CHAPTER 23

INSURANCE CODE

The California Insurance Code (CIC) consists of statutes written and passed by the state legislature. The governor signs these statutes into law. The insurance code is changed by the legislature passing a new statute that amends or repeals an existing statute. The code originally consisted of six divisions, but two divisions have been repealed. The remaining four divisions are (1) general rules governing insurance, (2) classes of insurance, (3) the insurance commissioner, and (4) insurance adjusters. Each division is further broken down into parts, chapters, and articles.

The Insurance Commissioner is elected by the people to serve a four-year term in the same general election in which the governor is elected. If a vacancy should occur during the term of the office, the governor shall appoint a replacement subject to approval by the legislature. (CIC 12900) The commissioner shall perform all duties imposed upon him by provisions of the insurance code and other laws regulating the business of insurance in this State, and he shall enforce the execution of such provisions and laws. (CIC 12921)

The California Code of Regulations (CCR) is made up of rules issued by the commissioner. The regulations may be changed or withdrawn by the commissioner. The CCRs are needed in order to administer the code. Although the commissioner does not write the code, he is responsible for enforcing the code. Even though the CCRs are not law, they carry the same weight as law. A person who violates a regulation is subject to the same penalty as someone who violates the code.

An insurance professional should have knowledge of the California Insurance Code and the Code of Regulations. These documents identify many unethical and illegal practices. However, they are not a complete guide to ethical behavior.

CLASSES OF INSURANCE

Insurance in California is divided into the following 20 categories:

1. Life
2. Fire
3. Marine
4. Title
5. Surety
6. Disability (includes all forms of health insurance and disability income)
7. Plate glass
8. Liability
9. Workers compensation

10. Common carrier liability
11. Boiler and machinery
12. Burglary
13. Credit
14. Sprinkler
15. Team and vehicle
16. Automobile
17. Mortgage
18. Aircraft
19. Mortgage guaranty (includes insolvency insurance and legal insurance)
20. Miscellaneous

Prior to a discussion of the code, certain terms should be understood. These include:

Shall: Shall is mandatory. There is no choice.
May: May is permissive. There is a choice to do or not to do something. (CIC 16)

DEFINITIONS

Insurance: Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent of unknown event. (CIC 22) In insurance the risk of loss is transferred to the insurer by the policyholder. There are many risks that may be insured as noted by the number of lines of insurance recognized by the California Department of Insurance.

Insurable events: Any contingent or unknown event, whether past or future, which may damage a person having an insurable interest, or create a liability against him, may be insured against. (CIC 250) In life or disability insurance, insurable interest shall be required to exist at the time the contract of life or disability interest becomes effective, but it need not exist at the time the loss occurs. (CIC 10110) In fire and casualty insurance, insurable interest is required at the inception of the policy and when the loss occurs.

Admitted: "Admitted" in relation to a person, means entitled to transact insurance business in this State, having complied with the laws imposing conditions precedent to transaction of such business. (CIC 24)

Non-admitted: "Non-admitted in relation to a person, means not entitled to transact insurance business in this State, whether by reason of failure to comply with conditions precedent thereto, or by reason of inability so to comply. (CIC 25)

Domestic, foreign and alien insurers: Companies may be classified according to where the company is domiciled meaning where the company has its principal legal residence, where it was organized, or where it was incorporated.

Domestic: A company is considered to be a domestic insurer in the state where it was organized. Therefore, any company organized under the laws of the state of California is considered to be a domestic insurer in California, whether or not it is admitted to do business in California. (CIC 26)

Foreign: A foreign insurer is an insurer organized under the laws of another state within the United States, whether or not it is admitted to do business. Thus, a company organized in Arizona is considered to be a foreign insurer in California. (CIC 27)

Alien: An alien insurer is an insurer organized under the laws of any jurisdiction other than a state of the United States, whether or not admitted to do business in California. For instance, a company organized in Canada is considered alien.

Person: "Person" means any person, association, organization, partnership, business trust, limited liability company, or corporation. (CIC 19)

Insurer: Any person capable of making a contract may be an insurer, subject to the restrictions of the code. (CIC 150)

Reinsurance: A contract of reinsurance is one by which an insurer procures a third person to insure him against loss or liability by reason of such original insurance. (CIC 620) An insurance company cedes part of the risk to another insurance company. The ceding insurer must disclose all knowledge and information to the reinsurer. The original insured does not need to be informed about the reinsurance contract. The ceding company will continue to service the contract.

Insurance agent: "Insurance agent" means a person authorized, by and on behalf of an insurer, to transact all classes of insurance other than life insurance or accident and health insurance. (CIC 1621) An insurance agent by this definition means someone who holds a fire and casualty license. Licenses to act as a fire and casualty agent are of the following types: (1) Property which entitles the licensee to transact insurance coverage on the direct or consequential loss or damage to property of every kind and (2) Casualty which entitles the licensee to transact insurance coverage against legal liability including that for death, injury, disability, or damage to real or personal property. (CIC 1625)

Life-only agent: A life-only agent means an insurance agent authorized, by and on behalf of a life insurer, to transact insurance on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income. (CIC 1626 [1]; 1622)

A licensed life agent may present a proposal for insurance to a prospective policyholder on behalf of a life insurer for which the life agent is not specifically appointed and may send an application for insurance to that insurer.

(Life agents cannot transmit an application to an insurer that only uses exclusive agents.) If a policy of insurance is issued, the insurer is considered to have authorized the agent to act on its behalf. The insurer must forward to the commissioner a notice of appointment of the life agent not more than 14 days after the life agent submits an application for insurance to the insurer for which the insurer issues a policy. Any payment made by the prospective insured must be made in the form of a draft, check, cashier's check, traveler's check, money order, or similar instrument made payable to the insurer. (CIC 1704.5)

Accident and health agent: An accident and health license entitles the licensee to transact insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income. (CIC 1626[2]) An accident and health agent may be authorized to transact 24-hour care coverage pursuant to certain requirements. (CIC 32)

Broker: "Insurance broker" means a person who, for compensation and on behalf of another person, transacts insurance other than life and accident and health with, but not on behalf of, an insurer. (CIC 33) Every application for insurance submitted by an insurance broker to an insurer shall show that the person is acting as an insurance broker. If the application shows that the person is acting as an insurance broker and is licensed as an insurance broker in the state in which the application is submitted, it shall be presumed, for licensing purposes only, that the person is acting as an insurance broker. (CIC 1623) There is no life broker or accident and health broker.

Surplus lines broker: (CIC 1760) A surplus lines broker places insurance with non-admitted insurers. A surplus lines broker may act as an agent for a non-admitted insurer in the transaction of insurance business in California, advertise a non-admitted insurer, and aid a non-admitted insurer to transact insurance business in California.

