Restricted account.

(1) There is created within the General Fund a restricted account known as the "Bail Bond Surety Administration Account."

(2) (a) The account shall be funded from the fees imposed under this chapter.

(b) The department shall deposit all fees collected under this part in the account.

(c) The funds in the account shall be used by the department to administer this chapter.
(d) The account shall earn interest, which shall be deposited in the account.

Enacted by Chapter 293, 1998 General Session

31A-35-501. Emergency action regarding a license.
(1) If the commissioner determines, based on an investigation, that the public health, safety, or welfare requires emergency action, the commissioner may order a summary suspension of a bail bond surety company license pending proceedings for revocation or other action.
(2) The order described in Subsection (1) shall:
(a) state the grounds upon which the summary suspension is issued, including the charges made against the licensee; and
(b) advise the licensee of the right to an administrative hearing before the commissioner within 60 days after the summary suspension is ordered.

Amended by Chapter 259, 2000 General Session

31A-35-502. Notification of violation of chapter.
If the commissioner has reason to believe a person licensed as a bail bond surety company or a bail bond producer has violated this chapter, written notice shall be sent to that person, advising the person of:
(1) the alleged violation;
(2) the commissioner's authority to take action against the person's license;
(3) the person's right to an administrative hearing under Title 63G, Chapter 4, Administrative Procedures Act; and
(4) the period of time within which the hearing described in Subsection (3) shall be requested if the person requests a hearing.

Amended by Chapter 382, 2008 General Session

31A-35-503. Disciplinary action -- Hearing -- Appeal.
(1) Based on information the commissioner receives during a hearing described in Section 31A-35-502 regarding a person licensed as a bail bond surety company or bail bond producer, the commissioner may:
(a) dismiss the complaint if the commissioner finds it is without merit;
(b) fix a period and terms of probation best adopted to educate the person;
(c) place the license on suspension for a period of not more than 12 months; or
(d) revoke the license.
(2) The commissioner shall advise the person described in Subsection (1) in writing of:
(a) the commissioner's findings based on the hearing; and
(b) the person's rights of appeal under this chapter.
(3) (a) Unless the conditions of Subsection (3)(b) are met, if a bail bond surety company license is suspended or revoked under this chapter, a member, employee,

officer, or director of that corporation may not:

(i) be licensed as a bail bond surety company or bail bond producer; or

(ii) be designated in any license to exercise authority under this chapter during the period of the suspension or revocation.

(b) Subsection (3)(a) does not apply if the commissioner determines upon substantial evidence that the member, employee, officer, or director:

(i) was not personally at fault; and

(ii) did not acquiesce in the matter on account of which the license was suspended or revoked.

Amended by Chapter 298, 2003 General Session

31A-35-504. Failure to pay bail bond forfeiture -- Grounds for suspension and revocation of bail bond surety license.

(1) As used in this section:

(a) "Company" means a bail bond surety company.

(b) "Judgment" means a judgment of bond forfeiture issued under Section 77-20b-104.

(2) (a) (i) A company shall pay a judgment not later than 15 days following service of notice upon the company from a prosecutor of the entry of the judgment.

(ii) A company may pay a bond forfeiture to the court prior to judgment.

(b) (i) A prosecutor who does not receive proof of or notice of payment of the judgment within 15 days after the service of notice to the company of a judgment shall notify the commissioner of the failure to pay the judgment.

(ii) The commissioner shall notify the company, by the most expeditious means available, of the nonpayment of the judgment.

(iii) The company shall satisfy the judgment within five business days after receiving notice under Subsection (2)(b)(ii). If the judgment is not satisfied at the end of the five days, the commissioner may suspend the company's license under Subsection (3).

(c) If notice of entry of judgment is served upon the company by mail, three additional days are added to the 15 days provided in Subsections (2)(a), (2)(b), and (2)(d).

(d) A prosecutor may not proceed under Subsection (2)(b) if a company, within 15 days after service of notice of the entry of judgment is served:

(i) files a motion to set aside the judgment or files an application for an extraordinary writ; and

(ii) provides proof that the surety has posted the judgment amount with the court in the form of cash, a cashier's check, or certified funds.

(e) As used in this section, the filing of the following tolls the time within which a company is required to pay a judgment if the motion or application is filed within 15 days after the day on which service of notice of the entry of a judgment is served:

(i) a motion to set aside a judgment; or

(ii) an application for extraordinary writ.

(3) The commissioner shall suspend the license of the company not later than five days following the company's failure to satisfy the judgment as required under

Subsection (2)(b).

(4) If the prosecutor receives proof of or notice of payment of the judgment during the suspension period under Subsection (3), the prosecutor shall immediately notify the commissioner of the payment. The notice shall be in writing and by the most expeditious means possible, including facsimile or other electronic means.

(5) The commissioner shall lift a suspension under Subsection (3) within five days of the day on which all of the following conditions are met:

(a) the suspension has been in place for no fewer than 14 days;

(b) the commissioner has received written notice of payment of the unpaid forfeiture from the prosecutor; and

(c) the commissioner has received:

(i) no other notice of any unpaid forfeiture from a prosecutor; or

(ii) if a notice of unpaid forfeiture is received, written notice from the prosecutor that the unpaid forfeiture has been paid.

(6) The commissioner shall commence an administrative proceeding and revoke the license of a company that fails to meet the conditions under Subsection (5) within 60 days following the initial date of suspension.

(7) This section does not restrict or otherwise affect the rights of a prosecutor to commence collection proceedings under Subsection 77-20b-104(5).

Amended by Chapter 178, 2010 General Session

31A-35-601. Acts of producer or agent.

(1) As used in this section:

(a) "Bail recovery agent" means an individual employed by a bail enforcement agent to assist the bail enforcement agent regarding civil or criminal defendants released on bail by:

(i) presenting a defendant for required court appearances;

(ii) apprehending or surrendering a defendant to a court; or

(iii) keeping the defendant under necessary surveillance.

(b) "Bail recovery apprentice" means an individual who:

(i) is employed by a bail enforcement agent; and

(ii) works under the direct supervision of that bail enforcement agent or under the direct supervision of a bail recovery agent employed also by the bail enforcement agent, unless the bail recovery apprentice is conducting activities at the direction of the employing bail enforcement agent that do not require direct supervision.

(2) The acts or conduct of any bail bond producer or bail enforcement agent, bail recovery agent, or bail recovery apprentice who acts within the scope of the authority delegated to him by the bail bond surety, are considered to be the acts or conduct of the bail bond surety for which the bail bond producer or bail bond enforcement agent, bail recovery agent, or bail recovery apprentice is acting as agent.

(3) The acts or conduct of any bail bond producer or bail enforcement agent, bail recovery agent, or bail recovery apprentice who acts within the scope of the authority delegated to him by the bail bond producer are considered to be the acts or conduct of the bail bond producer for which the bail enforcement agent is acting as agent.

Amended by Chapter 298, 2003 General Session

31A-35-602. Place of business -- Records to be kept there.

(1) (a) A bail bond surety company shall have and maintain in this state a place of business:

(i) accessible to the public; and

(ii) where the bail bond surety company principally conducts transactions authorized by its bail bond surety company license.

(b) The address of the place of business described in Subsection (1)(a) shall appear upon:

(i) the application for a bail bond surety company license; and

(ii) a bail bond surety company license issued under this chapter.

(c) In addition to complying with Subsection (1)(b), a bail bond surety company shall register and maintain with the commissioner the following at which the commissioner may contact the bail bond surety company:

(i) a telephone number; and

(ii) a business email address.

(d) A bail bond surety company shall notify the commissioner within 20 days of a change in the bail bond surety company's:

(i) place of business address;

(ii) telephone number; or

(iii) business email address.

(e) This section does not prohibit a bail bond surety company from maintaining the place of business required under this section in the licensee's residence, if the residence is in Utah.

(2) The bail bond surety company shall keep at the place of business described in Subsection (1)(a) the records required under Section 31A-35-604.

Amended by Chapter 284, 2011 General Session

31A-35-603. Collateral security.

(1) A bail bond producer may accept collateral security in connection with a bail transaction, if the collateral security is reasonable in relation to the face amount of the bail bond.

(2) (a) The collateral security described in Subsection (1) shall be received by the bail bond producer in the bail bond producer's fiduciary capacity.

(b) Before any judgment of forfeiture of bail, the bail bond producer shall keep the collateral separate and apart from any other funds or assets of the licensee.

(3) (a) Any collateral that is deposited with a bail bond producer or bail bond surety shall be returned to the person who deposited it within 10 days after the return is requested by the person who deposited it if:

(i) the bail bond has been exonerated; and

(ii) all fees owed to the bail bond producer or bail bond surety have been paid.

(b) A certified copy of the minute order from the court stating the bail or undertaking was ordered exonerated is prima facie evidence of exoneration or

termination of liability.

(4) (a) If a bail bond producer accepts collateral, the bail bond producer shall give a written receipt for the collateral.

(b) The receipt required by Subsection (4)(a) shall include a fully detailed account of the collateral received.

(5) Upon return of collateral to the person who posted it, if any amount has been deducted by the bail bond surety or bail bond producer as expense, the bail bond surety or bail bond producer shall:

(a) include with the returned collateral an itemized statement of all expenses deducted from the collateral; and

(b) maintain a copy of the statement required by Subsection (5)(a) in the records of the bail bond surety or bail bond producer.

(6) If the bail bond secured by the collateral is forfeited and the bail bond producer or bail bond surety retains possession of the collateral in payment of the forfeiture or otherwise disposes of the collateral, the person retaining possession or disposing of the property shall maintain a written record of the collateral, including any disposition.

(7) (a) If a document that conveys title to real property is used as collateral in a bail bond transaction, the document shall state on its face that it is executed as part of a security transaction.

(b) If the document described in Subsection (7)(a) is recorded, the bail bond producer or the bail bond surety shall:

(i) execute a reconveyance of the property, executed so that the reconveyance can be recorded; and

(ii) promptly deliver the reconveyance document to:

(A) the person executing the original conveyance; or

(B) the heirs, legal representative, or successor in interest of the person described in Subsection (7)(b)(ii)(A).

Amended by Chapter 298, 2003 General Session

31A-35-604. Records.

(1) A bail bond producer shall maintain at the bail bond producer's place of business:

(a) records of all bail bonds the bail bond producer executes or countersigns, so the public may obtain all necessary information concerning those bail bonds for at least one year after the liability of the bail bond surety has been terminated; and

(b) any additional information the commissioner may reasonably require by rule.

(2) Records required to be maintained under Subsection (1) shall be available for examination by the commissioner or the commissioner's representatives during regular business hours.

(3) The bail bond surety company shall maintain for three years after receipt all records of any bail bond executed or countersigned by a bail bond producer appointed by the bail bond surety company.

Amended by Chapter 298, 2003 General Session

31A-35-605. Guarantors -- Agreement and enforcement.

(1) All agreements of persons to act as guarantor for a bail bond shall be in writing or reduced to writing as soon as possible after completion.

(2) When a person executes an agreement to act as a guarantor, the bail bond surety company or the bail bond producer shall deliver to that person a copy of the agreement promptly upon that person's execution of the agreement.

(3) A bail bond producer may not enforce any guarantor agreement without disclosing to the guarantor all collateral held by the bail bond producer indemnifying the bond to which the agreement relates, and the identity of each other guarantor.

Amended by Chapter 298, 2003 General Session

31A-35-606. Bail agreement prior to commission of offense prohibited.

A bail bond surety or bail bond producer may not enter into an agreement or arrangement with any person, guaranteeing or assuring in advance of the commission of any offense that bail will be furnished to that person or any other party if arrested.

Amended by Chapter 298, 2003 General Session

31A-35-607. Filing of forms -- Commissioner maintains files.

(1) (a) In accordance with Section 31A-21-201, only a bail bond surety company that meets the financial capacity requirements through the use of a letter of credit, personal property, or real property, or a surety insurer shall file with the commissioner a copy of each form the bail bond surety company or surety insurer uses in the bail bond surety business.

(b) A surety insurer filing shall comply with the following:

(i) a form shall be identified by a unique form number;

(ii) the surety insurer shall file a form on behalf of each bail bond surety company appointed to write on behalf of the surety insurer;

(iii) once a filing is filed with the commissioner, it is the responsibility of the surety insurer to verify that the bail bond surety company and its producers are using the correct form;

(iv) a bail bond surety company and its producers are prohibited from using a form that has not been filed by the surety insurer; and

(v) a bail bond surety company and its producers are prohibited from making changes to a form that is filed by the surety insurer.

(c) A bail bond surety company filing, for a bail bond surety company that meets the financial capacity requirements through the use of a letter of credit, personal property, or real estate, shall comply with the following:

(i) a form shall be identified by a unique form number;

(ii) once a filing is filed with the commissioner, it is the responsibility of the bail bond surety company to verify that its producers are using the correct form;

(iii) a bail bond producer is prohibited from using a form that has not been filed by the bail bond surety company; and

(iv) a bail bond producer is prohibited from making changes to a form that is filed by the bail bond surety company.

(2) A form described in Subsection (1) shall be filed 30 days before the form:
(a) is first used by the bail bond surety company or surety insurer; and
(b) is changed after it is filed under Subsection (2)(a).
(3) (a) The commissioner shall maintain and make available for public inspection a file regarding each bail bond surety company and each surety insurer.
(b) A bail bond surety company and surety insurer shall maintain a form required to be filed under this section in the office of the bail bond surety company or surety insurer.

Amended by Chapter 253, 2012 General Session

31A-35-608. Premiums and authorized charges.
(1) A bail bond surety or bail bond producer may not, in any bail transaction or in connection with that transaction, directly or indirectly, charge or collect money or other valuable consideration from any person except to:
(a) pay the premium on the bail at the rates established by the bail bond surety;
(b) provide collateral;
(c) reimburse himself for actual expenses, as described in Subsection (2), incurred in connection with the bail bond transaction; or
(d) to reimburse himself, or to establish a right of action against the principal or any indemnitor, for actual expenses the bail bond surety or bail bond producer incurred:
(i) in good faith; and
(ii) which were by reason of breach by the defendant of any of the terms of the written agreement under which the undertaking of bail or bail bond was written.
(2) (a) A bail bond surety may bring an action in a court of law to enforce its equitable rights against the principal and the principal's indemnitors in exoneration if:
(i) a bail bond producer did not establish a written agreement; or
(ii) there is only an incomplete writing.
(b) Reimbursement claimed under this Subsection (2) may not exceed the sum of:
(i) the principal sum of the bail bond or undertaking; and
(ii) any reasonable expenses that:
(A) are verified by receipt;
(B) in total do not amount to more than the principal sum of the bail bond or undertaking; and
(C) are incurred in good faith by the bail bond surety, its producers, and employees by reason of the principal's breach.
(3) This section does not affect or impede the right of a bail bond producer to execute undertaking of bail on behalf of a nonresident producer of the bail bond surety the bail bond producer represents.

Amended by Chapter 298, 2003 General Session

31A-35-701. Prohibited acts.
(1) A bail bond producer or bail bond surety may not:
(a) solicit business in or about:

(i) any place where persons in the custody of the state or any local law enforcement or correctional agency are confined; or

(ii) any court;

(b) pay a fee or rebate or give or promise anything of value to any person in order to secure a settlement, compromise, remission, or reduction of the amount of any undertaking or bail bond;

(c) pay a fee or rebate or give anything of value to an attorney in regard to any bail bond matter, except payment for legal services actually rendered for the bail bond producer or bail bond surety;

(d) pay a fee or rebate or give or promise anything of value to the principal or anyone in the principal's behalf; or

(e) engage in any other act prohibited by the commissioner by rule.

(2) The following persons may not act as bail bond producers and may not, directly or indirectly, receive any benefits from the execution of any bail bond:

(a) a person employed at any jail, correctional facility, or other facility used for the incarceration of persons;

(b) a peace officer;

(c) a judge; and

(d) a trusty or prisoner incarcerated in any jail, correctional facility, or other facility used for the incarceration of persons.

(3) A bail bond producer may not:

(a) sign or countersign in blank any bail bond; or

(b) give the power of attorney to, or otherwise authorize anyone to, countersign in the bail bond producer's name to a bail bond.

(4) A bail bond producer may not advertise or hold himself out to be a bail bond surety.

(5) The following persons or members of their immediate families may not solicit business on behalf of a bail bond surety or bail bond producer:

(a) a person employed at any jail, correctional facility, or other facility used for the incarceration of persons;

(b) a peace officer;

(c) a judge; and

(d) a trusty or prisoner incarcerated in any jail, correctional facility, or other facility used for the incarceration of persons.

Amended by Chapter 274, 2004 General Session

31A-35-702. Early surrender without cause.

(1) The bail or bail bond premium shall be returned in full if a bail bond producer without good cause surrenders a defendant to custody before:

(a) the time specified in the undertaking of bail or the bail bond for the appearance of the defendant; or

(b) any other occasion where the presence of the defendant in court is lawfully required.

(2) As used in this section, "good cause" includes:

(a) the defendant providing materially false information on the application for bail

or a bail bond;

(b) the court's increasing the amount of bail beyond sound underwriting criteria employed by:

(i) the bail bond producer; or

(ii) the bail bond surety;

(c) a material and detrimental change in the collateral posted by:

(i) the defendant; or

(ii) a person acting on the defendant's behalf;

(d) the defendant changing the defendant's address or telephone number without giving reasonable notice to:

(i) the bail bond producer; or

(ii) the bail bond surety;

(e) the defendant commits another crime, other than a minor traffic violation, as defined by department rule, while on bail;

(f) failure by the defendant to appear in court at the appointed time; or

(g) a finding of guilt against the defendant by a court of competent jurisdiction.

Amended by Chapter 298, 2003 General Session

31A-35-703. Disciplinary action.

(1) A person found to be in violation of the statutes or rules governing the conduct of bail bond producers and bail bond sureties under this chapter is subject to:

(a) disciplinary action by the commissioner against that person's:

(i) license, if the person is a bail bond surety company or bail bond producer; or

(ii) certificate, if the person is a surety insurer; and

(b) imposition of civil penalties, as authorized under Title 31A, Chapter 2, Administration of the Insurance Laws.

(2) Penalties collected under this section shall be deposited in the restricted account created in Section 31A-35-407.

Amended by Chapter 298, 2003 General Session

31A-35-704. Submission of bail bond sureties and producers to jurisdiction of court.

By applying for and receiving a license or certificate to engage in the bail bond surety insurance business in accordance with this chapter, a bail bond surety or bail bond producer:

(1) submits to the jurisdiction of the court;

(2) irrevocably appoints the clerk of the court as agent upon whom any papers affecting the bail bond surety's or bail bond producer's liability on the undertaking may be served; and

(3) acknowledges that liability may be enforced on motion and upon notice as the court may require, without the necessity of an independent action.

Amended by Chapter 298, 2003 General Session

31A-36-101. Title.

This chapter is known as the "Life Settlements Act."

Amended by Chapter 355, 2009 General Session

31A-36-102. Definitions.

As used in this chapter:

(1) (a) "Advertising" means a communication placed before the public to:

(i) create an interest in a life settlement; or

(ii) induce a person pursuant to a life settlement to sell, assign, devise, bequest, or transfer the death benefit or ownership of:

(A) a policy; or

(B) an interest in a policy.

(b) "Advertising" includes the following, if the requirements of Subsection (1)(a) are met:

(i) a written, electronic, or printed communication;

(ii) a communication by means of a recorded telephone message;

(iii) a communication transmitted on radio, television, the Internet, or similar communications media; and

(iv) a film strip, motion picture, or video.

(2) "Business of life settlements" includes the following:

(a) offering a life settlement;

(b) soliciting a life settlement;

(c) negotiating a life settlement;

(d) procuring a life settlement;

(e) effectuating a life settlement;

(f) purchasing a life settlement;

(g) investing in a life settlement;

(h) financing a life settlement;

(i) monitoring a life settlement;

(j) tracking a life settlement;

(k) underwriting a life settlement;

(l) selling a life settlement;

(m) transferring a life settlement;

(n) assigning a life settlement;

(o) pledging a life settlement;

(p) hypothecating a life settlement; or

(q) in any other manner acquiring an interest in an insurance policy by means of a life settlement.

(3) "Chronically ill" means:

(a) being unable to perform at least two activities of daily living, such as eating, toileting, moving from one place to another, bathing, dressing, or continence;

(b) requiring substantial supervision for protection from threats to health and safety because of severe cognitive impairment; or

(c) having a level of disability similar to that described in Subsection (3)(a).

(4) "Depository institution" is as defined in Section 7-1-103.

(5) (a) "Financing entity" means a person:

(i) who has direct ownership in a policy that is the subject of a life settlement;

(ii) whose principal activity related to a life settlement is providing money to effect the life settlement or the purchase of one or more settled policies; and

(iii) who has an agreement in writing with one or more licensed life settlement providers to finance the acquisition of one or more life settlements.

(b) "Financing entity" includes, if the requirements of Subsection (5)(a) are met, the following:

(i) an underwriter;

(ii) a placement agent;

(iii) an enhancer of credit;

(iv) a lender;

(v) a purchaser of securities; and

(vi) a purchaser of a policy from a life settlement provider.

(c) "Financing entity" does not include:

(i) a nonaccredited investor; or

(ii) a life settlement purchaser.

(6) "Form" means, in addition to a form as defined in Section 31A-1-301:

(a) a life settlement;

(b) a disclosure to an owner;

(c) a notice of intent to settle; or

(d) a verification of coverage.

(7) "Life expectancy" means the mean number of months an individual insured under a policy to be settled can be expected to live considering medical records and appropriate experiential data.

(8) (a) "Life settlement" means a written agreement:

(i) between an owner and a life settlement provider; and

(ii) that establishes the terms for the payment of anything of value in exchange for the owner assigning, selling, transferring, devising, releasing, or bequeathing, at the time of or after the exchange, the death benefit or ownership of:

(A) any portion of a policy; or

(B) a beneficial interest in the policy.

(b) "Life settlement" includes:

(i) the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns a policy if the trust or other entity is formed or operated for the principal purpose of acquiring one or more policies; or

(ii) a premium finance loan made for a policy by a lender to an owner on, before, or after the date of issuance of the policy if the owner:

(A) receives on the date of the premium finance loan a guarantee of a future life settlement value of the policy; or

(B) agrees on the date of the premium finance loan to sell the policy or any portion of the policy's death benefit on a date following the issuance of the policy.

(c) An agreement described in Subsection (8)(a) is a "life settlement" even if it is referred to by a different name, including:

(i) a "viatical settlement"; or

(ii) a "senior settlement."

(d) "Life settlement" does not include:

(i) a loan or accelerated death benefit by an insurer pursuant to the terms of a policy;

(ii) loan proceeds that are used solely to pay:

(A) premiums for a policy; and

(B) the loan costs or other expenses incurred by the lender, including:

(I) interest;

(II) an arrangement fee;

(III) a use fee;

(IV) closing costs;

(V) attorney fees and expenses;

(VI) trustee fees and expenses; and

(VII) third party collateral provider fees and expenses, including fees payable to a letter of credit issuer;

(iii) (A) a loan made by a licensed lender in which the licensed lender takes an interest in a policy solely to secure repayment of a loan; or

(B) the transfer of a policy by a lender, if:

(I) the loan is:

(Aa) a loan described in Subsection (8)(d)(iii)(A); or

(Bb) a premium finance loan that is not a life settlement;

(II) the loan is defaulted on;

(III) the policy is transferred; and

(IV) neither the default itself nor the transfer of the policy in connection with the default is pursuant to an agreement with any other person for the purpose of evading regulation under this chapter;

(iv) an agreement where all the participants in the agreement:

(A) (I) are closely related to the insured by blood or law; or

(II) have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured; and

(B) are trusts established primarily for the benefit of the participants in the agreement;

(v) a designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee; or

(vi) a business succession planning arrangement not made for the purpose of evading regulation under this chapter:

(A) (I) between one or more shareholders in a corporation; or

(II) between a corporation and:

(Aa) one or more of its shareholders; or

(Bb) one or more trusts established by its shareholders;

(B) (I) between one or more partners in a partnership; or

(II) between a partnership and:

(Aa) one or more of its partners; or

(Bb) one or more trusts established by its partners; or

(C) (I) between one or more members in a limited liability company; or

(II) between a limited liability company and:

(Aa) one or more of its members; or

(Bb) one or more trusts established by its members.

(9) (a) "Life settlement producer" means a person licensed in the state as a life insurance producer that on behalf of an owner and for consideration offers or attempts to negotiate a life settlement between the owner and one or more life settlement providers.

(b) "Life settlement producer" does not include an attorney licensed to practice law in any state, a certified public accountant, or a financial planner accredited by a nationally recognized accrediting agency:

(i) that is retained to represent an owner; and

(ii) whose compensation is not paid directly or indirectly by:

(A) a life settlement provider; or

(B) a life settlement purchaser.

(10) (a) "Life settlement provider" means a person other than an owner that enters into or effectuates a life settlement.

(b) "Life settlement provider" does not include:

(i) a licensed lender that takes an assignment of a policy as security for a loan, including a:

(A) depository institution; or

(B) lender that makes a premium finance loan that is not described in Subsection (8)(b)(ii);

(ii) the issuer of a policy;

(iii) an authorized or eligible insurer that provides stop-loss coverage to:

(A) a life settlement provider;

(B) a life settlement purchaser;

(C) a financing entity;

(D) a special purpose entity; or

(E) a related provider trust;

(iv) a financing entity;

(v) a special purpose entity;

(vi) a related provider trust;

(vii) a life settlement purchaser; or

(viii) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A that purchases a settled policy from a life settlement provider.

(11) (a) "Life settlement purchaser" means a person that, to derive an economic benefit:

(i) provides a sum of money as consideration for a policy or an interest in the death benefits of a policy; or

(ii) owns, acquires, or is entitled to a beneficial interest in a trust that:

(A) owns a life settlement; or

(B) is the beneficiary of a policy that has been or will be the subject of a life settlement.

(b) "Life settlement purchaser" does not include:

(i) a life settlement provider;

(ii) a life settlement producer;

(iii) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec.

230.501;
(iv) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A;
(v) a financing entity;
(vi) a special purpose entity; or
(vii) a related provider trust.
(12) (a) "Owner" means any of the following who resides in this state and seeks to enter into a life settlement:
(i) the owner of a policy; or
(ii) the holder of a certificate of a group policy.
(b) "Owner" is not limited to an individual who is terminally ill or chronically ill except when the limitation is expressly provided in this chapter.
(c) "Owner" does not include:
(i) a life settlement provider;
(ii) a life settlement producer;
(iii) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A;
(iv) a financing entity;
(v) a special purpose entity; or
(vi) a related provider trust.
(13) "Policy" means:
(a) an individual or group life insurance policy;
(b) an individual or group annuity policy;
(c) a group life insurance certificate;
(d) a group annuity certificate; or
(e) a life insurance policy or an annuity policy, whether or not delivered or issued for delivery in Utah:
(i) affecting the rights of a resident of Utah; or
(ii) bearing a reasonable relation to Utah.
(14) "Premium finance loan" is a loan made primarily for the purpose of making premium payments on a policy if the loan is secured by an interest in the policy.
(15) "Related provider trust" means a trust established by a licensed life settlement provider or a financing entity solely to hold the ownership of or beneficial interests in purchased policies in connection with financing.
(16) "Settled policy" means a policy that is acquired by a life settlement provider pursuant to a life settlement.
(17) "Special purpose entity" means an entity formed by a licensed life settlement provider solely to enable the life settlement provider to gain access to institutional markets for capital.
(18) (a) "Stranger-originated life insurance" means an act, practice, or arrangement to initiate a policy for the benefit of a third party investor or other person who has no insurable interest in the insured resulting in the requirements of Section 31A-21-104 not being met.
(b) "Stranger-originated life insurance" includes when:
(i) a policy is purchased with resources or guarantees from or through a person who, at the time of policy origination, could not lawfully initiate the policy itself; and

(ii) at the time of policy origination, there is an agreement, whether oral or written, to directly or indirectly transfer to a third party the ownership of a policy, policy benefits, or both.

(c) "Stranger-originated life insurance" does not include:

(i) a life settlement that complies with:

(A) this chapter; and

(B) Section 31A-21-104; or

(ii) an act, practice, or arrangement described in Subsection (8)(d).

(19) "Terminally ill" means having a condition that reasonably may be expected to result in death within 24 months.

Amended by Chapter 10, 2010 General Session
Amended by Chapter 218, 2010 General Session

31A-36-103. Law governing.

(1) If there is more than one owner on a single policy and the owners are residents of different states, the law of the state in which the owner having the largest percentage ownership resides governs the life settlement. If the owners own equal fractions of a policy, the owners may agree in writing that the law of the state in which one resides governs the life settlement.

(2) A life settlement that is subject to this chapter may not:

(a) require that the life settlement be construed according to the laws of another jurisdiction; or

(b) deprive a court of competent jurisdiction in Utah to have jurisdiction over an action.

Amended by Chapter 355, 2009 General Session

31A-36-104. License requirements, revocation, and denial.

(1) (a) A person may not, without first obtaining a license from the commissioner, operate in or from this state as:

(i) a life settlement provider; or

(ii) a life settlement producer.

(b) A life settlement is included within the scope of the life insurance producer line of authority.

(2) (a) To obtain a license as a life settlement provider, an applicant shall:

(i) comply with Section 31A-23a-117;

(ii) file an application;

(iii) pay the license fee; and

(iv) provide evidence of financial responsibility.

(b) If an applicant for a life settlement provider license complies with Subsection (2)(a) and Section 31A-23a-117, the commissioner shall investigate the applicant and issue a life settlement provider license if the commissioner finds that the applicant is competent and trustworthy to engage in the business of providing life settlements by experience, training, or education.

(3) In addition to the requirements in Sections 31A-23a-111, 31A-23a-112 and

31A-23a-113, the commissioner may refuse to issue, suspend, revoke, or refuse to renew the license of a life settlement provider or life settlement producer if the commissioner finds that:

(a) a life settlement provider demonstrates a pattern of unreasonable payments to owners;

(b) the applicant, the licensee, an officer, partner, or member, or key management personnel:

(i) is, whether or not a judgment of conviction is entered by the court, found guilty of, or pleads guilty or nolo contendere to:

(A) a felony; or

(B) a misdemeanor involving fraud or moral turpitude;

(ii) violates this chapter; or

(iii) is subject to a final administrative action by another state or federal jurisdiction.

(c) a life settlement provider enters into a life settlement not approved under this chapter;

(d) a life settlement provider fails to honor obligations of a life settlement;

(e) a life settlement provider assigns, transfers, or pledges a settled policy to a person other than:

(i) a life settlement provider licensed under this chapter;

(ii) a life settlement purchaser;

(iii) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501;

(iv) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A;

(v) a financing entity;

(vi) a special purpose entity; or

(vii) a related provider trust;

(f) a life settlement provider fails to maintain a standard set forth in Subsection (2)(b);

(g) an applicant or licensee has a material misrepresentation in an initial or renewal application for a license; or

(h) the licensee engages in bad faith conduct with one or more owners.

(4) If the commissioner denies a license application or suspends, revokes, or refuses to renew the license of a life settlement provider or life settlement producer, the commissioner shall conduct an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 355, 2009 General Session

31A-36-105. Filing and use of forms for life settlement and disclosure.

(1) A person may not use a form unless the form is filed with the commissioner under Subsection 31A-21-201(1).

(2) The commissioner may prohibit the use of a form submitted under Subsection (1) pursuant to Subsection 31A-21-201(3).

(3) The commissioner may require the submission of advertising material before

its use.

Amended by Chapter 355, 2009 General Session

31A-36-106. Reporting requirements and privacy.

(1) (a) Subject to Subsection (1)(b), a life settlement provider shall file with the commissioner on or before March 1 of each year an annual report containing the information the commissioner prescribes under Section 31A-36-119.

(b) Notwithstanding Subsection (1)(a), the commissioner shall only require the information for those transactions that involve an owner.

(2) Except as otherwise allowed or required by law, the following may not disclose the identity, financial information, or medical information of an insured to any other person:

(a) a life settlement provider;

(b) a life settlement producer;

(c) a producer of insurance;

(d) an information bureau;

(e) a rating agency or company; or

(f) any other person knowing the identity of an insured.

(3) Notwithstanding Subsection (2), a person may disclose the identity of an insured if the disclosure is:

(a) necessary to effect a life settlement between an owner and a life settlement provider and both the owner and the insured give prior written consent to the disclosure;

(b) furnished in response to an investigation or examination by the commissioner or another governmental officer or agency;

(c) furnished pursuant to Section 31A-36-114;

(d) a term of or condition to the transfer of a policy by one life settlement provider to another life settlement provider;

(e) necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of a policy by a life settlement provider and the insured gives prior written consent to the disclosure;

(f) necessary to allow the life settlement provider or life settlement producer or the life settlement provider's or life settlement producer's authorized representatives to make a contact to determine the health status of an insured; or

(g) required to purchase stop-loss coverage.

Amended by Chapter 355, 2009 General Session

31A-36-107. Examinations and retention of records.

(1) The commissioner may conduct an examination of a life settlement provider or life settlement producer in accordance with Sections 31A-2-203, 31A-2-203.5, 31A-2-204, and 31A-2-205.

(2) A life settlement provider or life settlement producer shall retain for five years copies of:

(a) the following records, whether proposed, offered, or executed, from the later of the date of the proposal, offer, or execution:

(i) contracts;
(ii) purchase agreements;
(iii) underwriting documents;
(iv) policy forms; and
(v) applications;
(b) checks, drafts, and other evidence or documentation relating to the payment, transfer, or release of money, from the date of the transaction; and
(c) records and documents related to the requirements of this chapter.
(3) This section does not relieve a person of the obligation to produce a document described in Subsection (2) to the commissioner after the expiration of the relevant period if the person has retained the document.
(4) A record required by this section to be retained:
(a) shall be legible and complete; and
(b) may be retained in any form or by any process that accurately reproduces or is a durable medium for the reproduction of the record.
(5) An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in a person subject to examination under this chapter. This Subsection (5) does not automatically preclude an examiner from being:
(a) an owner;
(b) an insured in a settled policy; or
(c) a beneficiary in a policy that is proposed to be settled.
(6) (a) An examinee under this section shall reimburse the cost of an examination to the department consistent with Section 31A-2-205.
(b) Notwithstanding Subsection (6)(a), an individual life settlement producer is not subject to Section 31A-2-205.

Amended by Chapter 297, 2011 General Session

31A-36-108. Required disclosures.
(1) With an application for a life settlement, a life settlement provider or life settlement producer shall furnish to the owner the disclosures the commissioner may require under Section 31A-36-119, in a separate document signed by the owner and the life settlement provider or life settlement producer, no later than the time the application for the life settlement is signed by all the participants in the life settlement.
(2) A life settlement provider shall furnish to the owner the disclosures the commissioner may require under Section 31A-36-119, conspicuously displayed in the life settlement or in a separate document signed by the owner and the life settlement provider, no later than the time the life settlement is signed by all participants in the life settlement.

Amended by Chapter 355, 2009 General Session

31A-36-109. General requirements.
(1) If a life settlement provider transfers ownership or changes the beneficiary of a settled policy, the life settlement provider shall inform the insured of the transfer or

change within 20 calendar days.

(2) A life settlement provider that enters a life settlement shall first obtain:

(a) if the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter a life settlement;

(b) a witnessed document in which the owner represents that:

(i) the owner has a full and complete understanding of the life settlement and the benefits of the policy;

(ii) the owner has entered the life settlement freely and voluntarily; and

(iii) if applicable, the insured is terminally ill or chronically ill and that the illness was diagnosed after the policy was issued; and

(c) a document in which the insured consents to the release of the insured's medical records to:

(i) a life settlement provider;

(ii) a life settlement producer; and

(iii) the insurer that issued the policy covering the insured.

(3) Within 20 calendar days after an owner executes documents necessary to transfer rights under a policy, or enters into an agreement in any form, express or implied, to settle the policy, the life settlement provider shall give written notice to the issuer of the policy that the policy has or will become settled. The notice shall be accompanied by a copy of the documents required by Subsection (4).

(4) The life settlement provider shall deliver a copy of the following to the insurer that issued the policy that is the subject of the life settlement:

(a) the medical release required under Subsection (2)(c);

(b) a copy of the owner's application for the life settlement; and

(c) the notice required under Subsection (3).

(5) (a) An insurer shall complete and return a request for verification of coverage not later than 30 calendar days after the day on which the request is received. In its response, the insurer shall indicate whether the insurer intends to pursue an investigation regarding the validity of the insurance contract.

(b) An insurer may not require that a person making a request under Subsection (5)(a) provide the insurer additional information in order for the insurer to comply with Subsection (5)(a), if the person provides the insurer:

(i) a request for verification of coverage made on an original, facsimile, or electronic copy of a verification of coverage for a policy document adopted by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) an authorization that accompanies the verification described in Subsection (5)(b)(i) signed by the owner.

(6) Medical information solicited or obtained by a life settlement provider or life settlement producer is subject to:

(a) other laws of this state relating to the confidentiality of the information; and

(b) a rule relating to privacy of medical or personal information promulgated by the commissioner under Title V, Section 505 of the Gramm-Leach-Bliley Act of 1999, 15 U.S.C. Sec. 6805.

(7) (a) (i) A life settlement entered into in this state shall reserve to the owner an

unconditional right to rescind the life settlement within the rescission period provided for in this Subsection (7).

(ii) The rescission period ends 15 calendar days after the day on which the owner receives the proceeds of the life settlement.

(iii) Rescission by an owner may be conditioned on the owner giving notice and repaying to the life settlement provider within the rescission period all proceeds of the life settlement and any premium, loan, or loan interest paid by or on behalf of the life settlement provider in connection with or as a consequence of the life settlement.

(b) If the insured dies during the rescission period, the life settlement is considered to be rescinded if the proceeds, premiums, loans, and loan interest paid by the life settlement provider or life settlement purchaser are repaid within 60 calendar days of the day on which the insured dies.

(8) (a) Contact with an insured to determine the health status of the insured after a life settlement may be made only by a life settlement provider or life settlement producer that is licensed in this state, or its authorized representative, and no more than:

(i) once every three months if the insured has a life expectancy of one year or more; or

(ii) once every month if the insured has a life expectancy of less than one year.

(b) A life settlement provider or life settlement producer shall explain the procedure for the contacts allowed under this Subsection (8) to the owner when the application for the life settlement is signed by all participants in the life settlement.

(c) The limitations of this Subsection (8) do not apply to contacts for purposes other than determining health status.

(d) A life settlement provider or life settlement producer is responsible for the acts of its authorized representative in violation of this Subsection (8).

(9) The trustee of a related provider trust shall agree in writing with the life settlement provider that:

(a) the life settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements; and

(b) the trustee will make all records and files related to life settlements available to the commissioner as if those records and files were maintained directly by the life settlement provider.

(10) Regardless of the method of compensation, a life settlement producer:

(a) represents only the owner; and

(b) owes a fiduciary duty to the owner to act according to the owner's instructions and in the best interest of the owner.

Amended by Chapter 297, 2011 General Session

31A-36-110. Payment and document requirements.

(1) (a) A life settlement provider shall instruct the owner to send the executed documents required to effect the change in ownership or assignment or change of beneficiary of the affected policy to a designated independent escrow agent.

(b) Within three business days after the day on which the escrow agent receives the documents, or within three business days after the day on which the life settlement

provider receives the documents if by mistake they are sent directly to the life settlement provider, the life settlement provider shall deposit the proceeds of the life settlement into an escrow or trust account of the escrow agent in a federally insured depository institution.

(2) (a) Upon completion of the requirements of Subsection (1), the escrow agent shall deliver the original documents executed by the owner to:

(i) the life settlement provider; or

(ii) a related provider trust or other designated representative of the life settlement provider.

(b) Upon the life settlement provider's receipt from the insurer of an acknowledgment of the change in ownership or assignment or change of beneficiary of the affected policy, the life settlement provider shall instruct the escrow agent to pay the proceeds of the life settlement to the owner.

(3) Payment to the owner shall be made within three business days after the day on which the life settlement provider receives the acknowledgment from the insurer. Failure to make the payment within that time makes the life settlement voidable by the owner for lack of consideration until payment is tendered to and accepted by the owner.

Amended by Chapter 297, 2011 General Session

31A-36-111. Prohibited acts.

(1) An owner may not enter into a life settlement at any time before the application or issuance of a policy.

(2) An owner may not enter into a life settlement within two years after the date of issuance of the policy to which the life settlement relates unless the owner certifies to the life settlement provider that one of the following is satisfied:

(a) the policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy if:

(i) the total time covered under the conversion policy plus the time covered under the prior policy is at least 24 months; and

(ii) the time covered under a group policy, calculated without regard to any change in insurance carriers, is continuous and under the same group sponsorship; or

(b) the owner submits to the life settlement provider independent evidence that within the two-year period:

(i) the owner or insured is terminally ill;

(ii) the owner or insured is chronically ill;

(iii) the spouse of the owner dies;

(iv) the owner divorces the owner's spouse;

(v) the owner retires from full-time employment;

(vi) the owner acquires a physical or mental disability and a physician determines that the disability precludes the owner from maintaining full-time employment;

(vii) a final judgment or order is entered or issued by a court of competent jurisdiction, on the application of a creditor of the owner:

(A) adjudging the owner bankrupt or insolvent;

(B) approving a petition for reorganization of the owner; or

(C) appointing a receiver, trustee, or liquidator for all or a substantial part of the owner's assets;

(viii) the owner experiences a significant decrease in income that is unexpected and impairs the owner's reasonable ability to pay the policy premium; or

(ix) the owner or insured disposes of ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the policy is initially issued.

(3) An insurer may not, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a life settlement, require any of the following to sign a form, disclosure, consent, or waiver that is not filed with the commissioner for use in connection with a life settlement in this state:

(a) an owner;

(b) an insured;

(c) a life settlement provider; or

(d) a life settlement producer.

(4) (a) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, an insurer shall respond in writing within 30 calendar days of the day of receipt with written acknowledgment:

(i) confirming that the change is effective; or

(ii) specifying the reasons why the requested change cannot be processed.

(b) An insurer may not:

(i) unreasonably delay effecting a change of ownership or beneficiary; and

(ii) otherwise seek to interfere with a life settlement lawfully entered into in this state.

(5) A person may not issue, solicit, or market the purchase of a policy for the primary purpose of or with a primary emphasis on settling the policy.

(6) (a) Unless disclosed to an owner before the execution of a life settlement by the owner, a life settlement producer may not knowingly with respect to the life settlement solicit an offer from, effectuate the life settlement with, or make a sale to any of the following that is controlling, controlled by, or under common control with the life settlement producer:

(i) a life settlement provider;

(ii) a life settlement purchaser;

(iii) a financing entity; or

(iv) a related provider trust.

(b) Unless disclosed to an owner before the execution of a life settlement by the owner, with respect to the life settlement, a life settlement provider may not knowingly enter into the life settlement with the owner, if, in connection with the life settlement, anything of value will be paid to a life settlement producer that is controlling, controlled by, or under common control with:

(i) the life settlement provider;

(ii) the life settlement purchaser;

(iii) a financing entity; or

(iv) a related provider trust.

Amended by Chapter 366, 2011 General Session

31A-36-112. Advertising regulations.

(1) (a) A life settlement provider or life settlement producer shall establish and continuously maintain a system of control over the content, form, and method of dissemination of advertisements of the life settlement provider's or life settlement producer's contracts and services.

(b) An advertisement is the responsibility of the life settlement provider or life settlement producer as well as the person that creates or presents the advertisement.

(c) A system of control shall include at least annual notification to persons authorized by the life settlement provider or life settlement producer that disseminate advertisements of the requirements and procedures for approval before use of any advertisements not furnished by the life settlement provider or life settlement producer.

(2) An advertisement shall be truthful and not misleading in fact or by implication, as determined by the commissioner from the overall impression it may reasonably be expected to create upon a person of average education or intelligence in the segment of the public to which it is directed.

(3) A false or misleading statement is not remedied by:

(a) making a life settlement available for inspection before it is consummated; or

(b) offering to refund payment if the owner is not satisfied within the period prescribed in Subsection 31A-36-109(7).

Amended by Chapter 297, 2011 General Session

31A-36-113. Fraud.

(1) As used in this section, "recklessly" means engaging in conduct:

(a) when a person knows or should have known of a substantial likelihood of the existence of the relevant facts or risks; and

(b) involving a significant deviation from acceptable standards of conduct.

(2) A person may not, knowingly or with intent to defraud, to deprive another of property or for pecuniary gain, do or permit its employees or agents to engage in any of the following acts:

(a) (i) present, cause to be presented or prepare with knowledge or belief that it will be presented, false information to or by a life settlement provider or life settlement producer, a financing entity, an insurer, a provider of insurance or any other person, or to conceal information, as part of, in support of or concerning a fact material to:

(A) an application for the issuance of a policy or life settlement;

(B) the underwriting of a policy or life settlement;

(C) a claim for payment or other benefit under a policy or life settlement;

(D) a premium paid on a policy;

(E) a payment or change of beneficiary or ownership pursuant to a policy or life settlement;

(F) the reinstatement or conversion of a policy;

(G) the solicitation, offer, effectuation, or sale of a policy or life settlement;

(H) the issuance of written evidence of a policy or life settlement; or

(I) a financing transaction;

(ii) employ a device, scheme, or artifice to defraud in the business of life settlements;

(iii) enter into any plan or practice that involves stranger-originated life insurance; or

(iv) employ a device, scheme, or artifice resulting in a violation of Section 31A-21-104 in the solicitation, application, or issuance of a policy that is the subject of a life settlement;

(b) in furtherance of a fraud or to prevent detection of a fraud:

(i) remove, conceal, alter, destroy, or sequester from the commissioner assets or records of a person engaged in the business of life settlements;

(ii) misrepresent or conceal the financial condition of a licensee, a financing entity, an insurer, or other person;

(iii) transact the business of life settlements in violation of this chapter; or

(iv) file with the commissioner or analogous officer of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the commissioner or analogous officer;

(c) embezzle, steal, misappropriate, or convert money, premiums, credits, or other property of a life settlement provider, an owner, an insurer, an insured, an owner of a policy, or other person engaged in the business of life settlements or insurance;

(d) recklessly enter into, negotiate, or otherwise deal in a life settlement, the subject of which is a policy obtained when one or more persons intend to defraud the policy's issuer, the life settlement provider, or the owner by:

(i) presenting false information concerning a fact material to the policy; or

(ii) concealing, to mislead another, information concerning a fact material to the policy;

(e) facilitate a change of the state or jurisdiction of ownership of a policy or the state of residency of an owner to a state or jurisdiction that does not have a law similar to this chapter for the express purpose of evading or avoiding this chapter; or

(f) attempt to commit, assist, aid, abet, or conspire to commit an act or omission described in this Subsection (2).

(3) A person may not knowingly or intentionally interfere with the enforcement of this chapter or an investigation of a possible violation of this chapter.

(4) A person engaged in the business of life settlements may not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

(5) (a) An application or contract for a life settlement, however transmitted, shall contain the following or a substantially similar statement: "A person that knowingly presents false information in an application for insurance or a life settlement is guilty of a crime and may be subject to fines and confinement in prison."

(b) The lack of the statement described in Subsection (5)(a) is not a defense in a prosecution for violation of this section.

Amended by Chapter 355, 2009 General Session

31A-36-114. Reporting of fraud and immunity.

(1) A person engaged in the business of life settlements that knows or reasonably suspects that a violation of Section 31A-36-113 is being, has been, or will be committed shall provide to the commissioner the information required by, and in a

manner prescribed by, the commissioner.

(2) A person not engaged in the business of life settlements that knows or reasonably believes that a violation of Section 31A-36-113 is being, has been, or will be committed may furnish to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(3) Except as provided in Subsection (4), a person furnishing information of the kind described in this section is immune from liability and civil action if the information is furnished to or received from:

(a) the commissioner or the commissioner's employees, agents, or representatives;

(b) federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(c) another person involved in the prevention or detection of violations of Section 31A-36-113 or that person's employees, agents, or representatives;

(d) the following organizations or their employees, agents, or representatives:

(i) the National Association of Insurance Commissioners;

(ii) the Financial Industry Regulatory Authority;

(iii) the North American Securities Administrators Association; or

(iv) another regulatory body overseeing life insurance, life settlements, securities, or investment fraud; or

(e) the insurer that issued the policy concerned in the information.

(4) The immunity provided in Subsection (3) does not extend to a statement made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a violation of this section, the plaintiff shall plead specifically that the defendant acted with actual malice.

(5) A person furnishing information as identified in Subsection (3) is entitled to an award of attorney fees and costs if:

(a) the person is the prevailing party in a civil cause of action for libel, slander, or another relevant tort arising out of activities in carrying out the provisions of this chapter; and

(b) the action did not have a reasonable basis in law or fact at the time it was initiated.

(6) This section does not supplant or modify any other privilege or immunity at common law or under another statute.

Amended by Chapter 297, 2011 General Session

31A-36-115. Confidentiality.

(1) The following shall be classified as protected records under Title 63G, Chapter 2, Government Records Access and Management Act:

(a) a document or information furnished pursuant to Section 31A-36-114; and

(b) a document or information obtained by the commissioner in an investigation of a violation of Section 31A-36-113.

(2) Subsection (1) does not prohibit the commissioner from disclosing documents or evidence so furnished or obtained:

(a) in an administrative or judicial proceeding to enforce laws administered by

the commissioner;
(b) to federal, state, or local law enforcement or regulatory agencies;
(c) to an organization established to detect and prevent fraudulent life settlement acts;
(d) to the National Association of Insurance Commissioners; or
(e) to a person engaged in the business of life settlements that is aggrieved by the violation.
(3) Disclosure of a document or evidence under Subsection (2) does not abrogate or modify the privilege granted in Subsection (1).

Amended by Chapter 355, 2009 General Session

31A-36-116. Other law enforcement or regulatory authority.
This chapter does not:
(1) preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;
(2) prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the insurance department; or
(3) limit the powers granted elsewhere by law to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action.

Amended by Chapter 355, 2009 General Session

31A-36-117. Antifraud initiatives.
(1) The following shall establish and maintain antifraud initiatives which are reasonably calculated to prevent, detect, and assist in the prosecution of violations of Section 31A-36-113:
(a) a life settlement provider; and
(b) an agency that is a life settlement producer.
(2) The commissioner may order, or a licensee may request and the commissioner may approve, modifications of the measures otherwise required under this section, more or less restrictive than those measures, as necessary to protect against fraud.
(3) Antifraud initiatives shall include:
(a) fraud investigators, that may be either:
(i) employees of a life settlement provider or life settlement producer; or
(ii) independent contractors;
(b) an antifraud plan submitted to the commissioner, which shall include:
(i) a description of the procedures for:
(A) detecting and investigating possible violations of Section 31A-36-113; and
(B) resolving material inconsistencies between medical records and applications for insurance;
(ii) a description of the procedures for reporting possible violations to the commissioner;

(iii) a description of the plan for educating and training underwriters and other personnel against fraud; and

(iv) a description or chart of the organizational arrangement of the personnel responsible for detecting and investigating possible violations of Section 31A-36-113 and for resolving material inconsistencies between medical records and applications for insurance.

(4) A plan submitted to the commissioner shall be classified as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 355, 2009 General Session

31A-36-118. Criminal penalties and restitution.

(1) A person subject to this chapter is subject to:

(a) Section 31A-2-308 for an administrative violation of this title;

(b) prosecution under Section 76-6-412 for a criminal activity involving a life settlement; or

(c) prosecution under Section 31A-31-103 for insurance fraud involving a life settlement.

(2) A person found to be in violation of this chapter may:

(a) be ordered to pay restitution to persons aggrieved by the violation;

(b) be ordered to pay a forfeiture;

(c) be imprisoned if found guilty of a criminal law by a court of competent jurisdiction; and

(d) be subject to a combination of the penalties described in this Subsection (2).

(3) Except for a fraudulent act committed by an owner, this section does not apply to the owner.

Amended by Chapter 355, 2009 General Session

31A-36-119. Authority to make rules.

In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may adopt rules to:

(1) establish the requirements for the annual report required under Section 31A-36-106;

(2) establish standards for evaluating the reasonableness of payments under life settlements;

(3) establish appropriate licensing requirements, fees, and standards for continued licensure for:

(a) a life settlement provider; and

(b) a life settlement producer;

(4) (a) determine the amount and conditions of a bond or other assurance of financial responsibility required under Section 31A-23a-117 for a life settlement provider; and

(b) require, determine the amount, or determine the conditions of an assurance of financial responsibility for a life settlement producer, including a bond or an errors and omissions insurance policy;

(5) govern the relationship of insurers with a life settlement provider or life settlement producer during the settlement of a policy;
(6) determine the specific disclosures required under Section 31A-36-108;
(7) determine whether advertising for life settlements violates Section 31A-36-112;
(8) determine the information to be provided to the commissioner under Section 31A-36-114 and the manner of providing the information;
(9) determine additional acts or practices that are prohibited under Section 31A-36-111;
(10) establish payment requirements for the payments in Section 31A-36-110; and
(11) establish the filing procedure for the forms listed in Subsection 31A-36-105(1).