It is a misdemeanor to transact for or advertise a non-admitted insurer unless licensed as a surplus lines broker. Any person who willfully violates the surplus lines regulations is guilty of a public offense and is punishable by imprisonment in the state prison, or in a county jail, for not exceeding one year or a fine not exceeding $10,000, or by both. (CIC 703;1764.7)

Solicitor: "Insurance solicitor" means a natural person employed to aid a fire and casualty agent/broker acting as an insurance agent or insurance broker in transacting insurance other than life and accident and health. (CIC 34;1624) Agents are appointed by insurance companies and represent insurance companies. Solicitors are appointed by fire and casualty agents/brokers, not by insurance companies.

Life Settlement Broker: A life settlement broker means a person who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and

providers. A life settlement broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions, and in the best interest of the owner, not withstanding the manner in which the broker is compensated. (CIC 10113.l[b])

Life and disability insurance analyst: "Life and disability insurance analyst" means a person who, for a fee or compensation of any kind, paid by or derived from any person or source other than an insurer, advises, purports to advise, or offers to advise any person insured under, named as beneficiary of, or having any interest in, a life or disability insurance contract, in any manner concerning that contract or his or her rights in respect thereto. (CIC 32.5)

The license qualifications for an insurance analyst are as follows (CIC 1831-1849):

- Age 18 or older and a California resident.
- Makes a written application on a prescribed form.
- Answers under oath any questions asked by the commissioner.
- Has a good business reputation.
- Has thorough knowledge of life and disability insurance. No person shall be eligible for a life and disability insurance analyst license unless for five years preceding the date of the examination, he/she has worked as a life or disability licensee or as an employee of such a licensee.
- Has not been connected with any business transaction that shows unfitness to act in a fiduciary capacity.
- Has not willfully misstated any material fact in a license application or obtained a license by concealment or misrepresentation.
- Is a fit and proper person to hold a license.
- Does not seek the license to avoid or prevent enforcement of the insurance laws.
- Has passed the required examination.

A life and disability insurance analyst shall not receive any fee unless that fee is based upon a written agreement signed by the party to be charged. The agreement shall include a statement that the information and services concerning insurance policies may be obtained directly from the insurer without cost, an outline of the services to be performed for which a fee is charged, and the fee to be charged. Additionally, if the licensee is also licensed as a life agent, there shall be a statement indicating this fact. A copy of such agreement shall be retained for not less than three years after the services have been fully performed. (CIC 1848)

An employee or officer of any insurer is not eligible for license as a life and disability insurance analyst. A life insurer shall not pay a life and disability insurance analyst any commission directly or indirectly, on any life or disability insurance transacted by and in the capacity as a life and disability insurance analyst.

Anyone who acts or offers to act as a life analyst without a license can be punished by a fine of up to $1,000 or imprisonment for up to one year, or both imprisonment and fine.

LIFE	**FIRE AND CASUALTY**
Life-only Agent	Property Broker-Agent*
Accident and Health Agent	Casualty Broker-Agent*
Life Settlement Broker	Solicitor
Life Analyst	

Note: As of January 1, 2011 applicants for a fire and casualty broker-agent license need to apply for a property broker-agent license and a casualty broker-agent license. Both types of licenses may be applied for on the same application and just one fee needs to be paid.

Administrator: (CIC 1759) An administrator is a person who collects premiums from and who settles or adjusts claims on behalf of employers in connection with life or health insurance coverage or annuities.

Adjuster: (CIC 14000) An adjuster is a licensed person, other than a private investigator, who for a fee or other consideration, investigates and collects information for the purpose of adjusting or disposing of a claim under an insurance policy. It is most often a property and casualty policy. The requirements are as follows:

- Age 18 or older.
- Must not have committed any acts or violations of law for which a license could be denied.
- Must have at least two years of experience (or the equivalent) in adjusting insurance claims.
- Must meet any other qualifications established by the commissioner.
- Must pay the required license fee.

Public insurance adjuster: (CIC 15000) A public insurance adjuster is a licensed individual who, for compensation, works on behalf of an insured in settling a claim for loss or damage under a policy covering real or personal property.

Transact: "Transact" as applied to insurance includes any of the following:

(a) Solicitation (CIC 35[a])
(b) Negotiations preliminary to execution (CIC 35[b])
(c) Execution of a contract of insurance (CIC 35[c])
(d) Transaction of matters subsequent to execution of the contract and arising out of it (CIC 35[d]))

As noted above in the definitions section, a property/casualty insurance agent, life-only agent, accident and health agent, broker, and solicitor are licensed to transact various lines of insurance. A person shall not act in any of the capacities defined in transacting (solicitation, negotiation, execution, and transaction) unless he holds a valid license from the commissioner authorizing him to act in such capacity. (CIC 1631) Any person who acts, offers to act, or assumes to act in a capacity for which a license is required without a valid license so to act is guilty of a misdemeanor. (CIC 1633)

The unlawful transaction of insurance business by an insurer in willful violation of the requirement for a certificate of authority is a public offense punishable by imprisonment in the state prison, or in a county jail not exceeding one year, or by fine not exceeding one hundred thousand dollars ($100,000), or by both that fine and imprisonment, and shall be enforced by a court of competent jurisdiction on petition of the commissioner. (CIC 700(b).

Transacting without a license: (CIC 1631;1633) A person may not conduct any activities of an agent, broker, or solicitor unless he has a license issued by the commissioner authorizing him to act in that capacity. Anyone who acts, offers to act, or assumes to act in a capacity for which a license is required, without holding a license, is guilty of a misdemeanor. This is punishable by a fine not exceeding $50,000 or by imprisonment in a county jail for a period not exceeding one year, or by both fine and imprisonment.

Types of insurance companies:

Stock insurers are corporations organized for the purpose of making a profit for their stockholders. A stock company raises money by selling shares of stock; the stockholders are the owners of the company; and the affairs of the company are handled by a board of directors elected by the stockholders. The type of policy issued by stock companies is called **non-participating** (non-par) as the policyholders do not share in the company's profits. When declared, dividends are paid to the stockholders.

Mutual insurers are corporations owned by the policyowners. When a person buys an insurance policy from a mutual insurer that person is becoming an owner in the company as well as a policyholder. As an owner, the policyholder votes for the board of directors. The policies issued by mutual insurers are referred to as **participating** (par) policies as any surplus is returned to the policyowner in the form of a **dividend**. Surplus can be defined as excess earned or saved by the insurance company. Earned surplus is generated by:

- Mortality-----fewer people die than expected
- Interest------company earns more interest than assumed
- Expenses---company overhead is less than projected

Dividends are regarded by the federal government as a return to the policyowners of excess premiums charged for the insurance coverage. As such, dividends paid by mutual insurers are not taxable income. However, it also should be noted that dividends cannot be guaranteed as surplus will vary from year to year.