Amended by Chapter 355, 2009 General Session

31A-37-101. Title.
This chapter is known as the "Captive Insurance Companies Act."

Enacted by Chapter 251, 2003 General Session

31A-37-102. Definitions.
As used in this chapter:
(1) "Affiliated company" means a business entity that because of common ownership, control, operation, or management is in the same corporate system as:
(a) a parent;
(b) an industrial insured; or
(c) a member organization.
(2) "Alien captive insurance company" means an insurer:
(a) formed to write insurance business for a parent or affiliate of the insurer; and
(b) licensed pursuant to the laws of an alien jurisdiction that imposes statutory or regulatory standards:
(i) on a business entity transacting the business of insurance in the alien jurisdiction; and
(ii) in a form acceptable to the commissioner.
(3) "Association" means a legal association of two or more persons that has been in continuous existence for at least one year if:
(a) the association or its member organizations:
(i) 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
(ii) have complete voting control over an association captive insurance company incorporated as a mutual insurer;
(b) the association's member organizations collectively constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer; or
(c) the association or its member organizations have complete voting control

over an association captive insurance company formed as a limited liability company.

(4) "Association captive insurance company" means a business entity that insures risks of:

(a) a member organization of the association;

(b) an affiliate of a member organization of the association; and

(c) the association.

(5) "Branch business" means an insurance business transacted by a branch captive insurance company in this state.

(6) "Branch captive insurance company" means an alien captive insurance company that has a certificate of authority from the commissioner to transact the business of insurance in this state through a business unit with a principal place of business in this state.

(7) "Branch operation" means a business operation of a branch captive insurance company in this state.

(8) "Captive insurance company" means any of the following formed or holding a certificate of authority under this chapter:

(a) a branch captive insurance company;

(b) a pure captive insurance company;

(c) an association captive insurance company;

(d) a sponsored captive insurance company;

(e) an industrial insured captive insurance company;

(f) a captive reinsurance company;

(g) a special purpose captive insurance company; or

(h) a special purpose financial captive insurance company.

(9) "Captive reinsurance company" means a reinsurer that is:

(a) formed or has a certificate of authority pursuant to this chapter;

(b) wholly owned by a qualifying reinsurer parent company; and

(c) a stock corporation.

(10) "Common ownership and control" means that two or more captive insurance companies are owned or controlled by the same person or group of persons as follows:

(a) in the case of a captive insurance company that is a stock corporation, the direct or indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;

(b) in the case of a captive insurance company that is a mutual corporation, the direct or indirect ownership of 80% or more of the surplus and the voting power of the mutual corporation;

(c) in the case of a captive insurance company that is a limited liability company, the direct or indirect ownership by the same member or members of 80% or more of the membership interests in the limited liability company; or

(d) in the case of a sponsored captive insurance company, a protected cell is a separate captive insurance company owned and controlled by the protected cell's participant, only if:

(i) the participant is the only participant with respect to the protected cell; and

(ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored captive insurance company through common ownership and control.

(11) "Commissioner" means the Insurance Commissioner or the commissioner's designee.

(12) "Consolidated debt to total capital ratio" means the ratio of Subsection (12)(a) to (b).

(a) This Subsection (12)(a) is an amount equal to the sum of all debts and hybrid capital instruments including:

(i) all borrowings from depository institutions;

(ii) all senior debt;

(iii) all subordinated debts;

(iv) all trust preferred shares; and

(v) all other hybrid capital instruments that are not included in the determination of consolidated GAAP net worth issued and outstanding.

(b) This Subsection (12)(b) is an amount equal to the sum of:

(i) total capital consisting of all debts and hybrid capital instruments as described in Subsection (12)(a); and

(ii) shareholders' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(13) "Consolidated GAAP net worth" means the consolidated shareholders' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(14) "Controlled unaffiliated business" means a business entity:

(a) (i) in the case of a pure captive insurance company, that is not in the corporate system of a parent or the parent's affiliate; or

(ii) in the case of an industrial insured captive insurance company, that is not in the corporate system of an industrial insured or an affiliated company of the industrial insured;

(b) (i) in the case of a pure captive insurance company, that has a contractual relationship with a parent or affiliate; or

(ii) in the case of an industrial insured captive insurance company, that has a contractual relationship with an industrial insured or an affiliated company of the industrial insured; and

(c) whose risks are managed by one of the following in accordance with Subsection 31A-37-106(1)(k):

(i) a pure captive insurance company; or

(ii) an industrial insured captive insurance company.

(15) "Department" means the Insurance Department.

(16) "Industrial insured" means an insured:

(a) that produces insurance:

(i) by the services of a full-time employee acting as a risk manager or insurance manager; or

(ii) using the services of a regularly and continuously qualified insurance consultant;

(b) whose aggregate annual premiums for insurance on all risks total at least $25,000; and

(c) that has at least 25 full-time employees.

(17) "Industrial insured captive insurance company" means a business entity that:

(a) insures risks of the industrial insureds that comprise the industrial insured group; and

(b) may insure the risks of:

(i) an affiliated company of an industrial insured; or

(ii) a controlled unaffiliated business of:

(A) an industrial insured; or

(B) an affiliated company of an industrial insured.

(18) "Industrial insured group" means:

(a) a group of industrial insureds that collectively:

(i) own, control, or hold with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer; or

(ii) have complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer;

(b) a group that is:

(i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Section 3901 et seq., as amended, as a corporation or other limited liability association; and

(ii) taxable under this title as a:

(A) stock corporation; or

(B) mutual insurer; or

(c) a group that has complete voting control over an industrial captive insurance company formed as a limited liability company.

(19) "Member organization" means a person that belongs to an association.

(20) "Parent" means a person that directly or indirectly owns, controls, or holds with power to vote more than 50% of:

(a) the outstanding voting securities of a pure captive insurance company; or

(b) the pure captive insurance company, if the pure captive insurance company is formed as a limited liability company.

(21) "Participant" means an entity that is insured by a sponsored captive insurance company:

(a) if the losses of the participant are limited through a participant contract to the assets of a protected cell; and

(b)(i) the entity is permitted to be a participant under Section 31A-37-403; or

(ii) the entity is an affiliate of an entity permitted to be a participant under Section 31A-37-403.

(22) "Participant contract" means a contract by which a sponsored captive insurance company:

(a) insures the risks of a participant; and

(b) limits the losses of the participant to the assets of a protected cell.

(23) "Protected cell" means a separate account established and maintained by a sponsored captive insurance company for one participant.

(24) "Pure captive insurance company" means a business entity that insures risks of a parent or affiliate of the business entity.

(25) "Qualifying reinsurer parent company" means a reinsurer:

(a) authorized to write reinsurance by this state; and
(b) that has:
(i) a consolidated GAAP net worth of not less than $500,000,000; and
(ii) a consolidated debt to total capital ratio not greater than .50.
(26) "Special purpose financial captive insurance company" is as defined in Section 31A-37a-102.
(27) "Sponsor" means an entity that:
(a) meets the requirements of Section 31A-37-402; and
(b) is approved by the commissioner to:
(i) provide all or part of the capital and surplus required by applicable law; and
(ii) organize and operate a sponsored captive insurance company.
(28) "Sponsored captive insurance company" means a captive insurance company:
(a) in which the minimum capital and surplus required by applicable law is provided by one or more sponsors;
(b) that is formed or holding a certificate of authority under this chapter;
(c) that insures the risks of a separate participant through the contract; and
(d) that segregates each participant's liability through one or more protected cells.
(29) "Treasury rates" means the United States Treasury strip asked yield as published in the Wall Street Journal as of a balance sheet date.

Amended by Chapter 302, 2008 General Session

31A-37-103. Chapter exclusivity.
(1) Except as provided in Subsections (2) and (3) or otherwise provided in this chapter, a provision of this title other than this chapter does not apply to a captive insurance company.
(2) To the extent that a provision of the following does not contradict this chapter, the provision applies to a captive insurance company that receives a certificate of authority under this chapter:
(a) Chapter 2, Administration of the Insurance Laws;
(b) Chapter 4, Insurers in General;
(c) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
(d) Chapter 14, Foreign Insurers;
(e) Chapter 16, Insurance Holding Companies;
(f) Chapter 17, Determination of Financial Condition;
(g) Chapter 18, Investments;
(h) Chapter 19a, Utah Rate Regulation Act;
(i) Chapter 27, Delinquency Administrative Action Provisions; and
(j) Chapter 27a, Insurer Receivership Act.
(3) In addition to this chapter, and subject to Section 31A-37a-103:
(a) Chapter 37a, Special Purpose Financial Captive Insurance Company Act, applies to a special purpose financial captive insurance company; and
(b) for purposes of a special purpose financial captive insurance company, a reference in this chapter to "this chapter" includes a reference to Chapter 37a, Special

Purpose Financial Captive Insurance Company Act.

Amended by Chapter 284, 2011 General Session

31A-37-104. Applicability of reorganization, receivership, and injunction authority.

(1) Except as provided in Chapter 37a, Special Purpose Financial Captive Insurance Company Act, and Subsection (2), Chapter 27a, Insurer Receivership Act, applies to a captive insurance company formed or holding a certificate of authority under this chapter.

(2) In the case of a sponsored captive insurance company:

(a) the assets of a protected cell may not be used to pay an expense or claim other than one attributable to the protected cell; and

(b) the capital and surplus of the sponsored captive insurance company:

(i) shall at all times be available to pay:

(A) an expense of the sponsored captive insurance company; or

(B) a claim against the sponsored captive insurance company; and

(ii) may not be used to pay an expense or claim attributable to a protected cell.

Amended by Chapter 302, 2008 General Session

31A-37-105. Operation of a branch captive insurance company.

Except as otherwise provided in this chapter, a branch captive insurance company shall be a pure captive insurance company with respect to operations in this state, unless otherwise permitted by the commissioner under Section 31A-37-106.

Amended by Chapter 297, 2011 General Session

31A-37-106. Authority to make rules -- Authority to issue orders.

(1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may adopt rules to:

(a) determine circumstances under which a branch captive insurance company is not required to be a pure captive insurance company;

(b) require a statement, document, or information that a captive insurance company shall provide to the commissioner to obtain a certificate of authority;

(c) determine a factor a captive insurance company shall provide evidence of under Subsection 31A-37-202(4)(c);

(d) prescribe one or more capital requirements for a captive insurance company in addition to those required under Section 31A-37-204 based on the type, volume, and nature of insurance business transacted by the captive insurance company;

(e) establish:

(i) the amount of capital or surplus required to be retained under Subsection 31A-37-205(4) at the payment of a dividend or other distribution by a captive insurance company; or

(ii) a formula to determine the amount described in Subsection 31A-37-205(4);

(f) waive or modify a requirement for public notice and hearing for the following

by a captive insurance company:
(i) merger;
(ii) consolidation;
(iii) conversion;
(iv) mutualization; or
(v) redomestication;
(g) approve the use of one or more reliable methods of valuation and rating for:
(i) an association captive insurance company;
(ii) a sponsored captive insurance company; or
(iii) an industrial insured group;
(h) prohibit or limit an investment that threatens the solvency or liquidity of:
(i) a pure captive insurance company; or
(ii) an industrial insured captive insurance company;
(i) determine the financial reports a sponsored captive insurance company shall annually file with the commissioner;
(j) prescribe the required forms and reports under Section 31A-37-501; and
(k) establish one or more standards to ensure that:
(i) one of the following is able to exercise control of the risk management function of a controlled unaffiliated business to be insured by a pure captive insurance company:
(A) a parent; or
(B) an affiliated company of a parent; or
(ii) one of the following is able to exercise control of the risk management function of a controlled unaffiliated business to be insured by an industrial insured captive insurance company:
(A) an industrial insured; or
(B) an affiliated company of the industrial insured.
(2) Notwithstanding Subsection (1)(k), until the commissioner adopts the rules authorized under Subsection (1)(k), the commissioner may by temporary order grant authority to insure risks to:
(a) a pure captive insurance company; or
(b) an industrial insured captive insurance company.
(3) The commissioner may issue prohibitory, mandatory, and other orders relating to a captive insurance company as necessary to enable the commissioner to secure compliance with this chapter.

Amended by Chapter 297, 2011 General Session

31A-37-201. Certificate of authority.

The commissioner may issue a certificate of authority to act as an insurer in this state to a captive insurance company that meets the requirements of this chapter.

Enacted by Chapter 251, 2003 General Session

31A-37-202. Permissive areas of insurance.

(1) (a) Except as provided in Subsection (1)(b), when permitted by its articles of

incorporation or charter, a captive insurance company may apply to the commissioner for a certificate of authority to do all insurance authorized by this title except workers' compensation insurance.

(b) Notwithstanding Subsection (1)(a):

(i) a pure captive insurance company may not insure a risk other than a risk of:

(A) its parent or affiliate;

(B) a controlled unaffiliated business; or

(C) a combination of Subsections (1)(b)(i)(A) and (B);

(ii) an association captive insurance company may not insure a risk other than a risk of:

(A) an affiliate;

(B) a member organization of its association; and

(C) an affiliate of a member organization of its association;

(iii) an industrial insured captive insurance company may not insure a risk other than a risk of:

(A) an industrial insured that is part of the industrial insured group;

(B) an affiliate of an industrial insured that is part of the industrial insured group; and

(C) a controlled unaffiliated business of:

(I) an industrial insured that is part of the industrial insured group; or

(II) an affiliate of an industrial insured that is part of the industrial insured group;

(iv) a special purpose captive insurance company may only insure a risk of its parent;

(v) a captive insurance company may not provide:

(A) personal motor vehicle insurance coverage;

(B) homeowner's insurance coverage; or

(C) a component of a coverage described in this Subsection (1)(b)(v); and

(vi) a captive insurance company may not accept or cede reinsurance except as provided in Section 31A-37-303.

(c) Notwithstanding Subsection (1)(b)(iv), for a risk approved by the commissioner a special purpose captive insurance company may provide:

(i) insurance;

(ii) reinsurance; or

(iii) both insurance and reinsurance.

(2) To conduct insurance business in this state a captive insurance company shall:

(a) obtain from the commissioner a certificate of authority authorizing it to conduct insurance business in this state;

(b) hold at least once each year in this state:

(i) a board of directors meeting; or

(ii) in the case of a reciprocal insurer, a subscriber's advisory committee meeting;

(c) maintain in this state:

(i) the principal place of business of the captive insurance company; or

(ii) in the case of a branch captive insurance company, the principal place of business for the branch operations of the branch captive insurance company; and

(d) except as provided in Subsection (3), appoint a resident registered agent to accept service of process and to otherwise act on behalf of the captive insurance company in this state.

(3) Notwithstanding Subsection (2)(d), in the case of a captive insurance company formed as a corporation or a reciprocal insurer, if the registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the commissioner is the agent of the captive insurance company upon whom process, notice, or demand may be served.

(4) (a) Before receiving a certificate of authority, a captive insurance company:

(i) formed as a corporation shall file with the commissioner:

(A) a certified copy of:

(I) articles of incorporation or the charter of the corporation; and

(II) bylaws of the corporation;

(B) a statement under oath of the president and secretary of the corporation showing the financial condition of the corporation; and

(C) any other statement or document required by the commissioner under Section 31A-37-106;

(ii) formed as a reciprocal shall:

(A) file with the commissioner:

(I) a certified copy of the power of attorney of the attorney-in-fact of the reciprocal;

(II) a certified copy of the subscribers' agreement of the reciprocal;

(III) a statement under oath of the attorney-in-fact of the reciprocal showing the financial condition of the reciprocal; and

(IV) any other statement or document required by the commissioner under Section 31A-37-106; and

(B) submit to the commissioner for approval a description of the:

(I) coverages;

(II) deductibles;

(III) coverage limits;

(IV) rates; and

(V) any other information the commissioner requires under Section 31A-37-106.

(b) (i) If there is a subsequent material change in an item in the description required under Subsection (4)(a)(ii)(B) for a reciprocal captive insurance company, the reciprocal captive insurance company shall submit to the commissioner for approval an appropriate revision to the description required under Subsection (4)(a)(ii)(B).

(ii) A reciprocal captive insurance company that is required to submit a revision under Subsection (4)(b)(i) may not offer any additional types of insurance until the commissioner approves a revision of the description.

(iii) A reciprocal captive insurance company shall inform the commissioner of a material change in a rate within 30 days of the adoption of the change.

(c) In addition to the information required by Subsection (4)(a), an applicant captive insurance company shall file with the commissioner evidence of:

(i) the amount and liquidity of the assets of the applicant captive insurance company relative to the risks to be assumed by the applicant captive insurance company;

(ii) the adequacy of the expertise, experience, and character of the person who will manage the applicant captive insurance company;

(iii) the overall soundness of the plan of operation of the applicant captive insurance company;

(iv) the adequacy of the loss prevention programs for the following of the applicant captive insurance company:

(A) a parent;

(B) a member organization; or

(C) an industrial insured; and

(v) any other factor the commissioner:

(A) adopts by rule under Section 31A-37-106; and

(B) considers relevant in ascertaining whether the applicant captive insurance company will be able to meet the policy obligations of the applicant captive insurance company.

(d) In addition to the information required by Subsections (4)(a), (b), and (c), an applicant sponsored captive insurance company shall file with the commissioner:

(i) a business plan at the level of detail required by the commissioner under Section 31A-37-106 demonstrating:

(A) the manner in which the applicant sponsored captive insurance company will account for the losses and expenses of each protected cell; and

(B) the manner in which the applicant sponsored captive insurance company will report to the commissioner the financial history, including losses and expenses, of each protected cell;

(ii) a statement acknowledging that the applicant sponsored captive insurance company will make all financial records of the applicant sponsored captive insurance company, including records pertaining to a protected cell, available for inspection or examination by the commissioner;

(iii) a contract or sample contract between the applicant sponsored captive insurance company and a participant; and

(iv) evidence that expenses will be allocated to each protected cell in an equitable manner.

(5) (a) Information submitted pursuant to Subsection (4) is classified as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(b) Notwithstanding Title 63G, Chapter 2, Government Records Access and Management Act, the commissioner may disclose information submitted pursuant to Subsection (4) to a public official having jurisdiction over the regulation of insurance in another state if:

(i) the public official receiving the information agrees in writing to maintain the confidentiality of the information; and

(ii) the laws of the state in which the public official serves require the information to be confidential.

(c) This Subsection (5) does not apply to information provided by an industrial insured captive insurance company insuring the risks of an industrial insured group.

(6) (a) A captive insurance company shall pay to the department the following nonrefundable fees established by the department under Sections 31A-3-103,

31A-3-304, and 63J-1-504:

(i) a fee for examining, investigating, and processing, by a department employee, of an application for a certificate of authority made by a captive insurance company;

(ii) a fee for obtaining a certificate of authority for the year the captive insurance company is issued a certificate of authority by the department; and

(iii) a certificate of authority renewal fee.

(b) The commissioner may:

(i) assign a department employee or retain legal, financial, and examination services from outside the department to perform the services described in:

(A) Subsection (6)(a); and

(B) Section 31A-37-502; and

(ii) charge the reasonable cost of services described in Subsection (6)(b)(i) to the applicant captive insurance company.

(7) If the commissioner is satisfied that the documents and statements filed by the applicant captive insurance company comply with this chapter, the commissioner may grant a certificate of authority authorizing the company to do insurance business in this state.

(8) A certificate of authority granted under this section expires annually and shall be renewed by July 1 of each year.

Amended by Chapter 284, 2011 General Session
Amended by Chapter 297, 2011 General Session

31A-37-203. Deceptive name prohibited.

A captive insurance company may not adopt a name that is:

(1) the same as any other existing business name registered in this state;

(2) deceptively similar to any other existing business name registered in this state; or

(3) likely to be:

(a) confused with any other existing business name registered in this state; or

(b) mistaken for any other existing business name registered in this state.

Enacted by Chapter 251, 2003 General Session

31A-37-204. Paid-in capital -- Other capital.

(1) (a) The commissioner may not issue a certificate of authority to a company described in Subsection (1)(c) unless the company possesses and thereafter maintains unimpaired paid-in capital of:

(i) in the case of a pure captive insurance company, not less than $100,000;

(ii) in the case of an association captive insurance company incorporated as a stock insurer, not less than $400,000;

(iii) in the case of an industrial insured captive insurance company incorporated as a stock insurer, not less than $200,000;

(iv) in the case of a sponsored captive insurance company, not less than $500,000; or

(v) in the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro-formas, including the nature of the risks to be insured.

(b) The paid-in capital required under this Subsection (1) may be in the form of:

(i) (A) cash; or

(B) cash equivalent; or

(ii) an irrevocable letter of credit:

(A) issued by:

(I) a bank chartered by this state; or

(II) a member bank of the Federal Reserve System; and

(B) approved by the commissioner.

(c) This Subsection (1) applies to:

(i) a pure captive insurance company;

(ii) a sponsored captive insurance company;

(iii) a special purpose captive insurance company;

(iv) an association captive insurance company incorporated as a stock insurer; or

(v) an industrial insured captive insurance company incorporated as a stock insurer.

(2) (a) The commissioner may, under Section 31A-37-106, prescribe additional capital based on the type, volume, and nature of insurance business transacted.

(b) The capital prescribed by the commissioner under this Subsection (2) may be in the form of:

(i) cash; or

(ii) an irrevocable letter of credit issued by:

(A) a bank chartered by this state; or

(B) a member bank of the Federal Reserve System.

(3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, shall, through its branch operations, establish and maintain a trust fund:

(i) funded by an irrevocable letter of credit or other acceptable asset; and

(ii) in the United States for the benefit of:

(A) United States policyholders; and

(B) United States ceding insurers under:

(I) insurance policies issued; or

(II) reinsurance contracts issued or assumed.

(b) The amount of the security required under this Subsection (3) shall be no less than:

(i) the capital and surplus required by this chapter; and

(ii) the reserves on the insurance policies or reinsurance contracts, including:

(A) reserves for losses;

(B) allocated loss adjustment expenses;

(C) incurred but not reported losses; and

(D) unearned premiums with regard to business written through branch operations.

(c) Notwithstanding the other provisions of this Subsection (3), the commissioner may permit a branch captive insurance company that is required to post security for loss reserves on branch business by its reinsurer to reduce the funds in the trust account required by this section by the same amount as the security posted if the security remains posted with the reinsurer.

(4) (a) A captive insurance company may not pay the following without the prior approval of the commissioner:

(i) a dividend out of capital or surplus in excess of the limits under Section 16-10a-640; or

(ii) a distribution with respect to capital or surplus in excess of the limits under Section 16-10a-640.

(b) The commissioner shall condition approval of an ongoing plan for the payment of dividends or other distributions on the retention, at the time of each payment, of capital or surplus in excess of:

(i) amounts specified by the commissioner under Section 31A-37-106; or

(ii) determined in accordance with formulas approved by the commissioner under Section 31A-37-106.

Amended by Chapter 312, 2004 General Session

31A-37-205. Free surplus.

(1) (a) Except as provided in Subsection (2), the commissioner may not issue a certificate of authority to a captive insurance company unless the company possesses and maintains free surplus of:

(i) in the case of a pure captive insurance company, not less that $150,000;

(ii) in the case of an association captive insurance company incorporated as a stock insurer, not less than $350,000;

(iii) in the case of an industrial insured captive insurance company incorporated as a stock insurer, not less than $300,000;

(iv) in the case of an association captive insurance company incorporated as a mutual insurer, not less $750,000;

(v) in the case of an industrial insured captive insurance company incorporated as a mutual insurer, not less than $500,000;

(vi) in the case of a sponsored captive insurance company, not less than $500,000; and

(vii) in the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro-formas, including the nature of the risks to be insured.

(b) The surplus required under this Subsection (1) may be in the form of:

(i) cash; or

(ii) an irrevocable letter of credit issued by:

(A) a bank chartered by this state; or

(B) a member bank of the Federal Reserve System that is approved by the commissioner.

(2) Notwithstanding the requirements of Subsection (1), a captive insurance

company organized as a reciprocal insurer under this chapter may not be issued a certificate of authority unless the captive insurance company possesses and maintains free surplus of $1,000,000.

(3) (a) The commissioner may prescribe additional surplus based upon the type, volume, and nature of insurance business transacted.

(b) The capital required under this Subsection (3) may be in the form of an irrevocable letter of credit issued by:

(i) a bank chartered by this state; or

(ii) a member bank of the Federal Reserve System.

(4) (a) Without the prior approval of the commissioner, a captive insurance company may not pay:

(i) a dividend out of capital or surplus in excess of the limits under Section 16-10a-640; or

(ii) a distribution with respect to capital or surplus in excess of the limits under Section 16-10a-640.

(b) The commissioner shall condition approval of an ongoing plan for the payment of dividends or other distribution on the retention, at the time of each payment, of capital or surplus in excess of amounts:

(i) specified by the commissioner; or

(ii) determined in accordance with formulas approved by the commissioner.

Amended by Chapter 312, 2004 General Session

31A-37-301. Incorporation.

(1) A pure captive insurance company or a sponsored captive insurance company shall be incorporated as a stock insurer with the capital of the pure captive insurance company or sponsored captive insurance company:

(a) divided into shares; and

(b) held by the stockholders of the pure captive insurance company or sponsored captive insurance company.

(2) An association captive insurance company or an industrial insured captive insurance company may be:

(a) incorporated as a stock insurer with the capital of the association captive insurance company or industrial insured captive insurance company:

(i) divided into shares; and

(ii) held by the stockholders of the association captive insurance company or industrial insured captive insurance company;

(b) incorporated as a mutual insurer without capital stock, with a governing body elected by the member organizations of the association captive insurance company or industrial insured captive insurance company; or

(c) organized as a reciprocal.

(3) A captive insurance company may not have fewer than three incorporators of whom not fewer than two shall be residents of this state.

(4) (a) Before a captive insurance company formed as a corporation files the corporation's articles of incorporation with the Division of Corporations and Commercial Code, the incorporators shall obtain from the commissioner a certificate finding that the

establishment and maintenance of the proposed corporation will promote the general good of the state.

(b) In considering a request for a certificate under Subsection (4)(a), the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the incorporators;

(ii) the character, reputation, financial responsibility, insurance experience, business qualifications of the officers and directors;

(iii) any information in:

(A) the application for a certificate of authority; or

(B) the department's files; and

(iv) other aspects the commissioner considers advisable.

(5) (a) A captive insurance company formed as a corporation shall file with the Division of Corporations and Commercial Code:

(i) the captive insurance company's articles of incorporation;

(ii) the certificate issued pursuant to Subsection (4); and

(iii) the fees required by the Division of Corporations and Commercial Code.

(b) The Division of Corporations and Commercial Code shall file both the articles of incorporation and the certificate described in Subsection (4) for a captive insurance company that complies with this section.

(6) (a) The organizers of a captive insurance company formed as a reciprocal insurer shall obtain from the commissioner a certificate finding that the establishment and maintenance of the proposed association will promote the general good of the state.

(b) In considering a request for a certificate under Subsection (6)(a), the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the incorporators;

(ii) the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors;

(iii) any information in:

(A) the application for a certificate of authority; or

(B) the department's files; and

(iv) other aspects the commissioner considers advisable.

(7) (a) An alien captive insurance company that has received a certificate of authority to act as a branch captive insurance company shall obtain from the commissioner a certificate finding that:

(i) the home state of the alien captive insurance company imposes statutory or regulatory standards in a form acceptable to the commissioner on companies transacting the business of insurance in that state; and

(ii) after considering the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors of the alien captive insurance company, and other relevant information, the establishment and maintenance of the branch operations will promote the general good of the state.

(b) After the commissioner issues a certificate under Subsection (7)(a) to an alien captive insurance company, the alien captive insurance company may register to

do business in this state.

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

(9) At least one of the members of the board of directors of a captive insurance company formed as a corporation shall be a resident of this state.

(10) At least one of the members of the subscribers' advisory committee of a captive insurance company formed as a reciprocal insurer shall be a resident of this state.

(11) (a) A captive insurance company formed as a corporation under this chapter has the privileges and is subject to the provisions of the general corporation law as well as the applicable provisions contained in this chapter.

(b) If a conflict exists between a provision of the general corporation law and a provision of this chapter, this chapter shall control.

(c) Except as provided in Subsection (11)(d), the provisions of this title pertaining to a merger, consolidation, conversion, mutualization, and redomestication apply in determining the procedures to be followed by a captive insurance company in carrying out any of the transactions described in those provisions.

(d) Notwithstanding Subsection (11)(c), the commissioner may waive or modify the requirements for public notice and hearing in accordance with rules adopted under Section 31A-37-106.

(e) If a notice of public hearing is required, but no one requests a hearing, the commissioner may cancel the public hearing.

(12) (a) A captive insurance company formed as a reciprocal insurer under this chapter has the powers set forth in Section 31A-4-114 in addition to the applicable provisions of this chapter.

(b) If a conflict exists between the provisions of Section 31A-4-114 and the provisions of this chapter with respect to a captive insurance company, this chapter shall control.

(c) To the extent a reciprocal insurer is made subject to other provisions of this title pursuant to Section 31A-14-208, the provisions are not applicable to a reciprocal insurer formed under this chapter unless the provisions are expressly made applicable to a captive insurance company under this chapter.

(d) In addition to the provisions of this Subsection (12), a captive insurance company organized as a reciprocal insurer that is an industrial insured group has the privileges of Section 31A-4-114 in addition to applicable provisions of this title.

(13) The articles of incorporation or bylaws of a captive insurance company may not authorize a quorum of a board of directors to consist of fewer than one-third of the fixed or prescribed number of directors as provided in Section 16-10a-824.

Amended by Chapter 297, 2011 General Session

31A-37-302. Investment requirements.

(1) (a) Except as provided in Subsection (1)(b), an association captive insurance company, a sponsored captive insurance company, and an industrial insured group shall comply with the investment requirements contained in this title.

(b) Notwithstanding Subsection (1)(a) and any other provision of this title, the

commissioner may approve the use of alternative reliable methods of valuation and rating under Section 31A-37-106 for:

(i) an association captive insurance company;

(ii) a sponsored captive insurance company; or

(iii) an industrial insured group.

(2) (a) Except as provided in Subsection (2)(b), a pure captive insurance company or industrial insured captive insurance company is not subject to any restrictions on allowable investments contained in this title.

(b) Notwithstanding Subsection (2)(a), the commissioner may, under Section 31A-37-106, prohibit or limit an investment that threatens the solvency or liquidity of:

(i) a pure captive insurance company; or

(ii) an industrial insured captive insurance company.

(3) (a) (i) Except as provided in Subsection (3)(a)(ii), a captive insurance company may not make loans to:

(A) the parent company of the captive insurance company; or

(B) an affiliate of the captive insurance company.

(ii) Notwithstanding Subsection (3)(a)(i), a pure captive insurance company may make loans to:

(A) the parent company of the pure captive insurance company; or

(B) an affiliate of the pure captive insurance company.

(b) A loan under Subsection (3)(a):

(i) may be made only on the prior written approval of the commissioner; and

(ii) shall be evidenced by a note in a form approved by the commissioner.

(c) A pure captive insurance company may not make a loan from:

(i) the paid-in capital required under Subsection 31A-37-204(1); or

(ii) the free surplus required under Subsection 31A-37-205(1).

Amended by Chapter 297, 2011 General Session

31A-37-303. Reinsurance.

(1) A captive insurance company may provide reinsurance, as authorized in this title, on risks ceded by any other insurer.

(2) (a) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404.

(b) Unless the reinsurer is in compliance with Section 31A-17-404, a captive insurance company may not take credit for:

(i) reserves on risks ceded to a reinsurer; or

(ii) portions of risks ceded to a reinsurer.

Enacted by Chapter 251, 2003 General Session

31A-37-304. Rating organization.

A captive insurance company is not required to join a rating organization.

Enacted by Chapter 251, 2003 General Session

31A-37-305. Contributions to guaranty or insolvency fund prohibited.

(1) A captive insurance company, including a captive insurance company organized as a reciprocal insurer under this chapter, may not join or contribute financially to any of the following in this state:

(a) a plan;

(b) a pool;

(c) an association;

(d) a guaranty fund; or

(e) an insolvency fund.

(2) A captive insurance company, the insured of a captive insurance company, the parent of a captive insurance company, an affiliate of a captive insurance company, a member organization of an association captive insurance company, or in the case of a captive insurance company organized as a reciprocal insurer, a subscriber of the captive insurance company, may not receive a benefit from:

(a) a plan;

(b) a pool;

(c) an association;

(d) a guaranty fund for claims arising out of the operations of the captive insurance company; or

(e) an insolvency fund for claims arising out of the operations of the captive insurance company.

Enacted by Chapter 251, 2003 General Session

31A-37-306. Conversion or merger.

(1) An association captive insurance company or industrial insured group formed as a stock or mutual corporation may be:

(a) converted to a reciprocal insurer in accordance with a plan and this section; or

(b) merged with and into a reciprocal insurer in accordance with a plan and this section.

(2) A plan for a conversion or merger under this section:

(a) shall be fair and equitable to:

(i) the shareholders, in the case of a stock insurer; or

(ii) the policyholders, in the case of a mutual insurer; and

(b) shall provide for the purchase of:

(i) the shares of any nonconsenting shareholder of a stock insurer in substantially the same manner and subject to the same rights and conditions as are provided a dissenting shareholder; or

(ii) the policyholder interest of any nonconsenting policyholder of a mutual insurer in substantially the same manner and subject to the same rights and conditions as are provided a dissenting policyholder.

(3) In the case of a conversion authorized under Subsection (1):

(a) the conversion shall be accomplished under a reasonable plan and procedure that are approved by the commissioner;

(b) the commissioner may not approve the plan of conversion under this section

unless the plan:

(i) satisfies Subsections (2) and (6);

(ii) provides for the conversion of existing stockholder or policyholder interests into subscriber interests in the resulting reciprocal insurer, proportionate to stockholder or policyholder interests in the stock or mutual insurer; and

(iii) is approved:

(A) in the case of a stock insurer, by a majority of the shares entitled to vote represented in person or by proxy at a duly called regular or special meeting at which a quorum is present; or

(B) in the case of a mutual insurer, by a majority of the voting interests of policyholders represented in person or by proxy at a duly called regular or special meeting at which a quorum is present;

(c) the commissioner shall approve a plan of conversion if the commissioner finds that the conversion will promote the general good of the state in conformity with the standards under Subsection 31A-37-301(4);

(d) if the commissioner approves a plan of conversion, the commissioner shall amend the converting insurer's certificate of authority to reflect conversion to a reciprocal insurer and issue the amended certificate of authority to the company's attorney-in-fact;

(e) upon issuance of an amended certificate of authority of a reciprocal insurer by the commissioner, the conversion is effective; and

(f) upon the effectiveness of the conversion:

(i) the corporate existence of the converting insurer shall cease; and

(ii) the resulting reciprocal insurer shall notify the Division of Corporations and Commercial Code of the conversion.

(4) A merger authorized under Subsection (1) shall be accomplished substantially in accordance with the procedures set forth in this title except that, solely for purposes of the merger:

(a) the plan or merger shall satisfy Subsection (2);

(b) the subscribers' advisory committee of a reciprocal insurer shall be equivalent to the board of directors of a stock or mutual insurance company;

(c) the subscribers of a reciprocal insurer shall be the equivalent of the policyholders of a mutual insurance company;

(d) if a subscribers' advisory committee does not have a president or secretary, the officers of the committee having substantially equivalent duties are the president and secretary of the committee;

(e) the commissioner shall approve the articles of merger if the commissioner finds that the merger will promote the general good of the state in conformity with the standards under Subsection 31A-37-301(4);

(f) notwithstanding Sections 31A-37-204 and 31A-37-205, the commissioner may permit the formation, without capital and surplus, of a captive insurance company organized as a reciprocal insurer, into which an existing captive insurance company may be merged to facilitate a transaction under this section, if there is no more than one authorized insurance company surviving the merger; and

(g) an alien insurer may be a party to a merger authorized under Subsection (1) if:

(i) the requirements for the merger between a domestic and a foreign insurer under Chapter 16, Insurance Holding Companies, are applied to the merger; and

(ii) the alien insurer is treated as a foreign insurer under Chapter 16, Insurance Holding Companies.

(5) If the commissioner approves the articles of merger under this section:

(a) the commissioner shall endorse the commissioner's approval on the articles; and

(b) the surviving insurer shall present the name to the Division of Corporations and Commercial Code.

(6) (a) Except as provided in Subsection (6)(b), a conversion authorized under Subsection (1) shall provide for a hearing, of which notice has been given to the insurer, its directors, officers and stockholders, in the case of a stock insurer, or policyholders, in the case of a mutual insurer, all of whom have the right to appear at the hearing.

(b) Notwithstanding Subsection (6)(a), the commissioner may waive or modify the requirements for the hearing.

(c) If a notice of hearing is required, but no hearing is requested, after notice has been given under Subsection (6)(a), the commissioner may cancel the hearing.

Amended by Chapter 297, 2011 General Session

31A-37-401. Sponsored captive insurance companies -- Formation.

(1) One or more sponsors may form a sponsored captive insurance company under this chapter.

(2) A sponsored captive insurance company formed under this chapter may establish and maintain a protected cell to insure risks of a participant if:

(a) the shareholders of a sponsored captive insurance company are limited to:

(i) the participants of the sponsored captive insurance company; and

(ii) the sponsors of the sponsored captive insurance company;

(b) each protected cell is accounted for separately on the books and records of the sponsored captive insurance company to reflect:

(i) the financial condition of the protected cell;

(ii) the results of operations of the protected cell;

(iii) the net income or loss of the protected cell;

(iv) the dividends or other distributions to participants of the protected cell; and

(v) other factors that may be:

(A) provided in the participant contract; or

(B) required by the commissioner;

(c) the assets of a protected cell are not chargeable with liabilities arising out of any other insurance business the sponsored captive insurance company may conduct;

(d) a sale, exchange, or other transfer of assets is not made by the sponsored captive insurance company between or among any of the protected cells of the sponsored captive insurance company without the consent of the protected cells;

(e) a sale, exchange, transfer of assets, dividend, or distribution is not made from a protected cell to a sponsor or participant without the commissioner's approval, which may not be given if the sale, exchange, transfer, dividend, or distribution would result in insolvency or impairment with respect to a protected cell;

(f) a sponsored captive insurance company annually files with the commissioner financial reports the commissioner requires under Section 31A-37-106, including accounting statements detailing the financial experience of each protected cell;

(g) a sponsored captive insurance company notifies the commissioner in writing within 10 business days of a protected cell that is insolvent or otherwise unable to meet the claim or expense obligations of the protected cell;

(h) a participant contract does not take effect without the commissioner's prior written approval; and

(i) the addition of each new protected cell and withdrawal of a participant of any existing protected cell does not take effect without the commissioner's prior written approval.

Enacted by Chapter 251, 2003 General Session

31A-37-402. Sponsored captive insurance companies -- Certificate of authority mandatory.

(1) A sponsor of a sponsored captive insurance company shall be:

(a) an insurer authorized or approved under the laws of a state;

(b) a reinsurer authorized or approved under the laws of a state;

(c) a captive insurance company holding a certificate of authority under this chapter;

(d) an insurance holding company that:

(i) controls an insurer licensed pursuant to the laws of a state; and

(ii) is subject to registration pursuant to the holding company system of laws of the state of domicile of the insurer described in Subsection (1)(d)(i); or

(e) another person approved by the commissioner after finding that the approval of the person as a sponsor is not inconsistent with the purposes of this chapter.

(2) (a) The business written by a sponsored captive insurance company with respect to a protected cell shall be fronted by an insurer that is:

(i) authorized or approved:

(A) under the laws of a state; or

(B) under any jurisdiction if the insurance company is a wholly owned subsidiary of an insurance company licensed pursuant to the laws of a state;

(ii) reinsured by a reinsurer authorized or approved by this state; or

(iii) subject to Subsection (2)(b), secured by a trust fund:

(A) in the United States;

(B) for the benefit of policyholders and claimants; and

(C) funded by an irrevocable letter of credit or other asset acceptable to the commissioner.

(b) (i) The amount of security provided by the trust fund described in Subsection (2)(a)(iii) may not be less than the reserves associated with the liabilities of the trust fund, including:

(A) reserves for losses;

(B) allocated loss adjustment expenses;

(C) incurred but unreported losses; and

(D) unearned premiums for business written through the participant's protected

cell.

(ii) The commissioner may require the sponsored captive insurance company to increase the funding of a trust established pursuant to this Subsection (2).

(iii) If the form of security in the trust described in Subsection (2)(a)(iii) is a letter of credit, the letter of credit shall be established, issued, or confirmed by a bank that is:

(A) chartered in this state;

(B) a member of the federal reserve system; or

(C) chartered by another state if that state-chartered bank is acceptable to the commissioner.

(iv) A trust and trust instrument maintained pursuant to this Subsection (2) shall be in a form and upon terms approved by the commissioner.

(3) A risk retention group may not be either a sponsor or a participant of a sponsored captive insurance company.

Amended by Chapter 297, 2011 General Session

31A-37-403. Participants in sponsored captive insurance companies.

(1) Any of the following may be a participant in a sponsored captive insurance company holding a certificate of authority under this chapter:

(a) an association;

(b) a corporation;

(c) a limited liability company;

(d) a partnership;

(e) a trust; or

(f) any other business entity.

(2) A sponsor may be a participant in a sponsored captive insurance company.

(3) A participant need not be:

(a) a shareholder of the sponsored captive insurance company; or

(b) an affiliate of the sponsored captive insurance company.

(4) A participant shall insure only the participant's own risks through a sponsored captive insurance company unless otherwise approved by the commissioner.

Amended by Chapter 312, 2004 General Session

31A-37-404. Discounting of loss and loss adjustment expense reserves.

(1) The following may discount its loss and loss adjustment expense reserves at treasury rates applied to the applicable payments projected through the use of the expected payment pattern associated with the reserves:

(a) a sponsored captive insurance company; and

(b) a captive reinsurance company.

(2) (a) The following shall annually file with the department an actuarial opinion provided by an independent actuary on loss and loss adjustment expense reserves:

(i) a sponsored captive insurance company; and

(ii) a captive reinsurance company.

(b) The independent actuary described in Subsection (2)(a) may not be an

employee of:

(i) the company filing the actuarial opinion; or

(ii) an affiliate of the company filing the actuarial opinion.

(3) The commissioner may disallow the discounting of reserves by the following if the company violates this title:

(a) a sponsored captive insurance company; or

(b) a captive reinsurance company.

Enacted by Chapter 312, 2004 General Session

31A-37-501. Reports to commissioner.

(1) A captive insurance company is not required to make a report except those provided in this chapter.

(2) (a) Before March 1 of each year, a captive insurance company shall submit to the commissioner a report of the financial condition of the captive insurance company, verified by oath of two of the executive officers of the captive insurance company.

(b) Except as provided in Sections 31A-37-204 and 31A-37-205, a captive insurance company shall report:

(i) using generally accepted accounting principles, except to the extent that the commissioner requires, approves, or accepts the use of a statutory accounting principle;

(ii) using a useful or necessary modification or adaptation to an accounting principle that is required, approved, or accepted by the commissioner for the type of insurance and kind of insurer to be reported upon; and

(iii) supplemental or additional information required by the commissioner.

(c) Except as otherwise provided:

(i) an association captive insurance company and an industrial insured group shall file the report required by Section 31A-4-113; and

(ii) an industrial insured group shall comply with Section 31A-4-113.5.

(3) (a) A pure captive insurance company may make written application to file the required report on a fiscal year end that is consistent with the fiscal year of the parent company of the pure captive insurance company.

(b) If the commissioner grants an alternative reporting date for a pure captive insurance company requested under Subsection (3)(a), the annual report is due 60 days after the fiscal year end.

(4) (a) Sixty days after the fiscal year end, a branch captive insurance company shall file with the commissioner a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by two of the alien captive insurance company's executive officers.

(b) If the commissioner is satisfied that the annual report filed by the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed provides adequate information concerning the financial condition of the alien captive insurance company, the commissioner may waive the requirement for completion of the annual statement required for a captive insurance company under

this section with respect to business written in the alien jurisdiction.

(c) A waiver by the commissioner under Subsection (4)(b):

(i) shall be in writing; and

(ii) is subject to public inspection.

Amended by Chapter 302, 2008 General Session

31A-37-502. Examination.

(1) (a) As provided in this section, the commissioner or a person appointed by the commissioner, shall examine each captive insurance company in each three-year period.

(b) The three-year period described in Subsection (1)(a) shall be determined on the basis of three full annual accounting periods of operation.

(c) The examination is to be made as of:

(i) December 31 of the full three-year period; or

(ii) the last day of the month of an annual accounting period authorized for a captive insurance company under this section.

(d) In addition to an examination required under this Subsection (1), the commissioner, or a person appointed by the commissioner may examine a captive insurance company whenever the commissioner determines it to be prudent.

(2) During an examination under this section the commissioner, or a person appointed by the commissioner, shall thoroughly inspect and examine the affairs of the captive insurance company to ascertain:

(a) the financial condition of the captive insurance company;

(b) the ability of the captive insurance company to fulfill the obligations of the captive insurance company; and

(c) whether the captive insurance company has complied with this chapter.

(3) The commissioner upon application may enlarge the three-year period described in Subsection (1) to five years, if a captive insurance company is subject to a comprehensive annual audit during that period:

(a) of a scope satisfactory to the commissioner; and

(b) performed by independent auditors approved by the commissioner.

(4) The commissioner may accept a comprehensive annual independent audit in lieu of an examination:

(a) of a scope satisfactory to the commissioner; and

(b) performed by an independent auditor approved by the commissioner.

(5) A captive insurance company that is inspected and examined under this section shall pay, as provided in Subsection 31A-37-202(6)(b), the expenses and charges of an inspection and examination.

Amended by Chapter 349, 2009 General Session

31A-37-503. Classification and use of records.

(1) The following shall be classified as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act:

(a) examination reports under this section;

(b) preliminary examination reports or results under this section;
(c) working papers for an examination conducted under this section;
(d) recorded information for an examination conducted under this section; and
(e) documents and copies of documents produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination conducted under this section.
(2) This section does not prevent the commissioner from using the information provided under this section in furtherance of the commissioner's regulatory authority under this title.
(3) Notwithstanding other provisions of this section, the commissioner may grant access to the information provided under this section to:
(a) public officers having jurisdiction over the regulation of insurance in any other state or country; or
(b) law enforcement officers of this state or any other state or agency of the federal government, if the officers receiving the information agree in writing to hold the information in a manner consistent with this section.

Amended by Chapter 382, 2008 General Session

31A-37-504. Examinations for branch and alien captive insurance companies.
(1) The examination for a branch captive insurance company shall be of branch business and branch operations only, if the branch captive insurance company:
(a) provides annually to the commissioner a certificate of compliance, or an equivalent, issued by or filed with the licensing authority of the jurisdiction in which the branch captive insurance company is formed; and
(b) demonstrates to the commissioner's satisfaction that the branch captive insurance company is operating in sound financial condition in accordance with the applicable laws and regulations of the jurisdiction in which the branch captive insurance company is formed.
(2) As a condition of obtaining a certificate of authority, an alien captive insurance company shall grant authority to the commissioner to examine the affairs of the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed.

Amended by Chapter 284, 2011 General Session

31A-37-505. Suspension or revocation -- Grounds.
(1) The commissioner may suspend or revoke the certificate of authority of a captive insurance company to conduct an insurance business in this state for:
(a) insolvency or impairment of capital or surplus;
(b) failure to meet the requirements of Section 31A-37-204 or 31A-37-205;
(c) refusal or failure to submit:
(i) an annual report required by Section 31A-37-501; or
(ii) any other report or statement required by law or by lawful order of the commissioner;

(d) failure to comply with the charter, bylaws, or other organizational document of the captive insurance company;

(e) failure to submit to:

(i) an examination under Section 31A-37-502; or

(ii) any legal obligation relative to an examination under Section 31A-37-502;

(f) refusal or failure to pay the cost of examination under Section 31A-37-502;

(g) use of methods that, although not otherwise specifically prohibited by law, render:

(i) the operation of the captive insurance company detrimental to the public or the policyholders of the captive insurance company; or

(ii) the condition of the captive insurance company unsound with respect to the public or to the policyholders of the captive insurance company; or

(h) failure otherwise to comply with laws of this state.

(2) Notwithstanding any other provision of this title, if the commissioner finds, upon examination, hearing, or other evidence, that a captive insurance company has committed any of the acts specified in Subsection (1), the commissioner may suspend or revoke the certificate of authority of the captive insurance company if the commissioner considers it in the best interest of the public and the policyholders of the captive insurance company to revoke the certificate of authority.

Enacted by Chapter 251, 2003 General Session

31A-37-601. Incorporation of a captive reinsurance company.

(1) A captive reinsurance company shall be incorporated as a stock insurer with its capital:

(a) divided into shares; and

(b) held by the captive reinsurance company's shareholders.

(2) (a) A captive reinsurance company may not have fewer than three incorporators.

(b) At least two of the incorporators of a captive reinsurance company shall be residents of this state.

(3) (a) Before the articles of incorporation are filed with the Division of Corporations and Commercial Code, the incorporators shall obtain from the commissioner a certificate of finding that the establishment and maintenance of the proposed corporation promotes the general good of this state.

(b) In considering a request for a certificate under Subsection (3)(a), the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the incorporators;

(ii) the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors; and

(iii) other factors the commissioner considers advisable.

(4) The capital stock of a captive reinsurance company shall be issued at par value or greater.

(5) At least one of the members of the board of directors of a captive reinsurance company incorporated in this state shall be a resident of this state.

Amended by Chapter 297, 2011 General Session

31A-37-602. Requirements of a captive reinsurance company.

(1) (a) If permitted by its articles of incorporation or charter, a captive reinsurance company may apply to the commissioner for a certificate of authority to write reinsurance covering:

(i) property and casualty insurance; or

(ii) reinsurance contracts.

(b) A captive reinsurance company authorized by the commissioner may write reinsurance contracts covering risks in any state.

(2) To conduct business in this state, a captive reinsurance company shall:

(a) obtain from the commissioner a certificate of authority authorizing the captive reinsurance company to conduct business as a captive reinsurance company in this state;

(b) hold at least one board of directors' meeting each year in this state;

(c) maintain its principal place of business in this state; and

(d) appoint a registered agent to accept service of process and act otherwise on its behalf in this state.

(3) Before receiving a certificate of authority, a captive reinsurance company shall file with the commissioner:

(a) a certified copy of the captive reinsurance company's:

(i) (A) articles of incorporation; or

(B) charter; and

(ii) bylaws;

(b) a statement under oath of its president and secretary showing its financial condition; and

(c) other documents required by the commissioner.

(4) In addition to the information required by Subsection (3), the applicant captive reinsurance company shall file with the commissioner evidence of:

(a) the amount and liquidity of the captive reinsurance company's assets relative to the risks to be assumed;

(b) the adequacy of the expertise, experience, and character of the person who manages the captive reinsurance company;

(c) the overall soundness of the captive reinsurance company's plan of operation; and

(d) other overall factors considered relevant by the commissioner in ascertaining if the proposed captive reinsurance company is able to meet its policy obligations.

(5) (a) Notwithstanding Title 63G, Chapter 2, Government Records Access and Management Act, information submitted pursuant to this section is confidential and may not be made public by the commissioner or an agent or employee of the commissioner without the written consent of the company, except that:

(i) information may be discoverable by a party in a civil action or contested case to which the submitting captive reinsurance company is a party, upon a showing by the party seeking to discover the information that:

(A) the information sought is relevant to and necessary for the furtherance of the

action or case;

(B) the information sought is unavailable from other nonconfidential sources; and

(C) a subpoena issued by a judicial or administrative law officer of competent jurisdiction has been submitted to the commissioner; and

(ii) the commissioner may disclose the information to the public officer having jurisdiction over the regulation of insurance in another state if:

(A) the public official agrees in writing to maintain the confidentiality of the information; and

(B) the laws of the state in which the public official serves require the information to be confidential.

(b) This Subsection (5) does not apply to an industrial insured captive reinsurance company insuring the risks of an industrial insured group.

Amended by Chapter 302, 2008 General Session
Amended by Chapter 382, 2008 General Session

31A-37-603. Minimum capitalization or reserves for a captive reinsurance company.

(1) (a) The commissioner may not issue a certificate of authority to a captive reinsurance company unless a captive reinsurance company possesses and maintains capital or free surplus of not less than the greater of:

(i) $300,000,000; or

(ii) 10% of the reserves of the captive reinsurance company.

(b) The surplus required by this Subsection (1) may be in the form of:

(i) cash; or

(ii) securities.

(2) The commissioner may prescribe additional capital or surplus based upon the type, volume, and nature of the insurance business transacted.