An incorporated mutual insurer may be converted into an incorporated stock insurer. The process whereby a mutual insurer becomes a stock insurer is known as demutualization or conversion. (CIC 11535)

Fraternal insurers (fraternal benefit societies or fraternals) are life insurance carriers that are social organizations that normally are involved in charitable activities. Fraternal societies usually are incorporated without capital stock. To be considered a fraternal, the organization must be nonprofit, must have a lodge system with a ritualistic form of work involved, and have an elective form of government. Fraternal society insurance provides benefits for sickness, accident and death and such insurance may be sold only to members of the society for the benefit of its members and their families.

Distribution systems:

Agency system: Agents are appointed by insurers and solicit applications on behalf of insurers. Agents may be either exclusive or independent. The major of policies are sold using the agency system.

Direct response marketing is achieved by advertising through the mail, in newspapers and magazines, on television and radio and the internet. If someone is interested in the advertised products, he/she will respond to the company for more information. Mass marketing is a cost effective method of distribution and may achieve efficient market penetration.

Home service life insurance is a variation of industrial life insurance. Industrial life insurance policies are small policies essentially to cover a person's last expenses. The agent is responsible for servicing the policies and must personally collect the premiums on a weekly or monthly basis and provide the client with a written receipt. The major difference with home service life is that the face amount is larger. It normally is written for amounts of $10,000 or $15,000 and the premiums are either debited from a bank account or mailed.

Effective date of coverage: (C 1730.5) A life agent and a fire and casualty broker/agent shall provide to all insureds or applicants at the time of application or receipt of premium moneys the effective date of coverage, if known, or the circumstances under which coverage will be effective if there exists conditions precedent to coverage. This section applies only to coverage for personal lines of insurance, such as private passenger automobile, homeowner and renter insurance, personal liability, and individual disability and health insurance.

Free insurance: No insurer shall participate in any plan to offer or effect any kind or kinds of insurance or annuities in this state as an inducement to the purchase or rental by the public of any property, real or personal or mixed, or services, without a separate charge to the insured for such insurance, nor shall any agent, broker, or solicitor arrange the sale of any such insurance. (CIC 777.1) This article does not apply to insurance offered as a guarantee of the performance of goods which is insurance to protect the purchasers of such goods nor does it apply to any title insurance or life or disability insurance written to pay off the balance of a debt in the event of the death or disability of the insured.

If any insurer, agent, broker, or solicitor willfully violates this provision regarding free insurance, the commissioner may suspend or revoke the certificate or license or other authority to do business or engage in an insurance occupation for a period not exceeding one year.

Aiding non-admitted insurer to transact: (CIC 1760-1780) Except when performed by a surplus line broker, the following acts are misdemeanors when done in this State:

(a) Acting as agent for a non-admitted insurer in the transaction of insurance business in this State.
(b) In any manner advertising a non-admitted insurer in this State.
(c) In any other manner aiding a non-admitted insurer to transact insurance business in this State. (CIC 703)

The commissioner may penalize a person guilty of unauthorized dealings with a non-admitted insurer. The guilty person also will be penalized monetarily by the state.

Any person licensed by the commissioner who misrepresents to any surplus lines broker any material fact regarding insurance coverage, or facts regarding rules of submission or rates, or conspires to procure non-admitted insurance in violation of the law, may have his license suspended, revoked, or denied.

Surplus Lines Law: Any person may negotiate and effect insurance to protect himself, herself, or itself against loss, damage, or liability with any non-admitted insurer.

The rules limiting the insurance which may be place with non-admitted insurers do not apply to:

(1) Reinsurance of the liability of an admitted insurer.
(2) Insurance against perils of navigation, transit or transportation upon hulls, freights or disbursements, or other shipowner interests; upon goods, wares, merchandise and all other personal property and interests therein, in course of exportation from or importation into any

country, or transportation coastwise, including transportation by land or water from point of origin to final destination and including war risks; and marine builder's risks, drydocks and marine railways, including insurance of ship repairer's liability, and protection and indemnity insurance, but excluding insurance covering bridges and tunnels.

(3) Aircraft insurance.

(4) Insurance on property or operations of railroads engaged in interstate commerce.

The insurance specified in the above numbers 2, 3, and 4 may be placed with a non-admitted insurer only by and through a special lines' surplus lines broker.

A surplus line broker may solicit and place insurance with non-admitted insurers only if that insurance cannot be procured from insurers admitted for the particular class or classes of insurance and that actually write the particular type of insurance in this state. Each surplus line broker shall be responsible to ensure that a diligent search is made among admitted insurers before placing insurance with a non-admitted insurer. It shall be presumed that insurance is placed in violation of the code if the insurance is actually placed with a non-admitted insurer at a lower rate of premium or lower premium than the lowest rate of premium or the lowest premium that could be obtained from an admitted insurer unless, at the time the insurance attaches, there is filed with the commissioner a statement describing the insurance, specifying the rate and the nearest procurable rates from admitted insurers. The statement shall include an explanation of the reasons that the insurance must be placed with a non-admitted insurer even though it is available from an admitted insurer.

Every non-admitted insurer, in the case of insurance to be purchased by a resident of this state, and surplus line broker, in the case of any insurance with a non-admitted carrier to be transacted by the surplus line broker, shall be responsible to ensure that, at the time of accepting an application for any insurance policy, other than a renewal of that policy, issued by a non-admitted insurer, the signature of the applicant on a disclosure statement. The disclosure statement shall be in boldface 16-point type on a freestanding document. In addition, every policy issued by a non-admitted insurer and every certificate evidencing the placement of insurance shall contain, or have affixed to it by the insurer or surplus line broker, the disclosure statement in boldface 16-point type on the front page of the policy. In the case where the applicant has not received and completed the signed disclosure form, he/she may cancel the insurance so placed.

The following notice shall be provided to policyholders and applicants for insurance with a non-admitted insurer and shall be printed in English and in the language principally used by the surplus line broker and non-admitted insurer to advertise, solicit, or negotiate the sale and purchase of surplus line insurance. The surplus line broker and non-admitted insurer shall use the appropriate bracketed language for application and issued policy disclosures:

"NOTICE:

1. **THE INSURANCE POLICY THAT YOU (HAVE PURCHASED) (ARE APPLYING TO PURCHASE) IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NON-ADMITTED" OR "SURPLUS LINE" INSURERS.**
2. **THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT WHICH APPLIES TO CALIFORNIA LICENSED INSURERS.**
3. **THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIM OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
4. **CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST.**
5. **FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: ____."**

The list of eligible surplus lines insurers maintained by the California Department of Insurance is known as the LESLIE list (List of Eligible Surplus Lines Insurers).