(3) (a) A captive reinsurance company may not pay a dividend out of, or other distribution with respect to capital or surplus without the prior approval of the commissioner.

(b) Approval of an ongoing plan for the payment of dividends or other distributions shall be conditioned upon the retention at the time of each payment of capital or surplus in excess of amounts specified by, or determined in accordance with formulas approved by, the commissioner.

Amended by Chapter 302, 2008 General Session

31A-37-604. Management of assets of a captive reinsurance company.

At least 35% of the assets of a captive reinsurance company shall be managed by an asset manager domiciled in this state.

Enacted by Chapter 312, 2004 General Session

31A-37a-101. Title.

This chapter is known as the "Special Purpose Financial Captive Insurance Company Act."

Enacted by Chapter 302, 2008 General Session

31A-37a-102. Definitions.

(1) For purposes of this chapter:

(a) "Ceding insurer" means an insurer that:

(i) is approved by the commissioner;

(ii) is licensed or otherwise authorized to transact the business of insurance or reinsurance in the insurer's state or country of domicile; and

(iii) cedes risk to a special purpose financial captive insurance company pursuant to a reinsurance contract.

(b) Notwithstanding Section 31A-27a-102, "insolvency" or "insolvent" for purposes of applying Chapter 27a, Insurer Receivership Act, to a special purpose financial captive insurance company, means that a special purpose financial captive insurance company:

(i) is unable to pay an obligation when the obligation is due, unless the obligation is the subject of a bona fide dispute; or

(ii) fails to meet the criteria and conditions for solvency of the special purpose financial captive insurance company established by the commissioner by rule or order.

(c) (i) "Insurance securitization" means a transaction or a group of related transactions:

(A) that may include a capital market offering;

(B) that is effected through one or more related risk transfer instruments and facilitating administrative agreements;

(C) where all or part of the result of the transaction or group of related transactions is used to fund the special purpose financial captive insurance company's obligations under a reinsurance contract with a ceding insurer;

(D) by which:

(I) proceeds are obtained by a special purpose financial captive insurance company, directly or indirectly, through the issuance of one or more securities by the special purpose financial captive insurance company or another person; or

(II) a person provides one or more letters of credit or other assets for the benefit of the special purpose financial captive insurance company if the commissioner authorizes the special purpose financial captive insurance company to treat the letter of credit or asset as an admitted asset for purposes of the special purpose financial captive insurance company's annual report; and

(E) if all or a part of the proceeds, a letter of credit, or asset described in this Subsection (1)(c) is used to fund the special purpose financial captive insurance company's obligations under a reinsurance contract with a ceding insurer.

(ii) "Insurance securitization" does not include the issuance of a letter of credit for the benefit of the commissioner to satisfy all or part of the special purpose financial captive insurance company's capital and surplus requirements under Section 31A-37a-302.

(d) "Management" means:

(i) a board of directors of a special purpose financial captive insurance company;

(ii) a managing board of a special purpose financial captive insurance company; or

(iii) one or more individuals with the overall responsibility for the management of the affairs of the special purpose financial captive insurance company, including:

(A) an officer elected or appointed to act on behalf of the special purpose financial captive insurance company; or

(B) an agent elected or appointed to act on behalf of the special purpose financial captive insurance company.

(e) "Organizational document" means:

(i) in the case of a special purpose financial captive insurance company formed as a stock corporation, the special purpose financial captive insurance company's:

(A) articles of incorporation; and

(B) bylaws; and

(ii) in the case of a special purpose financial captive insurance company formed as a limited liability company, the special purpose financial captive insurance company's:

(A) articles of organization or certificate of organization; and

(B) operating agreement.

(f) "Reinsurance contract" means a contract between a special purpose financial captive insurance company and a ceding insurer pursuant to which the special purpose financial captive insurance company agrees to provide reinsurance to the ceding insurer for risks associated with the ceding insurer's insurance or reinsurance business.

(g) "Security" means:

(i) a security as defined in Section 31A-1-301; or

(ii) one or more of the following that the commissioner designates, by rule or order, as a "security" for purposes of this chapter:

(A) a debt obligation;

(B) equity;

(C) a surplus certificate;

(D) a surplus note;

(E) a funding agreement;

(F) a derivative; or

(G) another financial instrument.

(h) "Special purpose financial captive insurance company" means a captive insurance company has a certificate of authority under this chapter from the commissioner to operate as a special purpose financial captive insurance company pursuant to this chapter.

(i) "Special purpose financial captive insurance company security" means:

(i) a security issued by a special purpose financial captive insurance company; or

(ii) a security issued by a third party, the proceeds of which are obtained directly or indirectly by a special purpose financial captive insurance company.

(j) "Surplus note" means an unsecured subordinated debt obligation that has one or more characteristics that are consistent with paragraph 3 of the National

Association of Insurance Commissioners Statement of Statutory Accounting Principals No. 41, as amended from time to time and as modified or supplemented by rule or order of the commissioner.

(2) The terms defined in Section 31A-37-102 shall have the same meaning for purposes of this chapter.

Amended by Chapter 412, 2013 General Session

31A-37a-103. Applicable law.

(1) (a) A special purpose financial captive insurance company is subject to:

(i) this chapter; and

(ii) Chapter 37, Captive Insurance Companies Act.

(b) If there is a conflict between this chapter and Chapter 37, this chapter controls.

(2) A special purpose financial captive insurance company is subject to a rule made under Section 31A-37-106 that is in effect on or after May 5, 2008.

(3) The commissioner may, by order, exempt a special purpose financial captive insurance company from a provision of Chapter 37 or a rule made under Section 31A-37-106 if the commissioner determines that the application of the provision or rule is inappropriate on the basis of the special purpose financial captive insurance company's plan of operation.

Enacted by Chapter 302, 2008 General Session

31A-37a-104. Reporting -- Books and records.

(1) For purposes of Section 31A-37-501:

(a) the commissioner shall, by rule or order, establish the form and content of the annual report to be filed by a special purpose financial captive insurance company; and

(b) a special purpose financial captive insurance company shall report:

(i) using statutory accounting principles, unless the commissioner requires, approves, or accepts the use of a generally accepted accounting principle; and

(ii) with an appropriate or necessary modification or adaptation of the statutory or generally accepted accounting principle:

(A) required, approved, or accepted by the commissioner; and

(B) as supplemented by additional information required by the commissioner.

(2) (a) A special purpose financial captive insurance company may make written application to file its annual report on a fiscal-year basis.

(b) If an alternative reporting date is granted, the commissioner shall establish the due date and content of the filing required by the special purpose financial captive insurance company in addition to its annual report.

(3) (a) Unless the commissioner approves a variance before the special purpose financial captive insurance company implements the variance, a special purpose financial captive insurance company shall maintain in the state the following of the special purpose financial captive insurance company:

(i) a book;

(ii) record;
(iii) a document;
(iv) an account;
(v) a voucher; or
(vi) an agreement.
(b) A special purpose financial captive insurance company shall make an item listed in Subsection (3)(a) available for inspection by the commissioner at any time.
(c) A special purpose financial captive insurance company shall keep an item listed in Subsection (3)(a) in a manner so that:
(i) the special purpose financial captive insurance company's financial condition, affairs, and operations can be readily ascertained; and
(ii) the commissioner may readily:
(A) verify a financial statement of the special purpose financial captive insurance company; and
(B) determine the special purpose financial captive insurance company's compliance with this chapter and Chapter 37, Captive Insurance Companies Act.
(4) (a) Unless the commissioner approves a variance before the special purpose financial captive insurance company implements the variance, a special purpose financial captive insurance company shall preserve and keep an item listed in Subsection (3)(a) available in this state:
(i) for the purpose of examination and inspection; and
(ii) until the commissioner approves the destruction or other disposition.
(b) If the commissioner approves the keeping of an item listed in Subsection (3)(a) outside this state, the special purpose financial captive insurance company shall maintain a complete copy of the original in the state.
(c) An item listed in Subsection (3)(a) may be photographed, reproduced on film, or stored and reproduced electronically.

Enacted by Chapter 302, 2008 General Session

31A-37a-105. Transition.

(1) (a) Except as otherwise determined by the commissioner, a captive insurance company that on May 5, 2008 has a certificate of authority from the commissioner pursuant to Chapter 37, Captive Insurance Companies Act, and engages in insurance securitization:
(i) is subject to this chapter as a special purpose financial captive insurance company; and
(ii) is considered to have a certificate of authority issued under this chapter.
(b) The commissioner may require a captive insurance company described in Subsection (1)(a) to take an action that the commissioner determines is reasonably necessary to bring the captive insurance company into compliance with this chapter.
(2) The commissioner may issue an order described in Section 31A-37a-201 with respect to a captive insurance company described in Subsection (1)(a) if the captive insurance company is not in compliance with this chapter.

Enacted by Chapter 302, 2008 General Session

31A-37a-201. Certificate of authority requirements.

(1) A person may not reinsure the risks of a ceding insurer unless the person has a certificate of authority under this chapter as a special purpose financial captive insurance company.

(2) To apply for a certificate of authority under this chapter as a special purpose financial captive insurance company, a special purpose financial captive insurance company shall submit an application for the certificate of authority that, in addition to complying with Chapter 37, Captive Insurance Companies Act, complies with the following:

(a) A special purpose financial captive insurance company shall submit to the commissioner a plan of operation that includes:

(i) a complete description of:

(A) a significant transaction including:

(I) reinsurance;

(II) a reinsurance security arrangement;

(III) an insurance securitization; or

(IV) a transaction or arrangement related to a transaction described in Subsections (2)(a)(i)(A)(I) through (III);

(B) to the extent not included in Subsection (2)(a)(i)(A), a party other than the special purpose financial captive insurance company and the ceding insurer that is involved in the issuance of a special purpose financial captive insurance company security; and

(C) a pledge, hypothecation, or grant of a security interest in:

(I) an asset of the special purpose financial captive insurance company; or

(II) stock or a limited liability company interest in the special purpose financial captive insurance company;

(ii) the source and form of the special purpose financial captive insurance company's capital and surplus;

(iii) the proposed investment policy of the special purpose financial captive insurance company;

(iv) a description of an underwriting, reporting, and claims payment method by which losses covered by a reinsurance contract are reported, accounted for, and settled;

(v) pro forma balance sheets and income statements illustrating one or more adverse case scenarios, as determined under criteria required by the commissioner, for the performance of the special purpose financial captive insurance company under a reinsurance contract; and

(vi) the proposed rate and method for discounting reserves, if the special purpose financial captive insurance company is requesting authority to discount its reserves.

(b) The special purpose financial captive insurance company shall submit an affidavit:

(i) of the following of the special purpose financial captive insurance company:

(A) president;

(B) vice president;

(C) treasurer; or

(D) chief financial officer; and

(ii) that includes the following statements, to the best of knowledge and belief of the person submitting the affidavit after reasonable inquiry:

(A) the proposed organization and operation of the special purpose financial captive insurance company complies with this chapter and the applicable provisions of Chapter 37, Captive Insurance Companies Act;

(B) the special purpose financial captive insurance company's investment policy reflects and takes into account:

(I) the liquidity of assets; and

(II) the reasonable preservation, administration, and management of those assets with respect to the risks associated with:

(Aa) a reinsurance contract; and

(Bb) an insurance securitization transaction; and

(C) the following comply with this chapter:

(I) a reinsurance contract; and

(II) an arrangement for securing an obligation of the special purpose financial captive insurance company under the reinsurance contract, including an agreement or other documentation to implement the arrangement.

(c) A special purpose financial captive insurance company shall submit to the commissioner:

(i) a copy of an agreement or documentation described in Subsection (2)(b), unless otherwise approved by the commissioner; and

(ii) a statement or document required by the commissioner to evaluate the special purpose financial captive insurance company's application for a certificate of authority.

(d) (i) Subject to Subsection (2)(d)(ii), a special purpose financial captive insurance company shall submit with the application an opinion of a licensed attorney, in a form acceptable to the commissioner, that:

(A) the offer and sale of a special purpose financial captive insurance company security complies with:

(I) the registration requirements of federal securities laws; or

(II) the exemptions from or exceptions to a requirement of the federal securities laws; and

(B) the offer and sale of a security by the special purpose financial captive insurance company complies with:

(I) the registration requirements of this state's securities laws; or

(II) the exemptions from or exceptions to a requirement of this state's securities laws.

(ii) A special purpose financial captive insurance company is not required to submit an opinion described in Subsection (2)(d)(i) with an application if the special purpose financial captive insurance company includes a specific statement in its plan of operation that the opinion described in Subsection (2)(d)(i) will be provided to the commissioner before the offer or sale of a special purpose financial captive insurance company security.

(3) (a) The commissioner may issue a certificate of authority to a special purpose financial captive insurance company that complies with Subsection (2)

authorizing the special purpose financial captive insurance company to transact reinsurance business as a special purpose financial captive insurance company in this state if the commissioner finds that:

(i) the proposed plan of operation provides for a reasonable and expected successful operation;

(ii) the terms of the reinsurance contract or related transaction comply with this chapter;

(iii) the proposed plan of operation is not hazardous to a ceding insurer; and

(iv) subject to Subsection (3)(b), the insurance regulator of the state of domicile of a ceding insurer has notified the commissioner in writing or otherwise provided assurance satisfactory to the commissioner that the regulator of the state has approved or has not disapproved the transaction.

(b) Notwithstanding Subsection (3)(a)(iv), the commissioner may issue a certificate of authority to a special purpose financial captive insurance company if the insurance regulator of the state of domicile of a ceding insurer does not respond with respect to all or a part of the transaction.

(c) (i) A certificate of authority issued under this section is valid through the June 30 after the day on which the certificate of authority is issued.

(ii) A special purpose financial captive insurance company may renew its certificate of authority annually by, before the certificate of authority expires:

(A) submitting the affidavit required by Subsection (2); and

(B) paying a renewal fee.

(4) In conjunction with issuing a certificate of authority to a special purpose financial captive insurance company, the commissioner may issue an order that includes a provision, term, or condition regarding the organization, issuance of a certificate of authority, and operation of the special purpose financial captive insurance company that:

(a) the commissioner considers appropriate; and

(b) is not inconsistent with this chapter and Chapter 37, Captive Insurance Companies Act.

Enacted by Chapter 302, 2008 General Session

31A-37a-202. Revocation, suspension, amendment, or modification of a certificate of authority.

Except as provided in Sections 31A-37a-501 and 31A-37a-502, the commissioner may not revoke, suspend, amend, or modify a certificate of authority issued to a special purpose financial captive insurance company under this chapter or an order issued under Subsection 31A-37a-201(4) unless:

(1) the special purpose financial captive insurance company consents to the revocation, suspension, amendment, or modification; or

(2) the commissioner shows by clear and convincing evidence that the revocation, suspension, amendment, or modification is necessary to avoid irreparable harm to:

(a) a special purpose financial captive insurance company; or

(b) a ceding insurer.

Enacted by Chapter 302, 2008 General Session

31A-37a-203. Reporting related to transactions.

(1) A special purpose financial captive insurance company shall provide the commissioner with a copy of a complete set of executed documentation of an insurance securitization no later than 30 days after the day on which the insurance securitization transaction closes.

(2) Section 31A-37-503 applies to:

(a) information submitted pursuant to Subsection (1);

(b) information submitted pursuant to Subsection 31A-37a-201(2); or

(c) an order issued to a special purpose financial captive insurance company pursuant to Subsection 31A-37a-201(4).

Enacted by Chapter 302, 2008 General Session

31A-37a-204. Prior approval of a change in plan of operation and other transactions.

(1) A special purpose financial captive insurance company may not change its plan of operation without the prior approval of the commissioner.

(2) (a) Subject to Subsection (2)(b), a special purpose financial captive insurance company may not engage in a transaction or series of transactions without the prior approval of the commissioner if the transaction or series of transactions:

(i) is undertaken to dissolve the special purpose financial captive insurance company; or

(ii) results in the termination of all or a part of a special purpose financial captive insurance company's business.

(b) A special purpose financial captive insurance company is not required to obtain the prior approval of the commissioner for a transaction or series of transactions described in Subsection (2)(a)(ii) if:

(i) the transaction or series of transactions is done in accordance with a document or agreement described in the special purpose financial captive insurance company's plan of operation; and

(ii) the special purpose financial captive insurance company notifies the commissioner prior to the transaction or series of transactions.

(3) A special purpose financial captive insurance company shall notify the commissioner before a change in the legal ownership of a security issued by the special purpose financial captive insurance company.

Enacted by Chapter 302, 2008 General Session

31A-37a-205. Sponsored captives.

In addition to the other provisions of this chapter, this section applies to a sponsored captive insurance company under Chapter 37, Captive Insurance Companies Act, that has a certificate of authority as a special purpose financial captive insurance company pursuant to this chapter.

(1) A sponsored captive insurance company may have a certificate of authority as a special purpose financial captive insurance company under this chapter.

(2) (a) For purposes of a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company, "general account" means the assets and liabilities of the sponsored captive insurance company not attributable to a protected cell.

(b) For purposes of applying Chapter 27a, Insurer Receivership Act, to a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company, the definition of "insolvency" and "insolvent" in Section 31A-37a-102 shall be applied separately to:

(i) each protected cell; and

(ii) the special purpose financial captive insurance company's general account.

(3) (a) A participant in a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall be a ceding insurer, unless approved by the commissioner before a person becomes a participant.

(b) A change in a participant in a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company is subject to prior approval by the commissioner.

(4) Notwithstanding Section 31A-37-401, a special purpose financial captive insurance company that is a sponsored captive insurance company may issue a security to a person not described in Section 31A-37-401 if the issuance to that person is approved by the commissioner before the issuance of the security.

(5) Notwithstanding Section 31A-37a-302, a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall:

(a) at the time of initial application for a certificate of authority as a special purpose financial captive insurance company, possess unimpaired paid-in capital and surplus of not less than $500,000; and

(b) maintain at least $500,000 of unimpaired paid-in capital and surplus of not less than $500,000 during the time that it holds a certificate of authority under this chapter.

(6) (a) For purposes of a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company, this Subsection (6) applies to:

(i) a security issued by the special purpose financial captive insurance company with respect to a protected cell; or

(ii) a contract or obligation of the special purpose financial captive insurance company with respect to a protected cell.

(b) A sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall include with a security, contract, or obligation described in Subsection (6)(a):

(i) the designation of the protected cell; and

(ii) a disclosure in a form and content satisfactory to the commissioner to the effect that the holder of the security or a counterparty to the contract or obligation has no right or recourse against the special purpose financial captive insurance company

and its assets other than against an asset properly attributable to the protected cell.

(c) Notwithstanding the requirements of this Subsection (6) and subject to other statutes or rules including this chapter and Chapter 37, Captive Insurance Companies Act, a creditor, ceding insurer, or another person may not use a failure to include a disclosure described in Subsection (6)(b), in whole or part, as the sole basis to have recourse against:

(i) the general account of the special purpose financial captive insurance company; or

(ii) the assets of another protected cell of the special financial captive insurance company.

(7) In addition to Section 31A-37-401, a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company is subject to the following with respect to a protected cell:

(a) (i) A sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall establish a protected cell only for the purpose of insuring or reinsuring risks of one or more reinsurance contracts with a ceding insurer with the intent of facilitating an insurance securitization.

(ii) Subject to Subsection (7)(a)(iii), a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall establish a separate protected cell with respect to a ceding insurer described in Subsection (7)(a)(i).

(iii) A sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall establish a separate protected cell with respect to each reinsurance contract that is funded in whole or in part by a separate insurance securitization transaction.

(b) A sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company may not sale, exchange, or transfer an asset by, between, or among any of its protected cells without the prior approval of the commissioner.

(8) (a) A sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall attribute an asset or liability to a protected cell and to the general account in accordance with the plan of operation approved by the commissioner.

(b) Except as provided by Subsection (8)(a), a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company may not attribute an asset or liability between:

(i) its general account and a protected cell; or

(ii) its protected cells.

(c) A sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company shall attribute:

(i) an insurance obligation, asset, or liability relating to a reinsurance contract entered into with respect to a protected cell; and

(ii) an insurance securitization transaction related to the obligation, asset, or liability described in Subsection (8)(c)(i), including a security issued by the special purpose financial captive insurance company as part of the insurance securitization, to the protected cell.

(d) The following shall reflect an insurance obligation, asset, or liability relating to a reinsurance contract and the insurance securitization transaction that are attributed to a protected cell:

(i) a right, benefit, obligation, or a liability of a security attributable to a protected cell described in Subsection (8)(c);

(ii) the performance under a reinsurance contract and the related insurance securitization transaction; and

(iii) a tax benefit, loss, refund, or credit allocated pursuant to a tax allocation agreement to which the special purpose financial captive insurance company is a party, including a payment made by or due to be made to the special purpose financial captive insurance company pursuant to the terms of the tax allocation agreement.

(9) In addition to Section 31A-37a-502:

(a) Chapter 27a, Insurer Receivership Act, applies to each protected cell of a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company.

(b) A proceeding or action taken by the commissioner pursuant to Chapter 27a, Insurer Receivership Act, with respect to a protected cell of a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company may not be the sole basis for a proceeding pursuant to Chapter 27a, Insurer Receivership Act, with respect to:

(i) another protected cell of the special purpose financial captive insurance company; or

(ii) the special purpose financial captive insurance company's general account.

(c) (i) Except as provided in Subsection (9)(c)(ii), the receiver of a special purpose financial captive insurance company shall ensure that the assets attributable to one protected cell are not applied to the liabilities attributable to:

(A) another protected cell; or

(B) the special purpose financial captive insurance company's general account.

(ii) Notwithstanding Subsection (9)(c)(i), if an asset or liability is attributable to more than one protected cell, the receiver shall deal with the asset or liability in accordance with the terms of a relevant governing instrument or contract.

(d) The insolvency of a protected cell of a sponsored captive insurance company having a certificate of authority as a special purpose financial captive insurance company may not be the sole basis for the commissioner to prohibit:

(i) a payment by the special purpose financial captive insurance company made pursuant to a special purpose financial captive insurance company security or reinsurance contract with respect to another protected cell; or

(ii) an action required to make a payment described in Subsection (9)(d)(i).

Amended by Chapter 297, 2011 General Session

31A-37a-301. Formation.

(1) A special purpose financial captive insurance company may be:

(a) incorporated as a stock insurer with its capital divided into shares and held by its stockholders; or

(b) organized as a manager-managed limited liability company.

(2) A special purpose financial captive insurance company's organizational documents shall limit the special purpose financial captive insurance company's authority to transact the business of insurance or reinsurance to those activities that the special purpose financial captive insurance company conducts to accomplish its purposes as expressed in this chapter.

Enacted by Chapter 302, 2008 General Session

31A-37a-302. Minimum capital and surplus.

(1) The commissioner may not issue a special purpose financial captive insurance company a certificate of authority under this chapter unless it possesses unimpaired paid-in capital and surplus of not less than $250,000 on the day on which the certificate of authority is issued.

(2) A special purpose financial captive insurance company shall maintain unimpaired paid-in capital and surplus of not less than $250,000 at all times when having a certificate of authority under this chapter.

Enacted by Chapter 302, 2008 General Session

31A-37a-303. Disposition of assets -- Investments.

(1) A special purpose financial captive insurance company or a person on its behalf shall preserve and administer an asset of the special purpose financial captive insurance company to satisfy the liabilities and obligations of the special purpose financial captive insurance company incident to:

(a) the reinsurance contract;

(b) an insurance securitization; and

(c) an agreement related to Subsection (1)(a) or (b).

(2) In a special purpose financial captive insurance company insurance securitization, a security offering memorandum or other document issued to a prospective investor regarding the offer and sale of a surplus note or other security shall include a disclosure that all or part of the proceeds of the insurance securitization will be used to fund the special purpose financial captive insurance company's obligations to the ceding insurer.

(3) A special purpose financial captive insurance company is not subject to a restriction on investments other than the following:

(a) A special purpose financial captive insurance company may not make a loan to a person other than:

(i) as permitted under its plan of operation; or

(ii) as otherwise approved in advance of the loan by the commissioner.

(b) The commissioner may prohibit or limit an investment that threatens the solvency or liquidity of a special purpose financial captive insurance company unless the investment is otherwise approved in:

(i) the special purpose financial captive insurance company's plan of operation; or

(ii) an order issued to the special purpose financial captive insurance company pursuant to Section 31A-37a-201.

Enacted by Chapter 302, 2008 General Session

31A-37a-304. Securities.

(1) (a) A special purpose financial captive insurance company may:

(i) subject to the prior approval of the commissioner, account for the proceeds of a surplus note issued by the special purpose financial captive insurance company as surplus; and

(ii) except as provided in Subsection (1)(b), submit for prior approval of the commissioner a periodic written request for authorization to make a payment of interest on or a repayment of principal of a surplus note or other debt obligation issued by the special purpose financial captive insurance company.

(b) (i) The commissioner may not approve a payment described in Subsection (1)(a)(i) if the commissioner determines that the payment would jeopardize the ability of the special purpose financial captive insurance company or another person to fulfill its respective obligations pursuant to a special purpose financial captive insurance company insurance securitization agreement, reinsurance contract, or a related transaction.

(ii) In lieu of approval of a periodic written request for authorization to make a payment of interest on or repayment of principal of a surplus note or other debt obligation issued by the special purpose financial captive insurance company, the commissioner may approve a formula or plan for payment of interest, principal, or both with respect to the surplus note or debt obligation.

(iii) A special purpose financial captive insurance company shall include a formula or plan approved under Subsection (1)(b)(ii) in the special purpose financial captive insurance company's plan of operation.

(2) In addition to Section 31A-37-302, a special purpose financial captive insurance company may not declare or pay a dividend or distribution if the dividend or distribution jeopardizes the ability of the special purpose financial captive insurance company or another person to fulfill the special purpose financial captive insurance company's or other person's respective obligations pursuant to a special purpose financial captive insurance company insurance securitization agreement, a reinsurance contract, or a related transaction.

(3) (a) A special purpose financial captive insurance company security is not subject to regulation as an insurance or reinsurance contract.

(b) An investor in a special purpose financial captive insurance company security or a holder of a special purpose financial captive insurance company security may not be considered to be transacting the business of insurance in this state solely by reason of having an interest in the security.

(c) The following people involved in an insurance securitization by a special purpose financial captive insurance company may not be considered to be an insurance producer or broker, or to be conducting business as an insurer, reinsurer, insurance agency, brokerage, intermediary, advisory, or consulting business solely by virtue of the person's underwriting activities in connection with the insurance securitization:

(i) an underwriter's placement;

(ii) a selling agent; or
(iii) a partner, commissioner, officer, member, manager, employee, agent, representative, or advisor of a person listed in Subsection (3)(c)(i) or (ii).

Enacted by Chapter 302, 2008 General Session

31A-37a-401. Purchase of reinsurance.

Subject to the prior approval of the commissioner, a special purpose financial captive insurance company may purchase reinsurance to cede the risks assumed under a reinsurance contract.

Enacted by Chapter 302, 2008 General Session

31A-37a-402. Permitted reinsurance.

(1) (a) A special purpose financial captive insurance company may reinsure only the risks of a ceding insurer, pursuant to a reinsurance contract.
(b) A special purpose financial captive insurance company may not issue a contract of insurance or a contract for assumption of risk or indemnification of loss other than a reinsurance contract described in Subsection (1)(a).
(2) Unless otherwise approved in advance by the commissioner, a special purpose financial captive insurance company may not assume or retain exposure to insurance or reinsurance losses for its own account that are not funded by:
(a) proceeds from a special purpose financial captive insurance company insurance securitization;
(b) a letter of credit;
(c) an asset described in Subsection 31A-37a-102(1)(c);
(d) a premium or another amount payable by the ceding insurer to the special purpose financial captive insurance company pursuant to the reinsurance contract; or
(e) a return on investment of an item described in Subsections (2)(a) through (d).
(3) (a) A reinsurance contract shall contain a provision reasonably required or approved by the commissioner.
(b) A requirement described in Subsection (3)(a) shall take into account the laws applicable to the ceding insurer regarding the ceding insurer taking credit for the reinsurance provided under the reinsurance contract.
(4) Subject to the prior approval of the commissioner, a special purpose financial captive insurance company may cede risks assumed through a reinsurance contract to one or more reinsurers through the purchase of reinsurance.
(5) (a) This Subsection (5) applies to a contract or commercial activity that:
(i) relates to or is incidental to a reinsurance contract; and
(ii) is necessary to fulfill the purposes of:
(A) a reinsurance contract;
(B) insurance securitization; and
(C) this chapter.
(b) A special purpose financial captive insurance company may engage in a contract or commercial activity described in Subsection (5)(a) if the contract or

commercial activity is:

(i) in the special purpose financial captive insurance company's plan of operation; or

(ii) approved in advance by the commissioner.

(c) A contract or commercial activity described in Subsection (5)(a) includes:

(i) entering into a reinsurance contract;

(ii) issuing a special purpose financial captive insurance company security;

(iii) complying with a term of a contract or security described in Subsection (5)(c)(i) or (ii);

(iv) entering into:

(A) a trust;

(B) a guaranteed investment contract;

(C) a swap;

(D) a derivative transaction;

(E) a tax transaction;

(F) an administration transaction;

(G) a reimbursement transaction; or

(H) a fiscal agent transaction;

(v) complying with a trust indenture, reinsurance, or retrocession; and

(vi) another agreement necessary or incidental to effect an insurance securitization in compliance with:

(A) the special purpose financial captive insurance company's plan of operation; and

(B) this chapter.

(6) Unless otherwise approved in advance by the commissioner, a reinsurance contract may not contain a provision for payment by the special purpose financial captive insurance company in discharge of its obligations under the reinsurance contract to a person other than the ceding insurer or any receiver of the ceding insurer.

(7) A special purpose financial captive insurance company shall notify the commissioner immediately of an action by a ceding insurer or another person to foreclose on or otherwise take possession of collateral provided by the special purpose financial captive insurance company to secure an obligation of the special purpose financial captive insurance company.

Amended by Chapter 349, 2009 General Session

31A-37a-501. Suspension and revocation.

(1) (a) The commissioner shall notify a special purpose financial captive insurance company not less than 30 days before suspending or revoking the special purpose financial captive insurance company's certificate of authority pursuant to Section 31A-37-505.

(b) In the notice required by Subsection (1)(a) the commissioner shall state the basis for the suspension or revocation.

(c) The commissioner shall give a special purpose financial captive insurance company described in this Subsection (1) an opportunity for a hearing pursuant to Title 63G, Chapter 4, Administrative Procedures Act.

(2) Notwithstanding Subsection (1) and Title 63G, Chapter 4, Administrative Procedures Act, the commissioner is not required to provide prior notice or a hearing if the grounds for suspension or revocation of a special purpose financial captive insurance company's certificate of authority pursuant to Section 31A-37-505 relate primarily to:

(a) the financial condition or soundness of the special purpose financial captive insurance company; or

(b) a deficiency in the assets of the special purpose financial captive insurance company.

Enacted by Chapter 302, 2008 General Session

31A-37a-502. Delinquency.

(1) Except as otherwise provided in this section, Chapter 27a, Insurer Receivership Act, applies to a special purpose financial captive insurance company.

(2) Upon an order of supervision, rehabilitation, or liquidation of a special purpose financial captive insurance company, the receiver shall manage the assets and liabilities of the special purpose financial captive insurance company pursuant to this chapter.

(3) An amount recoverable by the receiver of a special purpose financial captive insurance company under a reinsurance contract may not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to a ceding insurer, notwithstanding a contract or other documentation governing the special purpose financial captive insurance company insurance securitization.

(4) The following applies notwithstanding Chapter 27a, Insurer Receivership Act, or another law of this state:

(a) An application, petition, a temporary restraining order, or injunction issued pursuant to Chapter 27a, Insurer Receivership Act, with respect to a ceding insurer does not prohibit the transaction of business by a special purpose financial captive insurance company, including:

(i) a payment by a special purpose financial captive insurance company made with respect to a special purpose financial captive insurance company security; or

(ii) an action or proceeding against a special purpose financial captive insurance company or its assets.

(b) (i) Subject to Subsection (4)(b)(ii), the commencement of a summary proceeding with respect to a special purpose financial captive insurance company and an order issued by the court in the summary proceeding may not prohibit:

(A) a payment by a special purpose financial captive insurance company; or

(B) the special purpose financial captive insurance company from taking an action required to make a payment described in this Subsection (4)(b)(i).

(ii) Subsection (4)(b)(i) applies only if the payment is made:

(A) pursuant to a special purpose financial captive insurance company security or reinsurance contract; and

(B) consistent with the special purpose financial captive insurance company's plan of operation and any order issued to the special purpose financial captive insurance company pursuant to Section 31A-37a-201.

(c) A receiver of a ceding insurer may not void a nonfraudulent transfer by a ceding insurer to a special purpose financial captive insurance company of money or other property made pursuant to a reinsurance contract.

(d) A receiver of a special purpose financial captive insurance company may not void a nonfraudulent transfer by the special purpose financial captive insurance company of money or other property:

(i) (A) made to a ceding insurer pursuant to a reinsurance contract; or

(B) made to or for the benefit of a holder of a special purpose financial captive insurance company security with respect to the special purpose financial captive insurance company security; and

(ii) made consistent with the special purpose financial captive insurance company's plan of operation and an order issued to the special purpose financial captive insurance company pursuant to Section 31A-37a-201.

(5) (a) Except to fulfill an obligation under a reinsurance contract and notwithstanding another provision of this chapter, Chapter 37, Captive Insurance Companies Act, or other laws of this state, the assets of a special purpose financial captive insurance company may not be consolidated with or included in the estate of a ceding insurer in a delinquency proceeding against the ceding insurer pursuant to this chapter for any purpose including a distribution to a creditor of the ceding insurer.

(b) This Subsection (5) applies to assets that include an asset held in trust:

(i) on a funds-withheld basis; or

(ii) under another arrangement to secure the special purpose financial captive insurance company's obligations under a reinsurance contract.

Enacted by Chapter 302, 2008 General Session

31A-38-101. Title.

This chapter is known as the "Federal Health Care Tax Credit Program Act."

Enacted by Chapter 2, 2004 General Session

31A-38-102. Definitions.

As used in this chapter:

(1) "Bridge program" means the program established by the Department of Workforce Services on July 1, 2003:

(a) to implement the federal health coverage tax credit program;

(b) with federal funds; and

(c) for qualified participants.

(2) "Federal health coverage tax credit program" means the health care tax credit program authorized by the Trade Reform Act.

(3) "Qualified participant" means an individual:

(a) eligible for coverage under the state program in accordance with Section 31A-38-103; and

(b) qualified by the Internal Revenue Service and the Department of the United States Treasury to participate in the federal health coverage tax credit program.

(4) "State program" means the program established under this chapter:

(a) to implement the federal health coverage tax credit program; and
(b) for qualified participants.
(5) "Trade Reform Act" means the Trade Adjustment Assistance Reform Act of 2002, 107 P.L. 210.

Enacted by Chapter 2, 2004 General Session

31A-38-103. Implementation of the federal health coverage tax credit program.

(1) An employee is considered to be an employee of the employee's last employer for purposes of participating in the federal health coverage tax credit program if:
(a) the employee is or was an employee of the employer;
(b) the employer is or was doing business in this state;
(c) the employee requires health care services from a licensed health care provider doing business in this state;
(d) the health insurance benefit plan covering the employee is terminated by the employer or former employer; and
(e) the employee is a qualified participant.
(2) (a) Qualified participants eligible for the federal health coverage tax credit program and qualifying family members of qualified participants shall be:
(i) grouped together under the state program;
(ii) considered a single group risk pool; and
(iii) considered to be a group for purposes of:
(A) implementing the federal health coverage tax credit program; and
(B) providing health insurance coverage.
(b) The coverage provided to the group formed under this Subsection (2) shall be considered to be group coverage.
(c) Notwithstanding that the coverage is considered group coverage, a member of the group may be individually underwritten and rated at the time of enrollment in the group.
(3) (a) Except as expressly provided in this chapter, the state program is excluded from regulation under this title if the state program:
(i) meets the requirements of this Subsection (3) upon implementation of the state program; and
(ii) continuously complies with the requirements listed in this Subsection (3).
(b) The Department of Workforce Services shall contract, in compliance with state purchasing rules:
(i) with an insurance company licensed to provide accident and health insurance:
(A) to provide insurance for the state program;
(B) to assume the risk of the health insurance coverage of the qualified participants in the state program; and
(C) to take an action described in this Subsection (3)(b)(i) in consideration of receipt of:
(I) a reasonable premium from qualified participants; and

(II) the advance health coverage tax credits from the United States Treasury; or

(ii) with a licensed third party administrator to administer the state program as a self-insurance program that provides accident and health insurance coverage of the qualified participants in the state program in consideration of receipt of:

(A) a reasonable premium from qualified participants; and

(B) the advance health coverage tax credit from the United States Treasury.

(c) (i) If the Department of Workforce Services contracts with a third party administrator under Subsection (3)(b)(ii), the Department of Workforce Services shall create and maintain a fund authorized under Subsection 31A-38-104(1)(b) to:

(A) pay claims covered by the state program; and

(B) receive the:

(I) reasonable premium from qualified participants; and

(II) advance health coverage tax credits from the United States Treasury.

(ii) The Department of Workforce Services shall ensure that the fund described in this Subsection (3)(c):

(A) is actuarially sound upon implementation of the state program; and

(B) is continuously maintained and managed on an actuarially sound basis.

(iii) The actuarial soundness of a fund created pursuant to this Subsection (3)(c) shall be supported by an opinion of an actuary that is a fellow in a nationally recognized actuary association designated by the Department of Workforce Services.

(d) (i) The insurance company or third party administrator under contract with the Department of Workforce Services shall:

(A) establish premium rates for health insurance coverage provided under this chapter that are reasonable and actuarially sound to:

(I) cover the payment of existing claims; and

(II) build reasonable and adequate reserves to pay future claims; and

(B) adjust its premium rates as needed to:

(I) reflect the claim experience of the group;

(II) cover administrative and reinsurance costs related solely to the group;

(III) provide for a reasonable margin of profit from the group's coverage, not to exceed 15% of its premiums; and

(IV) build actuarially reasonable reserves for the payment of future claims.

(ii) If the Department of Workforce Services creates a fund pursuant to Subsection (3)(c), the premiums paid by participants in the state program shall be designed to:

(A) cover claims paid from the fund; and

(B) build reasonable and appropriate reserves for the payment of future claims.

(e) (i) The insurance coverage designed by the insurance company or the third party administrator:

(A) shall reflect the characteristics of the group;

(B) shall meet the group's needs; and

(C) may offer coverage that includes or does not include variable benefits.

(ii) In designing the group coverage, the insurance company or third party administrator shall ensure that the coverage and the premiums are not discriminatory.

(f) The coverage under the state program shall comply with:

(i) all requirements of federal law pertaining to the federal health coverage tax

credit program; and

(ii) any federal requirement applicable to the health insurance coverage provided under the state program.

(g) The commissioner shall approve:

(i) the coverage design;

(ii) the policy or coverage form; and

(iii) the premium rates that are used to provide coverage under this section.

(h) (i) The commissioner shall certify that the state program complies with the requirements of this chapter:

(A) upon the initial implementation of the state program; and

(B) every third year after implementation of the state program.

(ii) If the Department of Workforce Services elects to operate the state program through a self-insurance program, before issuance of certification by the commissioner, the executive director of the Department of Workforce Services shall certify to the commissioner that:

(A) the following are in compliance with the requirements of this Subsection (3):

(I) state program coverage;

(II) premium rates;

(III) fund balances; and

(IV) reserves; and

(B) the state program is in compliance and will continue to be in compliance with the requirements of this chapter and the Trade Reform Act.

(4) Qualified participants enrolled in the bridge program prior to and after March 10, 2004, shall be enrolled in the state program provided for in this chapter retroactive to whichever of the following dates ensures the continuance of health insurance coverage:

(a) the date of their enrollment in the bridge program; or

(b) July 1, 2003.

(5) (a) The state is not liable, obligated, or responsible to guarantee the payment of claims of qualified participants enrolled in the state program created by this chapter.

(b) Any guaranty association created under Chapter 28, Guaranty Associations, is not liable, obligated, or responsible to guarantee the payment of the claims of:

(i) any fund created by this chapter; or

(ii) the insurance company that is under contract with the Department of Workforce Services to provide the health insurance coverage intended by this chapter.

Enacted by Chapter 2, 2004 General Session

31A-38-104. Authorization -- Money transferred for reserves.

(1) The Department of Workforce Services may:

(a) convert the bridge program to the state program through any of the following, or combination of the following, that the Department of Workforce Services considers best serves the needs of qualified participants:

(i) a contract with a licensed insurance company authorized to do business in the state;

(ii) through any other arrangement acceptable under the Trade Reform Act; or

(iii) a self-insurance program through a third party administrator as provided in Subsection 31A-38-103(3)(b)(ii); and

(b) obligate up to $2,000,000 of the Special Administrative Expense Account created in Section 35A-4-506 as reserves for the state program.

(2) The money in Subsection (1)(b) may be used until the reserves in the state program become adequate.

Amended by Chapter 303, 2011 General Session
Amended by Chapter 342, 2011 General Session

31A-39-101. Interstate Insurance Product Regulation Compact.

Pursuant to the terms and conditions of this Act, the State of Utah seeks to join with other States and establish the Interstate Insurance Product Regulation Compact, and thus become a member of the Interstate Insurance Product Regulation Commission. Utah's insurance commissioner is hereby designated to serve as the representative of this State to the Commission.

ARTICLE I. PURPOSES

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II. DEFINITIONS

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. "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.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Non-compacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

ARTICLE III. ESTABLISHMENT OF THE COMMISSION AND VENUE

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

ARTICLE IV. POWERS OF THE COMMISSION

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rulemaking authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact,

which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Non-compacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to

achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

ARTICLE V. ORGANIZATION OF THE COMMISSION

1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. establishing the fiscal year of the Commission;

ii. providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting, and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

viii. providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of

the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

(i) One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

(ii) Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws, and;

(iii) Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

iii. overseeing the offices of the Commission; and

iv. planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of

selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification

a. The Members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI. MEETINGS AND ACTS OF THE COMMISSION

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings

by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

ARTICLE VII. RULES & OPERATING PROCEDURES: RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving

long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

ARTICLE VIII. COMMISSION RECORDS AND ENFORCEMENT

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into

agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any non-complying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a non-complying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this Paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

ARTICLE IX. DISPUTE RESOLUTION

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Non-compacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

ARTICLE X. PRODUCT FILING AND APPROVAL

1. Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the

Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

ARTICLE XI. REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

1. Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third-Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

ARTICLE XII. FINANCE

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third-Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except

by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request, provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

ARTICLE XIII. COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

ARTICLE XIV. WITHDRAWAL, DEFAULT AND TERMINATION

1. Withdrawal

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e

of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the

Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

ARTICLE XV. SEVERABILITY AND CONSTRUCTION

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI. BINDING EFFECT OF COMPACT AND OTHER LAWS

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Enacted by Chapter 242, 2004 General Session

31A-40-101. Title.

This chapter is known as the "Professional Employer Organization Licensing Act."

Enacted by Chapter 318, 2008 General Session

31A-40-102. Definitions.

As used in this chapter:

(1) (a) Except as provided in Subsection (1)(b), "administrative fee" means a fee charged to a client by a professional employer organization for a professional employer service.

(b) "Administrative fee" does not include an amount or a fee received by a professional employer organization that is:

(i) compensation of a covered employee;

(ii) a benefit for a covered employee;

(iii) a payroll-related tax;

(iv) an unemployment insurance contribution;

(v) withholding of compensation for a covered employee;

(vi) a workers' compensation premium; or

(vii) another assessment paid by a professional employer organization to or on behalf of a covered employee under a professional employer agreement.

(2) "Assurance organization" means a person designated as an assurance organization in accordance with Section 31A-40-303.

(3) "Client" means a person who enters into a professional employer agreement with a professional employer organization.

(4) "Coemployer" means:

(a) a client; or

(b) a professional employer organization.

(5) "Coemployment relationship" means a relationship:

(a) that is intended to be ongoing rather than a temporary or project specific relationship; and

(b) wherein the rights and obligations of an employer that arise out of an employment relationship are allocated between coemployers pursuant to:

(i) a professional employer agreement; or

(ii) this chapter.

(6) Notwithstanding Section 31A-1-301, "controlling person" means a person who, individually or acting in concert with one or more persons, owns, directly or indirectly, 10% or more of the equity interest in a professional employer organization.

(7) "Covered employee" means an individual who has a coemployment relationship with a client and a professional employer organization if the conditions of Section 31A-40-203 are met.

(8) (a) "Employment related economic incentive" means:

(i) (A) a credit against or exemption from taxes due the state or a political subdivision of the state; or

(B) an economic inducement, including a loan or a grant; and

(ii) if the credit, exemption, or economic inducement described in Subsection

(8)(a)(i):

(A) is offered by the state or a political subdivision of the state; and

(B) has an eligibility requirement that relates in whole or in part to employment including:

(I) the number of employees; or

(II) the nature of the employment.

(9) "Guarantee" means to assume an obligation of another person if that person fails to meet the obligation.

(10) "Licensee" means a person licensed under this chapter.

(11) "Professional employer agreement" means a written contract by and between a client and a professional employer organization that provides for:

(a) the coemployment of a covered employee;

(b) with respect to a covered employee, the allocation of a right or obligation of an employer between:

(i) the client; and

(ii) the professional employer organization; and

(c) the assumption of the obligations imposed by this chapter by:

(i) the client; or

(ii) the professional employer organization.

(12) (a) Subject to Subsection (12)(b), "professional employer organization" means a person engaged in the business of providing a professional employer service.

(b) "Professional employer organization" does not include:

(i) a person that:

(A) does not:

(I) have as a principal business activity the entering into of a professional employer arrangement; or

(II) hold the person out as a professional employer organization; and

(B) shares an employee with a commonly owned company within the meaning of Sections 414(b) and (c), Internal Revenue Code;

(ii) an independent contractor arrangement by which a person:

(A) assumes responsibility for the product produced or service performed by the person or the person's agent; and

(B) retains and exercises primary direction and control over the work performed by an individual whose service is supplied under the independent contractor arrangement; or

(iii) a person providing temporary help service.

(13) "Professional employer organization group" means two or more professional employer organizations that are majority owned or commonly controlled or directed by the same one or more persons.

(14) "Professional employer service" means the service of entering into a coemployment relationship under this chapter under which all or a majority of the employees who provide a service to a client, or a division or work unit of a client, are covered employees.

(15) "Qualified actuary" means an individual who:

(a) is a member in good standing of a professional actuarial accreditation organization designated by the department by rule;

(b) is qualified to sign a statement of actuarial opinion or annual statement for a professional employer organization in accordance with the qualification standards for an actuary signing an opinion or annual statement as provided by the professional actuarial accreditation organization designated under Subsection (15)(a);

(c) is familiar with the valuation requirements applicable to a professional employer organization;

(d) has not been found by the commissioner, or if so found has subsequently been reinstated as a qualified actuary, following appropriate notice and hearing to have:

(i) violated a provision of, or an obligation imposed by, statute or other law in the course of the actuary's dealings as a qualified actuary;

(ii) been found guilty of a fraudulent or dishonest practice;

(iii) demonstrated the actuary's incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(iv) submitted to the commissioner during the past five years, pursuant to this rule, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of rule; or

(v) resigned or been removed as an actuary within the past five years as a result of an act or omission indicated in an adverse report on examination or as a result of failure to adhere to a generally acceptable actuarial standard; and

(e) has not failed to notify the commissioner of an action taken by any commissioner of another state similar to that under Subsection (15)(d).

(16) "Temporary help service" means a service consisting of a person:

(a) recruiting and hiring the person's own employee;

(b) finding another person that wants the services of that employee;

(c) assigning the employee to:

(i) perform services at or for the other person to support or supplement the other person's employees;

(ii) provide assistance in a special work situation such as:

(A) an employee absence;

(B) a skill shortage; or

(C) a seasonal workload; or

(iii) perform a special assignment or project; and

(d) customarily reassigning the employee to another organization when the employee finishes an assignment.

(17) "Working capital" means the current assets minus the current liabilities of a professional employer organization determined in accordance with generally accepted accounting principles.

Enacted by Chapter 318, 2008 General Session

31A-40-103. Duties of the commissioner.

(1) (a) The commissioner shall maintain a list of professional employer organizations that are licensed under this chapter.

(b) The commissioner shall make the list required by this Subsection (1) available to the public by electronic or other means.

(2) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking

Act, the commissioner:

(a) shall make rules to prescribe the requirements for forms required under this chapter;

(b) may make rules to prescribe the requirements and process for correcting under Section 31A-40-205:

(i) a deficiency in working capital; or

(ii) negative working capital;

(c) may make rules to prescribe the requirements for the review and submission of a financial statement under Section 31A-40-305:

(i) that are consistent with generally accepted accounting principles; and

(ii) including the timeliness of a financial statement; and

(d) may make rules to prescribe the requirements and process for when a professional employer organization license is terminated by:

(i) voluntary surrender of the professional organization license; or

(ii) involuntary surrender of the professional organization license.

(3) A rule in effect on May 5, 2008 under the repealed Title 58, Chapter 59, Professional Employer Organization Registration Act, remains in effect until such time as the commissioner modifies or repeals the rule.

Amended by Chapter 10, 2010 General Session

31A-40-104. Confidentiality -- Cooperation with other agencies.

(1) Notwithstanding Title 63G, Chapter 2, Government Records Access and Management Act, and except as provided in Subsection (2), (3), or (4), the commissioner or department may not disclose information obtained from a professional employer organization under this chapter.

(2) The commissioner or department may disclose information on an aggregate basis that does not identify an individual professional employer organization or client.

(3) The commissioner or department may disclose information obtained from a professional employer organization under this chapter to a government entity if the government entity requires the information to perform the government entity's duties.

(4) (a) The commissioner shall coordinate the commissioner's administration of this chapter and share information with:

(i) the Department of Workforce Services;

(ii) the Labor Commission; and

(iii) the State Tax Commission.

(b) An agency listed in Subsection (4)(a) shall treat the information obtained under this section as confidential unless disclosure of the information is required in accordance with:

(i) this title; or

(ii) Title 63G, Chapter 2, Government Records Access and Management Act.

Enacted by Chapter 318, 2008 General Session

31A-40-201. Enforceable rights and obligations.

(1) In a coemployment relationship under a professional employer agreement:

(a) a professional employer organization:
(i) may only enforce a right of an employer that is specifically allocated to the professional employer organization under the professional employer agreement or this chapter; and
(ii) is subject only to an obligation of an employer specifically allocated to the professional employer organization by the professional employer agreement or this chapter; and
(b) a client:
(i) may enforce a right of an employer:
(A) allocated to the client in the professional employer agreement or this chapter; or
(B) not specifically allocated to the professional employer organization under the professional employer agreement or this chapter; and
(ii) is subject to an obligation of an employer:
(A) allocated to the client by the professional employer agreement or this chapter; or
(B) not specifically allocated to a professional employer organization by the professional employer agreement or this chapter.
(2) A right or obligation of a professional employer organization as a coemployer of a covered employee is limited to a right or obligation arising pursuant to the professional employer agreement and this chapter during the term of coemployment of the covered employee by the professional employer organization.

Enacted by Chapter 318, 2008 General Session

31A-40-202. Professional employer agreement -- Specific responsibilities.
(1) Except as specifically provided in this chapter, a coemployment relationship between a client and a professional employer organization, and between each coemployer and a covered employee, is governed by a professional employer agreement.
(2) (a) As used in this Subsection (2), unless a professional employer organization expressly agrees to assume liability for the payment in a professional employer agreement, the term "compensation to a covered employee" does not include an obligation between a client and a covered employee for a payment beyond or in addition to the covered employee's salary, draw, or regular rate of pay, such as:
(i) a bonus;
(ii) a commission;
(iii) severance pay;
(iv) deferred compensation;
(v) profit sharing; or
(vi) pay for vacation, sick, or other paid time off.
(b) A professional employer agreement shall include the following:
(i) the allocation of a right or obligation consistent with Section 31A-40-201;
(ii) a requirement that the professional employer organization shall:
(A) pay compensation to a covered employee; and
(B) withhold, collect, report, and remit one or more of the following:

(I) a payroll-related tax; and

(II) an unemployment insurance contribution; and

(C) to the extent that the professional employer organization assumes responsibility in the professional employer agreement, make payments for an employee benefit of a covered employee;

(iii) that the professional employer organization has a right to hire, discipline, or terminate a covered employee to the extent necessary to fulfill the professional employer organization's obligations under the professional employer agreement and this chapter;

(iv) that the client has a right to hire, discipline, and terminate a covered employee; and

(v) the responsibility of the client or professional employer organization related to obtaining workers' compensation coverage for a covered employee in a manner consistent with Section 31A-40-209.