License qualifications: An applicant for an insurance license must submit (1) the Department of Insurance application form, (2) fees, and (3) certificates showing completion of the necessary course material. When applying as a life-only agent or an accident and health agent, the candidate must complete 20 hours of the material applicable to the license as well as 12 hours on code and ethics. If applying for a life-only/accident and health license, 40 hours of course material must be completed in addition to the 12 hours on code and ethics. The property/casualty (also called fire and casualty) agent, solicitor, and broker must complete 40 hours of material regarding the lines of insurance they may sell as well as 12 hours of code and ethics. However, starting on January 1, 2011, individuals and business entities may apply for only the property-agent license or only the casualty broker-agent license. In this case, the separate licenses will require 20 hours of pre-licensing plus the 12 hours on code and ethics. A person applying for a property and casualty personal lines license will need to complete 20 hours of study regarding personal lines and 12 hours of code and ethics. The commissioner may make an investigation or may require additional information, documents, or statements to determine if the applicant has met all

the requirements for a license. The applicant will be required to pass the state licensing examination and achieve a score of 70% correct.

A life-only agent, an accident and health agent, a property agent, a casualty agent, or a personal lines agent to act as an insurance agent shall have filed on his behalf with the commissioner a notice of appointment to act as an agent executed by an admitted insurer. Additional notices of appointment may be filed by other insurers before the license is issued and thereafter. (CIC 1704) Every property/casualty or personal lines solicitor applicant shall have filed on his behalf a notice executed by a property/casualty or personal lines broker/agent agreeing to employ the applicant. To act as a property/casualty broker or personal lines broker, a $10,000 bond must be filed with the Department of Insurance.

An agent's appointment by an insurer serves as notice to the commissioner that the insurer has deemed the applicant to be a person of good reputation and character. Appointments are effective as of the date the notice of appointment is signed by the insurer and continues in force until (1) the cancellation or expiration of the license applied for or held at the time the appointment was filed or (2) one of the parties (licensee or insurer) files a notice of termination.(CIC 1673) When all the appointments of a licensed life-only agent, accident and health agent, property/casualty agent, personal lines agent, or solicitor are terminated, the license becomes inactive. If a property/casualty or personal lines broker's bond is cancelled, his license becomes inactive. The license may be reactivated any time before it expires by filing a new appointment or broker's bond. An inactive license shall not permit its holder to transact any insurance for which a valid, active license is required. (CIC 1704a; 1705)

A life insurance producer who has been licensed as a life agent (or a licensed non-resident producer) in California for one year or longer may act as a life settlement broker by notifying the Commissioner and paying the life settlement broker license fee. A life insurance producer who has not held a life agent license for one year must first complete at least 15 hours of education on life settlement transactions and must complete an application and pay the life settlement broker license fee. A licensee licensed to act as a viatical settlement broker or provider as of December 31, 2009 is considered to have met the requirements for licensure as a life settlement broker or provider. The fee for the life settlement broker license is required to be paid every two years at the same time that the individual's life license is renewed. A life settlement broker license is not required for a licensed attorney, certified public accountant, or accredited financial planner who represents the policy owner and whose compensation is not paid directly or indirectly by the life settlement provider. (CIC 10113.29[b][1][B])

Certificate of convenience: Upon the filing of an application for a license, the commissioner may make such investigation and require the filing of such supplementary documents, affidavits and statements as may be necessary to

obtain a full disclosure of such information as will aid him in determining whether the prerequisites for the license have been met. If the applicant makes a showing satisfactory to the commissioner that he meets all such prerequisites, the commissioner may issue a certificate of convenience and, upon the applicant meeting any applicable examination requirements, may issue a permanent license. (CIC 1666)

Causes for denial after a hearing: The commissioner may deny a license, after a notice and hearing into the issue, for any of the following reasons**:** (CIC 1668)

a. The applicant is not properly qualified to perform the duties of a person to hold the license for which applied.
b. Granting the license would not be in the public interest.
c. The applicant does not intend actively and in good faith to conduct business with the general public which would be permitted under the license for which applied.
d. The applicant is not of good business reputation.
e. The applicant lacks integrity.
f. The applicant has been refused a professional, occupational, or vocational license, or has had such a license suspended or revoked for a reason that should preclude the granting of an insurance license.
g. The applicant is seeking the license to avoid or prevent the operation or enforcement of the state's insurance laws.
h. The applicant has knowingly or willfully made a misstatement in the license application or in a document filed to support the application, or has made a false statement to the commissioner in testimony given under oath.
i. The applicant has previously engaged in a fraudulent practice or act or has conducted a business in a dishonest manner.
j. The applicant has shown that he has been incompetent or untrustworthy in the conduct of a business, or has exposed the public or those dealing with him to the danger of loss, by committing a wrongful act or practice in the course of business.
k. The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract.
l. The applicant has failed to perform a duty expressly required by the insurance code or has committed an act expressly forbidden by the code.
m. The applicant has been convicted of a felony, a misdemeanor in violation of any insurance laws, or a public offense that involved fraud or dishonesty involving money or property.
n. The applicant has aided or abetted another person in an act or omission for which that person's license could be suspended, revoked, or refused.
o. The applicant has allowed any person employed by him to violate any provision of the insurance code.
p. The applicant has violated any law relating to conduct of a business which could lawfully be done only by authority conferred by such license.

A judgment, plea or verdict of guilty or a conviction following a plea of *nolo contendere* is considered to be the same as a conviction.

Denial of license application without a hearing: The commissioner may deny an application for a license without conducting a hearing for any of the following reasons: (CIC 1669)

a. The applicant has been convicted of a felony.
b. The applicant has been convicted of a misdemeanor denounced by any insurance law.
c. The applicant has had a previous application denied for cause within the last five (5) years.
d. The applicant has had a license suspended or revoked for cause within the last five (5) years.

License revocation or suspension: The commissioner may suspend or revoke a permanent license for any of the same grounds for which a license application may be denied. As noted above, some grounds require a hearing while others do not. (CIC 1738)

Title 18 United State Code Sections 1033-1034: According to Section 1033 it is a criminal offense for an individual who has been convicted of a felony involving dishonesty or breach of trust to willfully engage or participate in the business of insurance unless that person has first obtained the written consent of the appropriate regulatory official. Furthermore, it is a criminal offense for any person to willfully employ or willfully permit such prohibited persons to participate in the business of insurance without the required written consent.

The California Department of Insurance has jurisdiction under this act to consider requests for written consent filed by prohibited persons who propose to participate in the business of insurance in California with a domestic insurer or a resident licensee. Such prohibited persons who propose to engage in the business of insurance in California shall:

- File a 1033 consent waiver application
- Pay the application fee
- Provide all required documentation
- Receive written consent before engaging in such business

Implied declarations with appointment: (CIC 1705)

1. When an insurer or licensed property and casualty broker/agent files an appointment for an agent or solicitor applying for an original license, the insurer or broker/agent is declaring that the applicant is of good reputation and is worthy of the license sought.
2. If an applicant will not be issued a certificate of convenience pending examination, the insurer or broker/agent who files the appointment is declaring that the applicant has had the required experience or instruction

in the classes of insurance for which the license is sought or that he/she will be given the necessary instruction within 30 days after the license is issued.

3. If the applicant is a co-partnership, corporation, or association, the insurer making the appointment is deemed to have declared that the applicant is of good reputation and worthy of the license sought. This applies to the business organization and to each individual authorized to exercise agency powers who is named in the application. These implied declarations apply to any additional persons added to the license at a later date.

Termination of license: (CIC 1708-1714)

1. A licensee may voluntarily surrender his license for cancellation at any time by delivering the license to the commissioner. If the license is in the possession of the insurer or the licensee's employer, the license may be surrendered by providing written notice to the commissioner of the licensee's desire to cancel.
2. All licenses issued to a natural person terminate when the person dies.
3. An organization ceases to exist as an entity eligible to hold a license upon the following:
   a. A co-partnership dissolves or there is a change in membership.
   b. An association terminates.
   c. A corporation is dissolved.
4. A co-partnership may continue to transact business under its license if:
   a. The surviving partnership files an application within 30 days registering the change in membership, pays the required fee, and furnishes the required bond (if acting as a broker).
   b. At least one partner from the predecessor partnership continues to exercise the powers of agency or brokership with the new partnership.
   c. The application is signed by a general partner.

   Note: To return the old license to the commissioner with signatures of the original members is not a requirement.
5. When a licensed entity terminates, its right to transact insurance also terminates. However, a natural person, partnership, association, or corporation may continue to operate under an existing license as a different organization if:
   a. A natural person is named to exercise the agency or brokerage powers.
   b. There has been no substantial change in ownership or control of the licensed insurance business.
   c. Within 30 days after the change, the person or successor partnership, association or corporation files a license application and pays necessary fees.
6. The license of an organization licensed as a life-only agent, accident and health agent, property and casualty broker/agent, or personal lines broker/agent becomes inoperative when the last natural person named

on the license is removed or is no longer eligible to be licensed. The license will not be reactivated unless all deficiencies are corrected, including the addition of a natural person to transact insurance under the organization's license.

License renewal: (CIC 1720) An application on a form prescribed by the commissioner for the renewal of a license filed on or before the last day of the period for which the previous license was issued, accompanied by the renewal fee, shall entitle the applicant to continue operating under the existing license for 60 days after its specified expiration date or until notified by the department of insurance that the renewal application is deficient.

Printing license number on documents and advertisements: (CIC 1725.5) Every licensee shall prominently print his license number on business cards, written price quotations for insurance products, and printed advertisements for insurance products distributed exclusively in California. The license number must be printed in the same size type as any telephone number, address, or fax number. If the licensee maintains more than one organization license, one of the organization license numbers is adequate for compliance.

In the case of solicitors working as exclusive employees of a motor club, organizational license numbers shall be used. These requirements do not apply to general advertisements of motor clubs that simply list insurance products as one of several services offered by the motor club and do not provide any details regarding insurance products.

Any person in violation of this section is subject to a fine of $200 for the first offense, $500 for the second offense, and $1,000 for the third and subsequent offenses. The penalty will not exceed $1,000 for any one offense. Separate penalties will not be imposed upon each piece of printed material that does not conform to the requirements of this regulation. The money from these fines will be deposited into the Insurance Fund.

Internet advertisements: (CIC 1726) A person who is licensed in this state as an insurance agent or broker, advertises insurance on the Internet, and transacts insurance in this state, shall identify all of the following information on the Internet, regardless of whether the insurance agent or broker maintains his/her Internet presence or if the presence is maintained on his/her behalf:

1. His/her name as it appears on his/her insurance license and any fictitious name approved by the commissioner.
2. The state of his/her domicile and principal place of business.
3. His/her license number.

A person shall be deemed to be transacting insurance in this state when the person advertises on the Internet whether the licensee maintains his/her

Internet presence or if it is maintained on his/her behalf and does any of the following:

1. Provides an insurance premium quote to a California resident.
2. Accepts an application for coverage from a California resident.
3. Communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy.

Continuing Education: Licensees are subject to continuing education requirements. All licensees are required to complete 24 hours of continuing education per two-year license term. An agent who holds both a life-only and/or accident and health license and a property/casualty license needs only to complete 24 hours of continuing education per two-year licensing period and may take subjects relating to either license. (CIC 1749.3) A license year upon initial licensing starts on the date the license is issued. After that, each license year starts the first day of the month following the month in which the initial license was issued. A license year ends the following calendar year on the last calendar day of the month in which the initial license was issued. A license term is for two years. (CIC 1629-1630)

Failing to complete the continuing education requirements results in termination of license. In order to reactivate the license, the individual must complete the necessary continuing education requirements, pay late penalties and fees, and reinstate all appointments and endorsements. (CIC 1749.3)

Every licensee selling long-term care must complete the required continuing education requirements. An accident and health license is needed to sell long-term care and it is necessary to complete eight hours of long-term care education prior to selling such a policy. It is required that agents selling LTC complete eight hours of LTC every year for the first four years, and thereafter they must complete eight hours of LTC education every two-year licensing period. These courses shall consist of topics related to long-term care services and long-term care insurance, including, but not limited to, California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, and alternatives to the purchase of private long-term care insurance. (CIC 10234.93) Agents who sell California Partnership must meet long-term care requirements plus 4 hours per year of California partnership education for the first four years and eight hours of California partnership education per license term thereafter. These hours of long-term care and partnership continuing education count toward the required continuing education hours needed by licensees.

A life licensee who wishes to sell annuities must complete 8 hours of continuing education on annuities prior to selling an annuity. This 8 hours counts toward the necessary continuing education requirements. Subsequent renewals will require 4 hours of continuing education on annuities. (CIC 1749.8)

Property/casualty broker-agents and life-only and/or accident and health agents must complete 4 hours of ethics training each license terms. Personal lines broker-agents must complete 2 hours of ethics training each license term.

Everyone has a need for some type of insurance during his/her lifetime. Consequently, the public is relying on the advice of insurance licensees to make sure that they have adequate insurance to protect their family and assets. The agent must be careful in identifying a customer's needs and then should make recommendations of appropriate products and services. The agent should keep in touch with his clients and conduct periodic reviews to ascertain that their insurance coverage is adequate to meet current circumstances. Agents should protect the confidential relationship they have with their clients.