(3) A professional employer organization shall provide written notice to a covered employee of the general nature of the coemployment relationship between and among the professional employer organization, the client, and the covered employee.

(4) (a) Except to the extent otherwise expressly provided by the professional employer agreement:

(i) a client is solely responsible for the quality, adequacy, or safety of a good or service produced or sold in the client's business;

(ii) a client is solely responsible for directing, supervising, training, and controlling the work of a covered employee with respect to:

(A) a business activity of the client;

(B) the discharge of a fiduciary responsibility of the client; or

(C) compliance with a licensure, registration, or certification requirement applicable to the client or to the covered employee;

(iii) a client is solely responsible for an act, error, or omission of a covered employee with regard to a circumstance described in Subsection (4)(a)(ii);

(iv) a client is not liable for an act, error, or omission of:

(A) a professional employer organization; or

(B) a covered employee, if the covered employee is acting under the express direction and control of the professional employer organization; and

(v) a professional employer organization is not liable for an act, error, or omission of:

(A) a client; or

(B) a covered employee, if the covered employee is acting under the express direction and control of the client.

(b) This Subsection (4) may not be interpreted to limit a contractual liability or obligation specifically provided in a professional employer agreement.

(c) (i) Unless the conditions of Subsection (4)(c)(ii) are met, a covered employee is not, solely as the result of being a covered employee of a professional employer organization, an employee of the professional employer organization for purposes of one or more of the following carried by the professional employer organization:

(A) general liability insurance;

(B) a fidelity bond;

(C) a surety bond;
(D) an employer liability that is not covered by workers' compensation; or
(E) liquor liability insurance.
(ii) A covered employee is considered an employee of the professional employer organization for a purpose described in Subsection (4)(c)(i) if the covered employee is included by specific reference for that purpose in:
(A) the professional employer agreement; and
(B) a prearranged employment contract, insurance contract, or bond.

Enacted by Chapter 318, 2008 General Session

31A-40-203. Covered employee.
(1) (a) An individual is a covered employee of a professional employer organization if the individual is coemployed pursuant to a professional employer agreement subject to this chapter.
(b) An individual who is a covered employee under a professional employer agreement is a covered employer, whether or not the professional employer organization provides the notice required by Subsection 31A-40-202(3), the earlier of the day on which:
(i) the employee is first compensated by the professional employer organization; or
(ii) the client notifies the professional employer organization of a new hire.
(2) An individual who is an officer, director, shareholder, partner, or manager of a client is a covered employee:
(a) to the extent that the client and the professional employer organization expressly agree in the professional employer agreement that the individual is a covered employee;
(b) if the conditions of Subsection (1) are met; and
(c) if the individual acts as an operational manager or performs day-to-day an operational service for the client.

Enacted by Chapter 318, 2008 General Session

31A-40-204. Rights and obligations unaffected -- Licensed, registered, or certified occupations or professions.
(1) This chapter does not and a professional employer agreement may not affect, modify, or amend a:
(a) collective bargaining agreement; or
(b) right or obligation of a client, professional employer organization, or covered employee under:
(i) the federal National Labor Relations Act, 29 U.S.C. Sec. 151 et seq.;
(ii) the federal Railway Labor Act, 45 U.S.C. Sec. 151 et seq.; or
(iii) a state law similar to a federal law described in this Subsection (1)(b).
(2) (a) A professional employer agreement may not:
(i) diminish, abolish, or remove a right of a covered employee to a client or an obligation of the client to a covered employee that exists on or before the day on which

the professional employer agreement takes effect;

(ii) affect, modify, or amend a contractual relationship or restrictive covenant between a covered employee and a client in effect on the day on which the professional employer agreement takes effect; or

(iii) prohibit or amend a contractual relationship or restrictive covenant that is entered into between a covered employee and a client after the day on which the professional employer agreement takes effect.

(b) A professional employer organization is not responsible or liable in connection with, or arising out of, a contractual relationship or restrictive covenant described in Subsection (2)(a) unless the professional employer organization specifically agrees to be responsible in writing.

(3) This chapter does not and a professional employer agreement may not create an enforceable right of a covered employee against a professional employer organization that is not specifically provided by the professional employer agreement or this chapter.

(4) (a) Except as provided in this Subsection (4), this chapter does not and a professional employer agreement may not affect, modify, or amend a state, local, or federal license, registration, or certification requirement applicable to a client or a covered employee.

(b) If a covered employee is required by federal or state law to be licensed, registered, or certified, the covered employee is considered to be solely an employee of the client for purposes of the license, registration, or certification requirement.

(c) A professional employer organization is not considered to engage in an activity that is subject to licensing, registration, or certification by a local, state, or federal government or is regulated by a local, state, or federal government solely by entering into or maintaining a coemployment relationship with a covered employee who is:

(i) subject to licensing, registration, or certification; or

(ii) regulated by the local, state, or federal government.

(d) A client has the sole right to direct or control a professional, licensed, registered, or certified activity of:

(i) a covered employee; and

(ii) the client's business.

(e) Notwithstanding this chapter, a covered employee and client remain subject to regulation by the local, state, or federal government responsible for licensing, registration, or certification of the covered employee or client.

Enacted by Chapter 318, 2008 General Session

31A-40-205. Financial capability.

(1) Except as provided in Subsection (2) or (4), as of the day a person applies for licensure or renewal of a license and at all times while licensed, a professional employer organization or collectively a professional employer organization group shall:

(a) have at least $100,000 in working capital as determined by generally accepted accounting principles; or

(b) provide to the commissioner one of the following in an amount equal to or

greater than an amount calculated by subtracting the amount of working capital of the professional employer organization or professional employer organization group from $100,000:

(i) a bond;

(ii) an irrevocable letter of credit;

(iii) one or more credits or securities as determined by the market value of the credits or securities; or

(iv) a combination of Subsections (1)(b)(i) through (iii).

(2) (a) Except as provided in Subsection (2)(c), the license of a professional employer organization or professional employer organization group terminates 180 days from the day on which the commissioner finds that the professional employer organization has less than $100,000 in working capital, unless the professional employer organization or professional employer organization group eliminates the deficiency within 180 days of the day on which the commissioner makes the finding.

(b) During the 180-day period described in Subsection (2)(a), the professional employer organization or professional employer organization group shall submit quarterly to the commissioner:

(i) a quarterly financial statement; and

(ii) an attestation that:

(A) is signed by:

(I) the chief executive officer or a controlling person of the professional employer organization; or

(II) for a professional employer organization group, the chief executive officer or chief financial officer of each member of the professional employer organization group; and

(B) states that all of the following are paid for a covered employee when due by the professional employer organization or each member of the professional employer organization group:

(I) compensation;

(II) a benefit;

(III) a payroll-related tax;

(IV) an unemployment insurance contribution;

(V) withholding of compensation for a covered employee;

(VI) workers' compensation premium; or

(VII) another assessment paid by a professional employer organization to or on behalf of a covered employee under a professional employer agreement.

(c) The license of a professional employer organization or professional employer organization group terminates on the day on which the commissioner finds that the professional employer organization:

(i) has negative working capital; and

(ii) (A) is incapable of continued operations; or

(B) poses an immediate threat to the public welfare.

(3) A bond, letter of credit, or security described in Subsection (1) shall:

(a) be held as designated by the commissioner; and

(b) secure payment by the professional employer organization or the professional employer organization group of the following payments or other

entitlements due to or with respect to a covered employee, if the professional employer organization or each member of the professional employer organization group does not make a payment when due:

(i) compensation of a covered employee;

(ii) a benefit for a covered employee;

(iii) payroll-related taxes;

(iv) unemployment insurance contributions; and

(v) workers' compensation premiums.

(4) A professional employer organization is exempt from this section if the professional employer organization is licensed:

(a) through an assurance organization in accordance with Section 31A-40-303; or

(b) under this chapter with a small operation license in accordance with Section 31A-40-304.

Enacted by Chapter 318, 2008 General Session

31A-40-206. Professional employer service not insurance.

(1) A professional employer organization licensed under this chapter is not considered
engaged in the sale of insurance or as acting as a third party administrator when the professional employer organization engages in one or more of the following with respect to a professional employer service:

(a) offering;

(b) marketing;

(c) selling;

(d) administering; or

(e) providing.

(2) Subsection (1) applies to a professional employer service that includes an employee benefit plan for a covered employee.

Enacted by Chapter 318, 2008 General Session

31A-40-207. Taxation.

(1) (a) A covered employee whose service is subject to a sales or use tax under Title 59, Chapter 12, Sales and Use Tax Act, is considered the employee of the client for purposes of imposing and collecting the sales or use tax on the service performed by the covered employee.

(b) This chapter may not be interpreted to relieve a client of a sales or use tax liability with respect to a good or service of the client.

(2) (a) If the amount of a tax or fee described in Subsection (2)(b) is determined on the basis of the gross receipts of a professional employer organization, only an administrative fee collected by the professional employer organization is considered gross receipts.

(b) This Subsection (2) applies to:

(i) a tax on a professional employer service;

(ii) a business license fee; or
(iii) another fee or charge.
(3) A taxing entity shall assess a tax assessed on a per capita or per employee basis:
(a) on a client for a covered employee; and
(b) on the professional employer organization for an employee of the professional employer organization who is not a covered employee coemployed with a client.
(4) If a tax is imposed or calculated on the basis of total payroll, the professional employer organization is eligible to apply a small business allowance or exemption available to the client for a covered employee for the purpose of computing the tax.

Enacted by Chapter 318, 2008 General Session

31A-40-208. Benefit plan.
(1) A client and a professional employer organization licensed under this chapter shall each be considered an employer for purposes of sponsoring a retirement or welfare benefit plan for a covered employee.
(2) A fully insured welfare benefit plan offered to a covered employee of a single professional employer organization licensed under this chapter:
(a) is to be treated as a single employer welfare benefit plan for purposes of this title and rules made under this title;
(b) may not be considered an employer welfare fund or plan, as described in Section 31A-13-101; and
(c) the single professional employer organization that sponsors the fully insured welfare plan is exempt from the registration requirements under this title for:
(i) an insurance provider; or
(ii) an employer welfare fund or plan.
(3) For purposes of Chapter 30, Individual, Small Employer, and Group Health Insurance Act:
(a) a professional employer organization licensed under this chapter is considered the employer of a covered employee; and
(b) all covered employees of one or more clients participating in a health benefit plan sponsored by a single professional employer organization licensed under this chapter are considered employees of that professional employer organization.
(4) A professional employer organization licensed under this chapter may offer to a covered employee a health benefit plan that is not fully insured by an authorized insurer, only if:
(a) the professional employer organization has operated as a professional employer organization for at least one year before the day on which the professional employer organization offers the health benefit plan; and
(b) the health benefit plan:
(i) is administered by a third-party administrator licensed to do business in this state;
(ii) holds all assets of the health benefit plan, including participant contributions, in a trust account;

(iii) has and maintains reserves that are sound for the health benefit plan as determined by an actuary who:

(A) uses generally accepted actuarial standards of practice; and

(B) is an independent qualified actuary, including not being an employee or covered employee of the professional employer organization;

(iv) provides written notice to a covered employee participating in the health benefit plan that the health benefit plan is self-insured or is not fully insured;

(v) consents to an audit:

(A) on a random basis; or

(B) upon a finding of a reasonable need by the commissioner; and

(vi) provides for continuation of coverage in compliance with Section 31A-22-722.

(5) The cost of an audit described in Subsection (4)(b)(v) shall be paid by the sponsoring professional employer organization.

(6) A plan of a professional employer organization described in Subsection (4) that is not fully insured:

(a) is subject to the requirements of this section; and

(b) is not subject to another licensure or approval requirement of this title.

Amended by Chapter 169, 2012 General Session

31A-40-209. Workers' compensation.

(1) In accordance with Section 34A-2-103, a client is responsible for securing workers' compensation coverage for a covered employee.

(2) Subject to the requirements of Section 34A-2-103, if a professional employer organization obtains or assists a client in obtaining workers' compensation insurance pursuant to a professional employer agreement:

(a) the professional employer organization shall ensure that the client maintains and provides workers' compensation coverage for a covered employee in accordance with Subsection 34A-2-201(1) or (2) and rules of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) the workers' compensation coverage may show the professional employer organization as the named insured through a multiple coordinated policy, if:

(i) the client is shown as an insured by means of an endorsement for each individual client;

(ii) the experience modification of a client is used; and

(iii) the insurer files the endorsement with the Division of Industrial Accidents as directed by a rule of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(c) at the termination of the professional employer agreement, if requested by the client, the insurer shall provide the client records regarding the loss experience related to workers' compensation insurance provided to a covered employee pursuant to the professional employer agreement; and

(d) the insurer shall notify a client if the workers' compensation coverage for the client is terminated.

(3) In accordance with Section 34A-2-105, the exclusive remedy provisions of

Section 34A-2-105 apply to both the client and the professional employer organization under a professional employer agreement regulated under this chapter.

(4) Notwithstanding the other provisions in this section, an insurer may choose whether to issue:

(a) a policy for a client; or

(b) a multiple coordinated policy with the client shown as an additional insured by means of an individual endorsement.

Enacted by Chapter 318, 2008 General Session

31A-40-210. Unemployment compensation insurance.

(1) For purposes of Title 35A, Chapter 4, Employment Security Act, a covered employee of a professional employer organization licensed under this chapter is considered the employee of the professional employer organization.

(2) The professional employer organization described in Subsection (1) shall pay a contribution, penalty, or interest required under Title 35A, Chapter 4, Employment Security Act, on wages, as defined in Section 35A-4-208, paid by the professional employer organization to the covered employee during the term of the professional employer agreement.

(3) A professional employer organization shall report and pay a required contribution to the unemployment compensation fund when due using the state employer account number and the contribution rate of the professional employer organization.

(4) Unless a client is otherwise eligible for an experience rating, the Unemployment Insurance Division of the Department of Workforce Services shall treat a client as a new employer without a previous experience record beginning on the day on which:

(a) a professional employer agreement between the client and a professional employer organization terminates; or

(b) the professional employer organization fails to submit a report or make a tax payment when due as required by this chapter.

Enacted by Chapter 318, 2008 General Session

31A-40-211. Employment related economic incentives -- Employment information -- Client's status.

(1) Notwithstanding the other provisions of this chapter, for purposes of determining eligibility for an employment related economic incentive, a covered employee is considered only an employee of the client.

(2) (a) If eligibility for an employment related economic incentive relates to a covered employee, the client is entitled to the employment related economic incentive if the client is otherwise eligible for the employment related economic incentive.

(b) A professional employer organization is not eligible for an employment related economic incentive described in Subsection (2)(a).

(3) If eligibility for or the amount of an employment related economic incentive is determined on the basis of the number of employees, a client is treated as employing

only:

(a) a covered employee coemployed by the client under the professional employer agreement; or

(b) an employee solely employed by the client.

(4) Subject to a confidentiality provision in federal or state law, a professional employer organization shall provide employment information:

(a) upon the request of:

(i) the client; or

(ii) the governmental entity administering an employment related economic incentive; and

(b) reasonably required for:

(i) administration of an employment related economic incentive; or

(ii) necessary to support any of the following by a client seeking an employment related economic incentive:

(A) a request;

(B) a claim;

(C) an application; or

(D) another action.

(5) With respect to a bid, contract, purchase order, or agreement entered into with the state or a political subdivision of the state, the fact that the client enters into a professional employer agreement does not affect the client's status or certification as a:

(a) small business;

(b) minority-owned business;

(c) disadvantaged business;

(d) woman-owned business; or

(e) historically underutilized business.

Enacted by Chapter 318, 2008 General Session

31A-40-301. Licensing required.

(1) Except as otherwise provided in this chapter, a person may not engage in the following before the day on which the person is licensed under this chapter:

(a) providing a professional employer service in this state;

(b) advertising that the person provides a professional employer service in this state; or

(c) holding itself out as providing a professional employer service in this state.

(2) A person described in Subsection (1) is subject to this chapter regardless of whether the person uses one of the following terms with or without the term "registered" or "licensed":

(a) "administrative employer";

(b) "employee leasing company";

(c) "professional employer organization";

(d) "PEO";

(e) "staff leasing company"; or

(f) another name.

Enacted by Chapter 318, 2008 General Session

31A-40-302. Licensing process.

(1) To apply for an initial or renewal license under this chapter, a person shall:

(a) (i) submit an application with the commissioner on a form and in a manner the commissioner shall determine by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) pay a license fee determined in accordance with Section 31A-3-103 that is not refunded if the application:

(A) is denied;

(B) does not comply with Section 31A-40-303; or

(C) if incomplete, is never completed by the person filing the application; or

(b) comply with Section 31A-40-303.

(2) In the application described in Subsection (1)(a), the person shall provide:

(a) any name under which the professional employer organization will engage in a professional employer service;

(b) the address of the principal place of business of the professional employer organization;

(c) the address of each location the professional employer organization maintains in this state;

(d) the professional employer organization's federal taxpayer or employer identification number;

(e) the following information by jurisdiction of each name under which the professional employer organization operated in the five years preceding the day on which the person submits the application:

(i) the name;

(ii) an alternative name, if any;

(iii) a name of a predecessor; and

(iv) if known, a successor business entity;

(f) a statement of ownership that includes the name and evidence of the business experience of a person that, individually or acting in concert with one or more other persons, owns or controls, directly or indirectly, 10% or more of the equity interests of the professional employer organization;

(g) a statement of management that includes the name and evidence of the business experience of an individual who:

(i) serves as president of the professional employer organization;

(ii) serves as chief executive officer of the professional employer organization; or

(iii) may act as a senior executive officer of the professional employer organization; and

(h) a financial statement that:

(i) sets forth the financial condition of:

(A) the professional employer organization; or

(B) a professional employer organization group in which the professional employer organization is a member;

(ii) states whether or not the professional employer organization complies with Section 31A-40-205; and

(iii) complies with Section 31A-40-305.

(3) A professional employer organization shall renew its license by no later than October 1 of each year.

Amended by Chapter 10, 2010 General Session

31A-40-303. Licensed through an assurance organization.

(1) (a) A person may comply with Section 31A-40-302 by:

(i) filing with the commissioner:

(A) a certification that an assurance organization certifies the qualifications of the professional employer organization;

(B) the information required by Subsections 31A-40-302(2)(a) through (d) and 31A-40-302(2)(h); and

(C) any changes to the information required by Subsection (1)(a)(i)(B) within 30 days of the day on which the information changes; and

(ii) paying a license fee determined in accordance with Section 31A-3-103.

(b) A professional employer organization that meets the requirements of Section 31A-40-302 by complying with this section is not required to:

(i) renew its license until the day on which the assurance organization no longer certifies the qualifications of the professional employer organization;

(ii) provide the information in Subsections 31A-40-302(2)(e) through (g); or

(iii) comply with Section 31A-40-205.

(c) If a professional employer organization that meets the requirements of Section 31A-40-302 by complying with this section receives a new or renewed certification by the assurance organization, the professional employer organization shall file with the commissioner a new certification within 30 days from the day on which the professional employer organization receives the new or renewed certification from the assurance organization.

(d) (i) If a professional employer organization authorizes an assurance organization to act on behalf of the professional employer organization for purposes of licensure under this section, the commissioner shall accept the assurance organization's filing of the information required by Subsection (1)(a) or (1)(c) if the information otherwise complies with this section and commission rules.

(ii) Notwithstanding Subsection (1)(d)(i), if the assurance organization fails to make a required filing under this section, the commissioner may not accept, not renew, or terminate the professional employer organization's license.

(2) The commissioner shall designate one or more assurance organizations by rule:

(a) consistent with this section;

(b) made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(c) that requires that an assurance organization designated by the commissioner be licensed by one or more states other than Utah to certify the qualifications of a professional employer organization.

(3) The qualifications certified by an assurance organization designated by the commissioner shall include at a minimum that a professional employer organization:

(a) ensure that each controlling person of the professional employer organization:

(i) be competent to manage a professional employer organization;

(ii) be responsible in the controlling person's finances; and

(iii) not have a history of or be engaged in unlawful activities;

(b) has a history that is verifiable that the professional employer organization:

(i) complies with regulatory requirements; and

(ii) engages in financially responsible conduct;

(c) has or is able to obtain audited financial statements;

(d) has an adjusted net worth equal to or in excess of the greater of:

(i) $100,000; or

(ii) 5% of total adjusted liabilities;

(e) has liquid assets that are sufficient to pay short-term liabilities as demonstrated by a ratio determined by dividing current assets by current liabilities or a similar formula;

(f) has on its books adequate financial reserves for all local, state, and federal self-insurance and any insurance policy or plan in which the final cost of coverage is affected by claim losses;

(g) operates in conformity with all applicable laws and regulations including those laws and regulations in addition to this chapter;

(h) does not engage in deceptive trade practices or misrepresentations of an employer's obligation or liability;

(i) has a written professional employer agreement with each client;

(j) has or is willing to obtain a written acknowledgment, as part of an existing form or separately, from each covered employee stating that the covered employee understands and accepts the nature, terms, and conditions of the coemployment relationship;

(k) establishes and maintains a coemployment relationship by assuming key employer attributes with respect to covered employees as demonstrated by the professional employer agreement and employment forms, policies, and procedures;

(l) provides all covered employees with a written copy of the professional employer organization's employment policies and procedures;

(m) ensures that all covered employees are covered in a regulatory compliant manner by workers' compensation insurance;

(n) does not knowingly use the coemployment relationship to assist a client to evade or avoid the client's obligations under:

(i) the National Labor Relations Act, 29 U.S.C. Sec. 151 et seq.;

(ii) the federal Railway Labor Act, 45 U.S.C. Sec. 151 et seq.; or

(iii) any collective bargaining agreement;

(o) except through a licensed insurance agent, does not:

(i) represent or imply that it can sell insurance;

(ii) attempt to sell insurance; or

(iii) sell insurance;

(p) markets and provides, or is willing to market and provide professional employer service under a separate and distinct trade name from any affiliated professional employer organization that is not certified by the assurance organization;

(q) does not allow any person not certified by the assurance organization to use the professional employer organization's trade name in the sale or delivery of the professional employer organization's professional employer service;

(r) does not guarantee, participate in, transfer between, or otherwise share liabilities with any other professional employer organization that is not certified by the assurance organization:

(i) in the employment of covered employees; or

(ii) in any employee benefit or insurance policy or plan that is not fully insured and fully funded; and

(s) has the ability to provide a regulatory agency or insurance carrier upon request with:

(i) a client's name, address, and federal tax identification number;

(ii) payroll data by:

(A) client;

(B) (I) client SIC Code of the 1987 Standard Industrial Classification Manual of the federal Executive Office of the President, Office of Management and Budget; or

(II) client classification under the 2002 North American Industry Classification System of the federal Executive Office of the President, Office of Management and Budget; and

(C) workers' compensation classification;

(iii) the names of covered employees by:

(A) the worksite of a client; and

(B) workers' compensation classification; and

(iv) workers' compensation certificates of insurance.

(4) This section does not modify the commissioner's authority or responsibility to accept, renew, or terminate a license.

Amended by Chapter 340, 2011 General Session

31A-40-304. Small operation license.

(1) A professional employer organization may obtain a small operation license under this chapter if the professional employer organization:

(a) files an application for a small operation license with the commissioner:

(i) on a form and in a manner the commissioner shall determine by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) that includes the information and documentation the commissioner determines is necessary to show that the professional employer organization qualifies for a small operation license;

(b) pays a small operation license fee determined in accordance with Section 31A-3-103, that is not refunded if the application:

(i) is denied; or

(ii) if incomplete, is never completed by the person filing the application;

(c) is domiciled outside of this state;

(d) is licensed or registered as a professional employer organization in another state;

(e) does not maintain an office in this state or directly solicit a client that:

(i) is domiciled in this state; or
(ii) maintains a location within this state;
(f) does not have at any time more than 50 covered employees employed or domiciled in this state; and
(g) is not owned or directed by another professional employer organization operating in the state.
(2) (a) A small operation license is valid for one year.
(b) A professional employer organization may annually renew a small operation license.
(3) A professional employer organization with a small operation license under this chapter is not subject to Section 31A-40-205.

Enacted by Chapter 318, 2008 General Session

31A-40-305. Financial statements required for licensing.

(1) (a) A person that files a financial statement with an application for an initial license under Section 31A-40-302 shall file the professional employer organization's most recent audit as of the day the application is filed, except that the financial statement may not be older than 10 months from the day on which the application is filed.
(b) A person that files a financial statement to renew a license shall file the most recent financial statement of the professional employer organization as of the day the application for renewal is filed with the commission.
(c) (i) The person filing an application may apply for an extension with the commissioner if the request for an extension is accompanied by a letter from the person conducting the audit for the financial statement stating:
(A) the reason for the delay; and
(B) the anticipated date on which the audit will be completed.
(ii) If a person complies with Subsection (1)(c)(i), the commissioner may grant an extension up to 30 days from the day on which the financial statement is due under this section.
(d) A professional employer organization may file a combined or consolidated financial statement if:
(i) the professional employer organization is owned by or in common control with another person; and
(ii) the combined or consolidated financial statement clearly identifies the following of the professional employer organization:
(A) its working capital;
(B) its assets; and
(C) its liabilities.
(2) A financial statement required by this chapter shall be:
(a) prepared in accordance with generally accepted accounting principles;
(b) audited by an independent certified public accountant licensed to practice in the jurisdiction in which the person conducting the audit is located; and
(c) without qualification as to the going concern status of the professional employer organization.

(3) Notwithstanding the other provisions of this section, the commissioner shall license a professional employer organization that does not have sufficient operating history to have an audited financial statement on the basis of at least 12 months if:

(a) the professional employer organization complies with the other requirements for licensure, including Section 31A-40-205; and

(b) the person filing the application for license files a financial statement that is reviewed by a certified public accountant.

Enacted by Chapter 318, 2008 General Session

31A-40-306. Professional employer organization group.

(1) Subject to Subsection (2), a professional employer organization that is a member of a professional employer organization group may comply with Section 31A-40-205 or Sections 31A-40-302 through 31A-40-305 on a combined or consolidated basis if each member of the professional employer organization group guarantees the obligations under this chapter of each other member of the professional employer organization group.

(2) The controlling entity of a professional employer organization group shall guarantee the obligations of a professional employer organization under this chapter if the professional employer organization group files a combined or consolidated audited financial statement that includes a person that is not:

(a) a professional employer organization; or

(b) a member of the professional employer organization group.

Enacted by Chapter 318, 2008 General Session

31A-40-307. Voluntary surrender of professional employer organization license.