To be professional, agents must observe insurance laws and the rules of the insurance companies that they represent. Agents must accurately and truthfully represent products and services. It is important to use simple language to make sure clients understand what the agent is saying. In other words, layman's language should be used when possible. Agents should maintain a friendly attitude toward competitors. Criticizing other agents and companies does not reflect a professional attitude. Agents should always be careful not to make misleading remarks about insurance companies or insurance products.

As a large percentage of the population has no knowledge about insurance, it is essential that the agent be well informed. Part of being informed is to constantly keep updated by doing continuing education courses and reading insurance trade journals and business publications. By being more knowledgeable, the agent will be better able to serve clients. The most important thing for the agent to remember is to place the client's welfare first, not his/her own. By keeping the foregoing in mind, the agent will provide exemplary service to clients.

Change of address: (CIC 1729) Every licensee and applicant for a license must immediately notify the commissioner in writing of any change in his residence address, business address, or mailing address.

Notice: Any notice required to be given to any person by any provision of the code may be given by mailing notice, postage prepaid, addressed to the person to be notified at his residence or principal place of business in California. The affidavit of the person who mails the notice, stating the facts of such mailing, is prima facie evidence that the notice was thus mailed. (CIC 38)

Agency names: (CIC 1724.5, 1729.5) Every individual and organization licensee and every applicant for such a license shall file with the commissioner in writing the true name of the individual or organization and also all fictitious names under which he conducts or intends to conduct his business and after licensing shall file with the commissioner any change in or discontinuance of such names. The commissioner may in writing disapprove the use of any true or fictitious

name (other than the bona fide natural name of an individual) by any licensee on any of the following grounds:

1. The name interferes with or is too similar to a name already filed and used by another licensee.
2. Using the name may mislead the public in any way.
3. The name states or implies that the licensee is an insurer, motor club, hospital service plan or that the licensee is entitled to engage in insurance activities not allowed under the license.
4. The name states or implies that the licensee is an underwriter. However, this does not prohibit a natural person from using a designation like Chartered Life Underwriter (CLU) or Charter Property and Casualty Underwriter (CPCU) or a trade association whose members are individually licensed from using a name that includes the word "underwriter" (e.g. National Association of Life Underwriters).
5. The licensee has filed and has not discontinued use of more than two names, including the true name. A licensee who has bought an insurance business may use two additional names used by the previous owner(s) in conducting the business.

A licensee may not continue to use a true or fictitious name after the commissioner has notified the licensee in writing to stop. If there are mitigating facts in connection with the use of a particular name, the commissioner may permit continued use of the name for a reasonable time if there are conditions imposed that adequately protect the public.

A fire and casualty broker/agent or life-only and/or accident and health agent who has a service contract with a corporation licensed under this code or who is a stockholder or member of any incorporated association or corporation organized under the Corporations Code for the purpose of providing services to fire and casualty broker/agents or life-only and/or accident and health agents may use the name of such a corporation or association on any stationery or advertisements and other written or printed matter used to identify the business of the fire and casualty broker/agent or life-only and/or accident and health agent provided that the name of the fire and casualty broker/agent or life-only and/or accident and health agent is clearly identified as bearing only that relationship to the corporation or association in one of the following ways:

- "Representing_____;"
- "A stockholder of_____:"
- "Placing business through_____:"
- "Using services of_____."

Policy defined: The written instrument, in which a contract of insurance is set forth, is the policy. (CIC 380)

Required contents: A policy shall specify:

(a) The parties between whom the contract is made.
(b) The property or life insured.
(c) The interest of the insured in property insured, if he is not the absolute owner thereof.
(d) The risks insured against.
(e) The period during which the insurance is to continue.
(f) Either:
(1) A statement of the premium, or
(2) If the insurance is of a character where the exact premium is only determinable upon the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid. (CIC 381)

The financial rating of the insurer is not required to be specific in the insurance policy.

Parties to the contract: Any person capable of making a contract may be an insurer, subject to the restrictions imposed by the code. (CIC 150) Any person except a public enemy may be insured. (CIC 151)

If the insured has no insurable interest, the contract is void. (CIC 280) The measure of insurable interest in property is the extent to which the insured might be damnified by loss or injury thereof. (CIC 284) An interest in property insured must exist when the insurance takes effect, and when the loss occurs, but need not exist in the meantime; an interest in the life or health of a person insured must exist when the insurance takes effect, but need not exist thereafter or when the loss occurs. (CIC 286)

Concealment: Concealment is defined as the neglect to communicate that which a party knows and ought to communicate. Whether or not concealment is intentional or unintentional, the injured party has the right to rescind the insurance contract. Rescission means the contract is made null and void. All parties to a contract shall communicate in good faith all information believed to be material to the contract.

Each party to the contract must: (1) communicate in good faith with one another; (2) disclose all facts of which the party has knowledge and which are of importance to the contract; and (3) identify all facts that the party cannot warranty and of which the party has no means to ascertain.

It is not necessary to disclose to the other party: (1) information which the other party already has knowledge; (2) information which, in the exercise of ordinary care, the other ought to know, and of which the party has no reason to suppose him ignorant; (3) information to which the other party waives communication; and (4) information which is not material to the contract. (CIC 330-333)

Materiality: Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries. (CIC 334)

Each party to a contract of insurance is bound to know all the general causes open to inquiry that may affect either the political or material perils contemplated. The right to information of material facts may be waived either by the terms of insurance or by neglect to make inquiries as to such facts where they are distinctly implied in other facts which are communicated. Information regarding the nature or amount of one's insurable interest need not be communicated unless in response to an inquiry. An intentional and fraudulent omission on the part of one insured to communicate information of matters proving or tending to prove the falsity of a warranty entitles the insurer to rescind. (CIC 335-338)

Representation: A representation is a statement to the best knowledge and belief of the party making the statement. A representation can be written or oral. The language of a representation is to be interpreted by the same rules as a contract in general. A representation as to the future is a promise, unless it is merely a statement of belief or an expectation. **A representation** cannot qualify an express provision in a contract of insurance, but it **may qualify an implied warranty**. A representation may be made at the time of, or before, issuance of the policy. A representation may be altered or withdrawn before the insurance is effected, but not afterwards. (CIC 355) The completion of the contract of insurance is the time to which a representation must be presumed to refer.

When an insured has no personal knowledge of a fact, he may nevertheless repeat information which he has upon the subject, and which he believes to be true, with the explanation that he does so based on the information of others. He is not responsible for its truth, unless it proceeds from an agent of the insured, whose duty it is to give the information.