(1) When a professional employer organization wants to voluntarily surrender its professional employer organization license, the professional employer organization shall:

(a) notify in writing each coemployer regarding the impending loss of the following provided under the professional employer agreement:

(i) workers' compensation insurance coverage;

(ii) health care benefits, if a coemployers' employee welfare plan includes fully insured or partially insured health insurance benefits; and

(iii) any other insurance benefit provided to coemployers by the professional employer organization; and

(b) submit a letter of intent to voluntarily surrender the license to the commissioner:

(i) after providing the notice to coemployers under Subsection (1)(a); and

(ii) not less than 45 days before the day on which the professional employer organization surrenders its professional employer organization license.

(2) The letter of intent to voluntarily surrender a professional employer organization license shall include the following:

(a) the reason the professional employer organization license is being

surrendered;
(b) a discussion of each process or plan to handle the obligations to coemployers and employees;
(c) a list of coemployers as of the date of the letter;
(d) a copy of the notice sent to the coemployers under Subsection (1)(a);
(e) certification that the professional employer organization has notified the coemployers located in Utah of the professional employer organization's intent to cease doing business in Utah; and
(f) the signature of the professional employer organization's chief executive officer or controlling individual.

Enacted by Chapter 10, 2010 General Session

31A-40-308. Material changes.
A professional employer organization shall notify the commissioner within 30 days of a change in:
(1) ownership;
(2) an address or telephone number;
(3) a contact person; or
(4) business email address at which the commissioner may contact the professional employer organization.

Enacted by Chapter 284, 2011 General Session

31A-40-309. Applicability of other provisions of law.
A professional employer organization is subject to Sections 31A-23a-402 and 31A-23a-402.5.

Enacted by Chapter 169, 2012 General Session

31A-40-401. Prohibited acts.
(1) A person may not:
(a) offer or provide a professional employer service if the person is not licensed under this chapter;
(b) use one of the following names if the person is not licensed under this chapter:
(i) "administrative employer";
(ii) "employee leasing";
(iii) "PEO";
(iv) "professional employer organization";
(v) "staff leasing"; or
(vi) other name that represents the provision of a professional employer service;
(c) knowingly provide false or fraudulent information to the commissioner:
(i) in conjunction with an application to be licensed or to renew a license under this chapter; or
(ii) in a report required under this chapter;

(d) knowingly make a material misrepresentation to the commissioner or other governmental agency;

(e) fail to make a filing with a state agency that is required by this chapter or the professional employer agreement within 30 days of the day on which the filing is due;

(f) fail to make a payment to a state agency that is required by this chapter or the professional employer agreement within 30 days of the day on which the payment is due;

(g) (i) offer a covered employee a self-funded medical plan unless the self-funded medical plan is maintained for the sole benefit of covered employees;

(ii) misrepresent that a self-funded medical plan it offers is other than self-funded; or

(iii) offer to a covered employee a self-funded or partially self-funded medical plan without delivering to a plan participant a summary plan description that accurately describes the terms of the plan, including disclosure that the plan is self-funded or partially self-funded;

(h) subject to Subsection (2), divert to another purpose or use other than as designated funds paid by a client to the professional employer organization and designated for:

(i) compensation of a covered employee;

(ii) a benefit of a covered employee;

(iii) a payroll-related tax;

(iv) an unemployment insurance contribution;

(v) withholding of compensation for a covered employee;

(vi) a workers' compensation premium; or

(vii) another assessment paid by a professional employer organization to or on behalf of a covered employee under a professional employer agreement;

(i) provide a covered employee to a client under a provision, term, or condition that is not contained in a professional employer arrangement between the professional employer organization and client;

(j) engage in a willful, fraudulent, or deceitful act that:

(i) is by a professional employer organization, caused by a professional employer organization, or at a professional employer organization's direction; and

(ii) causes material injury to a client or covered employee;

(k) fail to comply with a federal law or state law, to the extent state law is not preempted by federal law, regarding an employee benefit offered to an employee; or

(l) willfully or recklessly violate this chapter or an order or rule issued by the commissioner under this chapter.

(2) If a client defaults on a professional employer agreement or otherwise fails to pay a professional employer organization, the professional employer organization is not in violation of this section if the professional employer organization allocates the deficient payment to the portions of an invoice.

Enacted by Chapter 318, 2008 General Session

31A-40-402. Disciplinary action.

(1) Notwithstanding Section 31A-2-308, in accordance with this section the

commissioner may take action against a person if the commissioner finds that the person:

(a) is violating or has violated Section 31A-40-401; or

(b) (i) is a:

(A) professional employer organization licensed under this chapter; or

(B) controlling person of a professional employer organization licensed under this chapter; and

(ii) is convicted of a crime that relates to:

(A) the operation of a professional employer organization;

(B) fraud or deceit; or

(C) the ability of the professional employer organization or a controlling person of the professional employer organization to operate a professional employer organization.

(2) After notice and an opportunity for a hearing in accordance with Title 63G, Chapter 4, Administrative Procedures Act, if the commissioner makes a finding described in Subsection (1), the commissioner may:

(a) deny an application for a license;

(b) revoke, restrict, or refuse to renew a license;

(c) place a licensee on probation for the period and subject to conditions specified by the commissioner;

(d) impose an administrative penalty in an amount not to exceed $2,500 for each violation; or

(e) issue a cease and desist order.

Enacted by Chapter 318, 2008 General Session

31A-41-101. Title.

This chapter is known as the "Title Insurance Recovery, Education, and Research Fund Act."

Enacted by Chapter 220, 2008 General Session

31A-41-102. Definitions.

As used in this chapter:

(1) "Commission" means the Title and Escrow Commission created in Section 31A-2-403.

(2) "Fund" means the Title Insurance Recovery, Education, and Research Fund created in Section 31A-41-201.

(3) "Title insurance licensee" means:

(a) an agency title insurance producer; or

(b) an individual title insurance producer.

Amended by Chapter 319, 2013 General Session

31A-41-103. Authority to take disciplinary action not limited.

(1) This chapter does not limit the authority of the commissioner or the

commission to take disciplinary action against a title insurance licensee for a violation of this title or rules made by the department or commission under this title.

(2) The repayment in full of obligations to the fund by a title insurance licensee does not nullify or modify the effect of another disciplinary proceeding brought pursuant to this title or rules and regulations made by the department or commission under this title.

Enacted by Chapter 220, 2008 General Session

31A-41-201. Creation of Title Insurance Recovery, Education, and Research Fund.

(1) There is created an expendable special revenue fund to be known as the "Title Insurance Recovery, Education, and Research Fund."

(2) The fund shall consist of:

(a) assessments on individual title insurance producers and agency title insurance producers made under this chapter;

(b) amounts collected under Section 31A-41-305; and

(c) interest earned on the fund.

(3) Interest on fund money shall be deposited into the fund.

(4) The department shall administer the fund.

Amended by Chapter 319, 2013 General Session
Amended by Chapter 400, 2013 General Session

31A-41-202. Assessments.

(1) Beginning January 1, 2009, an agency title insurance producer licensed under this title shall pay an annual assessment determined by the commission by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the annual assessment:

(a) may not exceed $1,000; and

(b) shall be determined on the basis of title insurance premium volume.

(2) Beginning January 1, 2009, an individual who applies for a license or renewal of a license as an individual title insurance producer, shall pay in addition to any other fee required by this title, an assessment not to exceed $20, as determined by the commission by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that if the individual holds more than one license, the total of all assessments under this Subsection (2) may not exceed $20 in a fiscal year.

(3) (a) To be licensed as an agency title insurance producer on or after July 1, 2008, a person shall pay to the department an assessment of $1,000 before the day on which the person is licensed as a title insurance agency.

(b) (i) By no later than July 15, 2008, the department shall assess on an agency title insurance producer licensed as of June 30, 2008, an amount equal to the greater of:

(A) $1,000; or

(B) subject to Subsection (3)(b)(ii), 2% of the balance as of December 31, 2007,

in the agency title insurance producer's reserve account described in Subsection 31A-23a-204(3).

(ii) The department may assess on an agency title insurance producer an amount less than 2% of the balance described in Subsection (3)(b)(i)(B) if:

(A) before issuing the assessments under this Subsection (3)(b) the department determines that the total of all assessments under Subsection (3)(b)(i) will exceed $250,000;

(B) the amount assessed on the agency title insurance producer is not less than $1,000; and

(C) the department reduces the assessment in a proportionate amount for agency title insurance producers assessed on the basis of the 2% of the balance described in Subsection (3)(b)(i)(B).

(iii) An agency title insurance producer assessed under this Subsection (3)(b) shall pay the assessment by no later than August 1, 2008.

(4) The department may not assess a title insurance licensee an assessment for purposes of the fund if that assessment is not expressly provided for in this section.

Amended by Chapter 319, 2013 General Session

31A-41-203. Use of money.

(1) Money in the fund may be used to pay claims made under Part 3, Claims on Fund.

(2) (a) Except as limited by Subsection (2)(b), money in the fund in excess of $250,000 may be used by the commissioner, with the consent of the commission, to:

(i) investigate violations of this chapter related to fraud by a title insurance licensee;

(ii) conduct education and research in the field of title insurance; or

(iii) examine a title insurance licensee's:

(A) escrow and trust account;

(B) search and examine procedures; or

(C) compliance with applicable statutes and rules.

(b) The commissioner may not use more than 75% of money collected under this chapter in a fiscal year from assessments and interest for the purposes outlined in this Subsection (2).

(3) The disclosure of an examination conducted under this section is governed by Section 31A-2-204.

Enacted by Chapter 220, 2008 General Session

31A-41-301. Procedure for making a claim against the fund.

(1) (a) To bring a claim against the fund a person shall notify the department within 30 business days of the day on which the person files an action against a title insurance licensee alleging the following related to a title insurance transaction:

(i) fraud;

(ii) misrepresentation; or

(iii) deceit.

(b) The notification required by Subsection (1)(a) shall be:
(i) in writing; and
(ii) signed by the person who provides the notice.
(c) Within 30 days of the day on which the department receives a notice under Subsection (1)(a), the department may intervene in the action described in Subsection (1)(a).
(2) (a) Subject to the other provisions in this section, a person who provides the notice required under Subsection (1) may maintain a claim against the fund if:
(i) in an action described in Subsection (1), the person obtains a final judgment in a court of competent jurisdiction in this state against a title insurance licensee;
(ii) all proceedings including appeals related to the final judgment described in Subsection (2)(a)(i) are at an end; and
(iii) the person files a verified petition in the court where the judgment is entered for an order directing payment from the fund for the uncollected actual damages included in the judgment and unpaid.
(b) A court may not direct the payment from the fund of:
(i) punitive damages;
(ii) attorney fees;
(iii) interest; or
(iv) court costs.
(c) Regardless of the number of claimants or parcels of real estate involved in a single real estate transaction, the liability of the fund may not exceed:
(i) $15,000 for a single real estate transaction; or
(ii) $50,000 for all transactions of a title insurance license.
(d) A person shall:
(i) serve the verified petition required by Subsection (2)(a) on the department; and
(ii) file an affidavit of service with the court.
(3) (a) A court shall conduct a hearing on a petition filed with the court within 30 days after the day on which the department is served.
(b) The person who files the petition may recover from the fund only if the person shows all of the following:
(i) the person is not a spouse of the judgment debtor or the personal representative of the spouse;
(ii) the person complied with this chapter;
(iii) the person has obtained a final judgment in accordance with this section indicating the amount of the judgment awarded;
(iv) the amount still owing on the judgment at the date of the petition;
(v) the person has had a writ of execution issued under the judgment, and the officer executing the writ has returned showing that:
(A) no property subject to execution in satisfaction of the judgment could be found; or
(B) the amount realized upon the execution levied against the property of the judgment debtor is insufficient to satisfy the judgment;
(vi) the person has made reasonable searches and inquiries to ascertain whether the judgment debtor has any interest in property, real or personal, that may

satisfy the judgment; and

(vii) the person has exercised reasonable diligence to secure payment of the judgment from the assets of the judgment debtor.

(4) If the person described in Subsection (3) satisfies the court that it is not practicable for the person to comply with one or more of the requirements in Subsections (3)(b)(v) through (vii), the court may waive those requirements.

(5) (a) A judgment that is the basis for a claim against the fund may not have been discharged in bankruptcy.

(b) If a bankruptcy proceeding is still open or is commenced during the pendency of the claim, the person bringing a claim against the fund shall obtain an order from the bankruptcy court declaring the judgement and debt to be nondischargeable.

Amended by Chapter 253, 2012 General Session

31A-41-302. Department's authority to act upon receipt of petition.

(1) Upon receipt of a petition required by Section 31A-41-301, the department may answer, initiate review proceedings of its own, or appear in any proceeding:

(a) in the name of the defendant to the action; or

(b) on behalf of the fund.

(2) Subject to court approval, the department may compromise a claim on the basis of an application of the person who files the petition.

Enacted by Chapter 220, 2008 General Session

31A-41-303. Court determination and order.

Subject to the requirements of this part, if the court determines that a claim should be levied against the fund, the court shall enter an order directing the department to pay from the fund that portion of the petitioner's judgment that is payable from the fund.

Enacted by Chapter 220, 2008 General Session

31A-41-304. Insufficient funds to satisfy judgment.

If the money in the fund is insufficient to satisfy a claim ordered to be paid under Section 31A-41-303, when sufficient money is in the fund, the department shall pay a person with an unpaid claim:

(1) in the order that petitions related to unpaid claims are originally served on the department; and

(2) an amount equal to the sum of:

(a) the unpaid claim; and

(b) interest on the unpaid claim at a rate of 5% per annum from the date the court orders payment from the fund until the day on which the claim is paid.

Amended by Chapter 342, 2011 General Session

31A-41-305. Department subrogated -- Authority to revoke license.

(1) (a) If the department makes payment from the fund, the department is subrogated to all the rights of the person who received money from the fund for the amounts paid out of the fund.

(b) Any amounts recovered by the department under the subrogated rights shall be deposited in the fund.

(2) (a) The license of a title insurance licensee for whom payment from the fund is made under this chapter is automatically revoked.

(b) Before a title insurance licensee whose license is revoked under this section may apply for a new license under this title, the title insurance licensee shall pay to the department for deposit in the fund:

(i) the amounts paid by the fund because of an action brought against the title insurance licensee; and

(ii) interest at a rate determined by the commissioner with the concurrence of the commission.

Enacted by Chapter 220, 2008 General Session

31A-41-306. Failure to comply constitutes a waiver.

The failure of a person to comply with this chapter constitutes a waiver of any right provided under this chapter.

Enacted by Chapter 220, 2008 General Session

31A-42-101. Title.

This chapter is known as the "Defined Contribution Risk Adjuster Act."

Enacted by Chapter 12, 2009 General Session

31A-42-102. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the Utah Defined Contribution Risk Adjuster created in Section 31A-42-201.

(2) "Defined benefit plan" is as defined in Section 31A-30-202.

(3) "Risk adjuster" means the defined contribution risk adjustment mechanism created in Section 31A-42-201.

Amended by Chapter 68, 2010 General Session

31A-42-103. Applicability and scope.

This chapter applies to a carrier as defined in Section 31A-30-103 who offers a defined contribution arrangement health benefit plan under Chapter 30, Part 2, Defined Contribution Arrangements.

Amended by Chapter 68, 2010 General Session

31A-42-201. Creation of risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity within the department.

(2) (a) The risk adjuster is under the direction of a board of directors composed of up to nine members described in Subsection (2)(b).

(b) The board of directors shall consist of:

(i) the following directors appointed by the governor with the consent of the Senate:

(A) at least three, but up to five, directors with actuarial experience who represent insurers:

(I) that are participating or have committed to participate in the defined contribution arrangement market in the state; and

(II) including at least one and up to two directors who represent an insurer that has a small percentage of lives in the defined contribution market;

(B) one director who represents either an individual employee or employer; and

(C) one director who represents the Office of Consumer Health Services within the Governor's Office of Economic Development;

(ii) one director representing the Public Employees' Benefit and Insurance Program with actuarial experience, appointed by the director of the Public Employees' Benefit and Insurance Program; and

(iii) the commissioner, or a representative of the commissioner who:

(A) is appointed by the commissioner; and

(B) has actuarial experience.

(c) The commissioner, or a representative appointed by the commissioner may vote only in the event of a tie vote.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members appointed by the governor expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(c) Notwithstanding the requirements of Subsection (3)(a), a board member shall continue to serve until the board member is reappointed or replaced by another individual in accordance with this section.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) (a) A board member who is not a government employee may not receive compensation or benefits for the board member's services.

(b) A state government member who is a board member because of the board member's state government position may not receive per diem or expenses for the member's service.

(6) The board shall elect annually a chair and vice chair from its membership.

(7) A majority of the board members is a quorum for the transaction of business.

(8) The action of a majority of the members of the quorum is the action of the board.

Amended by Chapter 10, 2010 General Session
Amended by Chapter 68, 2010 General Session

31A-42-202. Contents of plan.

(1) The board shall submit a plan of operation for the risk adjuster to the commissioner. The plan shall:

(a) establish the methodology for implementing:

(i) Subsection (2) for the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements; and

(ii) the participation of small employer group defined contribution arrangement health benefit plans;

(b) establish regular times and places for meetings of the board;

(c) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(d) contain additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster; and

(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.

(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include:

(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and

(ii) underwriting mechanisms and employer eligibility guidelines:

(A) consistent with the federal Health Insurance Portability and Accountability Act; and

(B) necessary to protect insurance carriers from adverse selection in the defined contribution market.

(b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual are determined, including:

(i) the identification of an initial rate for a qualified individual based on:

(A) standardized age bands submitted by participating insurers; and

(B) wellness incentives for the individual as permitted by federal law; and

(ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and 31A-30-106.1.

(c) The plan adopted under Subsection (2)(a) shall outline how:

(i) premium contributions for qualified individuals shall be submitted to the Health Insurance Exchange in the amount determined under Subsection (2)(b); and

(ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's rating factor determined in accordance with the plan.

(d) The plan adopted under Subsection (2)(a) shall outline a mechanism for

adjusting risk between insurers that:

(i) identifies health care conditions subject to risk adjustment;

(ii) establishes an adjustment amount for each identified health care condition;

(iii) determines the extent to which an insurer has more or less individuals with an identified health condition than would be expected; and

(iv) computes all risk adjustments.

(e) The board may amend the plan if necessary to:

(i) maintain the proper functioning and solvency of the defined contribution arrangement market and the risk adjuster mechanism;

(ii) mitigate significant issues of risk selection; or

(iii) improve the administration of the risk adjuster mechanism.

(3) The board shall establish a mechanism in which the participating carriers shall submit their plan base rates, rating factors, and premiums to the commissioner for an actuarial review under the provisions of Section 31A-30-115 prior to the publication of the premium rates on the Health Insurance Exchange.

Amended by Chapter 400, 2011 General Session

31A-42-203. Powers and duties of board.

(1) The board shall have the power to:

(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking legal action necessary to implement and enforce the plan for risk adjustment adopted pursuant to this chapter; and

(c) establish appropriate rate adjustments, underwriting policies, and other actuarial functions appropriate to the operation of the defined contribution arrangement market in accordance with Section 31A-42-202.

(2) (a) The board shall prepare and submit an annual report no later than July 1, each year to the department for inclusion in the department's annual market report, which shall include:

(i) the expenses of administration of the risk adjuster for the defined contribution arrangement market;

(ii) a description of the types of policies sold in the defined contribution arrangement market;

(iii) the number of insured lives in the defined contribution arrangement market; and

(iv) the number of insured lives in health benefit plans that do not include state mandates.

(b) The budget for operation of the risk adjuster is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

Amended by Chapter 253, 2012 General Session

31A-42-204. Powers of commissioner.

(1) The commissioner shall, after notice and hearing, approve the plan of operation if the commissioner determines that the plan:

(a) is consistent with this chapter; and

(b) is a fair and reasonable administration of the risk adjuster.

(2) The plan shall be effective upon the adoption of administrative rules by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) If the board fails to submit a proposed plan of operation by January 1, 2010, or any time thereafter fails to submit proposed amendments to the plan of operation within a reasonable time after requested by the commissioner, the commissioner shall, after notice and hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

(4) Rules promulgated by the commissioner shall continue in force until modified by the commissioner or until superseded by a subsequent plan of operation submitted by the board and approved by the commissioner.

(5) The commissioner may designate an executive secretary from the department to provide administrative assistance to the board in carrying out its responsibilities.

Enacted by Chapter 12, 2009 General Session

31A-43-101. Title.

This chapter is known as the "Small Employer Stop-Loss Insurance Act."

Enacted by Chapter 341, 2013 General Session

31A-43-102. Definitions.

For purposes of this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer is in compliance with the provisions of this chapter, based upon the individual's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the stop-loss insurer in establishing attachment points and other applicable determinations in conjunction with the provision of stop-loss insurance coverage.

(2) "Aggregate attachment point" means the dollar amount in losses for eligible expenses incurred by a small employer plan beyond which the stop-loss insurer incurs liability for all or part of the losses incurred by the small employer plan, subject to limitations included in the contract.

(3) "Coverage" means the combination of the employer plan design and the stop-loss contract design.

(4) "Expected claims" means the amount of claims that, in the absence of a stop-loss contract, are projected to be incurred by a small employer health plan using reasonable and accepted actuarial principles.

(5) "Lasering":

(a) means increasing or removing stop-loss coverage for a specific individual within an employer group; and

(b) includes other practices that are prohibited by the commissioner by administrative rule that result in lowering the stop-loss premium for the employer by transferring the risk for an individual.

(6) "Small employer" means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(7) "Specific attachment point" means the dollar amount in losses for eligible expenses attributable to a single individual covered by a small employer plan in a contract year beyond which the stop-loss insurer assumes all or part of the liability for losses incurred by the small employer plan, subject to limitations included in the contract.

(8) "Stop-loss insurance" means insurance purchased by a small employer for which the stop-loss insurer assumes, on a per-loss basis, all loss amounts of the small employer's plan in excess of a stated amount, subject to the policy limit.

Enacted by Chapter 341, 2013 General Session

31A-43-201. Scope of chapter.

(1) This chapter establishes criteria for the issuance of stop-loss insurance contracts or re-insurance contracts for small employers that establish self-funded or partially self-funded health plans for the small employer's employees. This chapter does not:

(a) impose any requirement or duty on any person other than a stop-loss insurer or re-insurer who issues a stop-loss insurance contract to a small employer;

(b) treat any stop-loss insurance contract as a direct policy of health insurance; or

(c) constitute an attempt to exercise authority over self-funded or partially self-funded health benefit plans sponsored by a small employer.

(2) This chapter applies to a small employer stop-loss contract issued or renewed on or after July 1, 2013.

Enacted by Chapter 341, 2013 General Session

31A-43-202. Laws applicable to stop-loss insurance.

A stop-loss insurance contract or a re-insurance contract issued to a small employer that establishes a self-funded or partially self-funded health plan:

(1) is not reinsurance under this title, and is not subject to the regulations for reinsurance under this title;

(2) is subject to regulation as stop-loss insurance under this chapter; and

(3) is subject to the contract provisions of this title in the same manner as insurance contracts issued by any other insurer.

Enacted by Chapter 341, 2013 General Session

31A-43-301. Stop-loss insurance coverage standards.

(1) A small employer stop-loss insurance contract shall:

(a) be issued to the small employer to provide insurance to the group health benefit plan, not the employees of the small employer;

(b) use a standard application form developed by the commissioner by administrative rule;

(c) have a contract term with guaranteed rates for at least 12 months, without adjustment, unless there is a change in the benefits provided under the small employer's health plan during the contract period;

(d) include both a specific attachment point and an aggregate attachment point in a contract;

(e) align stop-loss plan benefit limitations and exclusions with a small employer's health plan benefit limitations and exclusions, including any annual or lifetime limits in the employer's health plan;

(f) have an annual specific attachment point that is at least $10,000;

(g) have an annual aggregate attachment point that may not be less than 90% of expected claims;

(h) pay stop-loss claims:

(i) incurred during the contract period; and

(ii) submitted within 12 months after the expiration date of the contract; and

(i) include provisions to cover incurred and unpaid claims if a small employer plan terminates.

(2) A small employer stop-loss contract shall not:

(a) include lasering; and

(b) pay claims directly to an individual employee, member, or participant.

Enacted by Chapter 341, 2013 General Session

31A-43-302. Stop-loss restrictions -- Filing requirements.

(1) A stop-loss insurer shall demonstrate to the commissioner that the rates associated with specific and aggregate attachment points retained by a small employer group under the insurer's stop-loss plan are actuarially sound.

(2) A stop-loss insurer shall file the stop-loss insurance contract form and rates with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1 before the stop-loss insurance contract may be issued or delivered in the state.

(3) A stop-loss insurer shall file with the commissioner, annually on or before April 1, in a form and manner required by the commissioner by administrative rule adopted by the commissioner:

(a) an actuarial memorandum and certification which demonstrates that the insurer is in compliance with this chapter; and

(b) the stop-loss insurer's stop-loss experience.

(4) Each insurer shall maintain at its principal place of business:

(a) a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate the

rating methods and practices are:
(i) based upon commonly accepted actuarial assumptions; and
(ii) in accordance with sound actuarial principles; and
(b) a copy of the actuarial certification required by Subsection (3).

Enacted by Chapter 341, 2013 General Session

31A-43-303. Stop-loss insurance disclosure.

A stop-loss insurance contract delivered, issued for delivery, or entered into shall include the disclosure exhibit required by the commissioner through administrative rule, which shall include at least the following information:
(1) the complete costs for the stop-loss contract;
(2) the date on which the insurance takes effect and terminates, including renewability provisions;
(3) the aggregate attachment point and the specific attachment point;
(4) any limitations on coverage;
(5) an explanation of monthly accommodation and disclosure about any monthly accommodation features included in the stop-loss contract; and
(6) a description of terminal liability funding, including:
(a) cost of processing claims before and after the termination of the contract; and
(b) maximum claims liability to the employer.

Enacted by Chapter 341, 2013 General Session

31A-43-304. Administrative rules.

The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:
(1) implement this chapter;
(2) assure that differences in rates charged are reasonable and reflect objective differences in plan design;
(3) define lasering practices that are prohibited by this chapter;
(4) establish the form and manner of the actuarial certification and the annual report on stop-loss experience required by Section 31A-43-302;
(5) establish the form and manner of the disclosure required by Section 31A-43-303;
(6) assure the rates associated with the specific attachment points and aggregate attachment points are actuarially sound and are not against the public interest; and
(7) assure that stop-loss contracts include provisions to cover incurred and unpaid claims if a small employer plan terminates.

Enacted by Chapter 341, 2013 General Session