A representation is considered to be false when the facts fail to correspond with its assertions or stipulations. (CIC 358) If a representation is false in a material point, the injured party is entitled to rescind the contract from the time the representation becomes false. The materiality of a representation is determined by the same rule as the materiality of a concealment. All of the above provisions apply to the modification of a contract of insurance as well as to the original contract. (CIC 350-361)

Opinion: Neither party to a contract of insurance is bound to communicate, even upon inquiry, information of his own judgment upon the matters in question. (CIC 339)

Misrepresentation: (CIC 780-784) A misrepresentation is a false oral or written statement made with the intent to defraud another. An insurer or an insurance

licensee shall not cause or permit to be issued, circulated or used, any misrepresentation of the following:

(1) The terms of a policy issued by the insurer or sought to be negotiated by the person making or permitting the misrepresentation.
(2) The benefits or privileges promised thereunder;
(3) The future dividends, payable thereunder. (CIC 780)

Twisting: A person shall not make any representation or comparison of insurers or policies to an insured which is misleading, for the purpose of inducing or tending to induce him to lapse, forfeit, change or surrender his insurance, whether on a temporary or permanent plan. (CIC 781)

Any person violating the rules regarding misrepresentation or twisting may be fined up to $25,000 or in a case in which the loss of the victim exceeds $10,000, by a fine not exceeding three times the amount of the loss suffered by the victim, by imprisonment in a county jail for a period not to exceed one year, or by both a fine and imprisonment. Following a hearing, the commissioner may suspend the license of the insurance producer for up to three years. If an insurer or its representatives violate the rules regarding misrepresentation or twisting, the commissioner, after a hearing, may suspend the insurer's certificate of authority to do the class of insurance in respect to which the violation occurred. (CIC 782- 783)

Any person may be compelled to testify and produce books and writings at the trial or hearing of any person charged with violating any provision regarding misrepresentation and twisting even though such testimony or evidence may incriminate him. A person shall not be prosecuted for any act concerning which he is compelled so to testify or produce evidence, except for perjury committed in so testifying. (CIC 784)

Warranty: A warranty is a guaranteed truth. Warranties are either express or implied. A statement in a policy of a matter relating to the person or thing insured, or to the risk, as a fact, is an express warranty thereof. An implied warranty is a statement, not in writing, that insurable conditions exist. An implied warranty is included in the policy even though not specifically stated in it. A representation in an insurance contract qualifies as an implied warranty.

A particular form of words is not necessary to create a warranty. Every express warranty made at or before the execution of a policy shall be contained in the policy or in another instrument signed by the insured and made part of the policy. A warranty may relate to the past, the present, the future, or to any or all of these. A statement in a policy that imports that there is an intention to do or not to do a thing, which materially affects the risk, is a warranty that such act or omission will take place. (CIC 440-445)

If a loss insured against takes place and the performance of the warranty has become unlawful at the place of the contract or impossible, the omission to fulfill the warranty does not void the policy. If there is a violation of a material warranty, the wronged party may rescind the contract. The breach of an immaterial warranty will not void the policy unless the policy states that a violation of specified provisions will void it. A breach of warranty without fraud merely exonerates an insurer from the time that it occurs, or where the warranty is broken in its inception, prevents the policy from attaching to the risk. (CIC 447)

Rescission: To rescind a contract is to terminate or void the contract. The policy is considered null and void from the beginning and treated as if it had never existed. As noted above, a wronged party has the right to rescind the contract when there has been a material concealment whether intentional or unintentional (CIC 331), an intentional and fraudulent omission proving the falsity of a warranty (CIC 338), a material false representation (CIC 359), or a violation of a material warranty or other material provision of a policy (CIC 447).

Unfair trade practices: (CIC 790-790.10) The insurance industry is subject to the laws of California which apply to all types of business, including, but not limited to, the Unruh Civil Rights Act, anti-trust, and unfair business practice laws. The purpose of the rules regarding unfair practices is to define and regulate trade practices in the business of insurance that are considered to be unfair, deceptive, or misleading. These provisions apply to all types of insurers and to all producers engaged in the insurance business. No one may engage in any practice that is prohibited by law or that is considered to be an unfair method of competition or an unfair or deceptive trade practice in the business of insurance.

The article regarding unfair trade practices applies to reciprocal and interinsurance exchanges, Lloyds insurers, fraternal benefit societies, fraternal fire insurers, grants and annuities societies, insurers holding certificates of exemptions, motor clubs, nonprofit hospital associations, life agents, broker/agents, surplus line brokers and special lines surplus line brokers as well as all other persons engaged in the business of insurance.

The following are unfair trade practices:

(a) **Misrepresentation.** It is against the law to make, issue, or circulate any estimate, illustration, circular or statement which:
    1. Misrepresents the benefits, terms, or advantages of an insurance policy.
    2. Misrepresents the dividends to be paid on an insurance policy.
    3. Misrepresents the dividends paid in the past on a policy or similar policies.
    4. Misrepresents the financial condition of an insurer or the legal reserve system used by an insurer.
    5. Uses a policy name that misrepresents the true nature of a policy or class of policies.

6. Makes a misrepresentation to a policyholder that induces that policyholder to lapse, forfeit, or surrender his policy.

(b) **Untrue or deceptive information about a person engaged in insurance.** It is an unfair practice to advertise or distribute information about the insurance business, an insurer, or any person engaged in the business of insurance which is untrue, deceptive, or misleading.

(c) **Boycott, coercion, intimidation.** It is unlawful to commit or conspire to commit an act of boycott, coercion, or intimidation which results in unreasonable restraint of, or monopoly in the business of insurance.

(d) **Filing false financial statement.** It is unlawful to knowingly file with any public official or to publish, circulate, or place before the public a false statement of an insurer's financial condition, with intent to deceive.

(e) **False entries.** It is against the law to knowingly make an entry or deliberately omit an entry of a material fact in a book, report, statement or record which an insurer is required to file with the insurance department or any other public agency with intent to deceive a public official or examiner.

(f) **Unfair discrimination.** It is prohibited to make or allow unfair discrimination between persons of the same class and life expectancy in the rates charged or the terms, conditions, benefits, or dividends of a life insurance policy or an annuity. Differences based on sex are permitted it they can be substantiated by mortality data and other statistical information.

(g) **Advertising membership in the state's Guarantee Association.** Although membership in the California Insurance Guarantee Association is required for all insurers which offer the kinds of insurance protected by the Association, a member insurer may not advertise directly or indirectly that it is an Association member or that it is insured against insolvency.

(h) **Unfair claims practices.** The following unfair claims practices are prohibited:

1) Misrepresenting to claimants any pertinent facts or policy provisions which relate to the coverage at issue.
2) Failing to acknowledge and act reasonably promptly on communications relative to policy claims.
3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims.
4) Failing to affirm or deny coverage within a reasonable time after proof of loss statements have been completed and submitted.
5) Failing to make prompt, fair, and equitable settlement of claims where the company's liability has become reasonably clear.
6) Requiring claimants to sue to recover amounts due under a policy by offering substantially less than the amounts ultimately recovered in lawsuits brought by insureds, when insureds have made claims for amounts similar to those ultimately recovered.

7) Trying to settle a claim for less than a reasonable person would expect to receive by referring to printed advertising material accompanying or made part of the application.
8) Trying to settle a claim on the basis of an application which was altered without the knowledge and consent of the insured.
9) After payment of a claim, failing to inform insureds or beneficiaries of the coverage under which payment was made, when such information has been requested by them.
10) Telling an insured or claimant that the insurer will appeal any judgment in favor of the claimant or insured in order to get him to accept less than the amount awarded in arbitration.
11) Delaying an investigation or settlement of a claim by requiring the insured, claimant, and/or physician to file a preliminary claim report, then making them file formal claim papers which contain substantially the same information.
12) Failing to settle claims promptly where liability is clear under one section of the policy in order to influence settlement under another section of the policy.
13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy for denying a claim or offering a compromise settlement.
14) Directly advising a claimant not to obtain the services of an attorney.
15) Misleading a claimant about the applicable statute of limitations.
16) Delaying the payment of or providing hospital, medical, or surgical benefits for services rendered for AIDS for more than 60 days after the insurer has received a claim in order to investigate and determine if the claim was for a pre-existing condition. Time spent waiting for information from an attending physician or other health care provider is not counted in this 60-day period.

Any person who engages in any unfair method of competition or any unfair or deceptive act or practice is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act.

If any person violates a cease and desist order or an order of the court, after it has become final and while it remains in effect, the commissioner may call a hearing to determine whether such violation has occurred. If it is determined that a violation was committed, the commissioner may order the person to pay either (1) a fine up to $5,000 if the violation is not found to be willful plus the amount of any outstanding penalty for violating the code or (2) a fine of up to $55,000 if the violation

is found to be willful plus the amount of any outstanding penalty for violating the code. For any subsequent violation of a cease and desist order, court order, or order to pay a penalty, the commissioner may, after a hearing, suspend or revoke the person's license or Certificate of Authority for a period of up to one year.

The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in the state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by the code. The powers vested in the commissioner in this section of the code are in additional to any other powers to enforce any penalties, fines or forfeitures, denials, suspensions or revocations of licenses or certificates authorized by law with respect to the methods, acts and practices herebv declared to be unfair or deceptive.

(i) **Advertising insurance that the insurer will not sell.** It is an $10,000. This section does not apply to an insurer which refuses to sell a policy on the basis of its underwriting guidelines. This section does not apply to advertisements by an insurer where the ads are broadcasted (TV, radio) and originate from outside the state.

Cancellation, lapse, renewal, and non-renewal:

Cancellation is the termination of coverage by an insurer during a policy period. It does not mean the termination of the contract at the request of the policyholder.

Lapse refers to policy termination due to non-payment of the premium by the policyholder. A policy will lapse at the end of the grace period, which is a period of time after the premium due date, during which the policy remains in force without penalty.

Renewal refers to continued coverage under the policy for an additional period of time upon expiration of the current policy period.

Non-renewal refers to the giving of notice by the insurer to the policyholder that the insurer is unwilling to renew a policy.

Life policies are incontestable after being in force for two years. After this period of time, the insurer can cancel only for non-payment. Some term contracts are written as renewable which means the policyholder has the right to renew without proof of insurability, but premiums can be adjusted.

Disability contracts may be cancelled for non-payment and on the grounds of fraud on the part of the insured. Disability contracts can be written as non-

renewable/cancelable, optionally renewable, conditionally renewable, guaranteed renewable, or non-cancelable.

Insurance Information and Privacy Protection Act (IPPA): (CIC 791-791.26) The purpose of this article is to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance-support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

Notice of information practices: An insurance company or agent must provide a notice of information practices to all applicants or policyholders (1) when the policy is delivered if the only information to be used is collected from the applicant, insured or public records or (2) at the time of application if personal information will be collected from any source other than the applicant, insured or public records.

The notice must be in writing and must state:

1. Whether personal information may be collected from persons other than the applicant proposed for coverage.
2. The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect the information.
3. The circumstances under which the disclosures may be made without prior authorization.
4. A description of the applicant's rights and the manner in which those rights may be exercised.
5. That information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

An acknowledgment that the company's information practices have been disclosed must be signed by the applicant and submitted with the application. Further, an insurance institution or agent must clearly specify questions on an application designed to obtain information solely for marketing or research purposes.

Disclosure authorizations are forms or statements with which a person authorizes personal or confidential information about him to be disclosed. This authorization must:

1. Be written in plain language.
2. Be dated.
3. Specify the types of persons authorized to disclose information (i.e. friends, neighbors, employer).
4. Specify the nature of the information authorized to be disclosed (habits, personal traits).
5. Name the insurance institution or agent to whom the individual authorizes information to be disclosed.
6. Specify the purposes for which the information is collected (e.g. to underwrite an application for insurance).
7. Specify the length of time for which the disclosure authorization is valid. The maximum length of time for life, health or disability insurance is 30 months and one year for property and casualty insurance.
8. Advise the individual that he is entitled to receive a copy of the authorization form.
9. This section shall not be construed to require any authorization for the receipt of personal or privileged information about an individual.

Corrections in reports may be requested by individuals. An individual may request that the information be corrected, amended, or deleted. The individual must provide the facts to support the request. Within 30 days of receiving the request, the insurance company, agent, or insurance support organization must (1) correct, amend or delete the portion of record information in dispute or (2) notify the individual that it will not make the alteration in the record, giving the reasons for that refusal and notify the individual of his right to file a statement.

Penalties: The commissioner has the right to examine and investigate every insurance organization or agent doing business in the state to determine if the privacy laws have been violated. If the commissioner has reason to believe that the law is being violated, he may serve notice and conduct a hearing into the allegation. An insurance support organization transacting business outside of the state, which has an effect on a person residing in California, is deemed to have appointed the commissioner to accept service of process on its behalf, provided that the commissioner sends a copy of the service by registered mail to the insurance support organization.

After a hearing, the commissioner must put his findings in writing and can issue a cease and desist order if he finds the law has been broken. If the person violates the cease and desist order, the commissioner can impose a fine of up to $10,000 for each violation. If the violations occur with such frequency that they clearly are a general business practice, the fine can be up to $50,000. If a

company or agent knew or should have known that the rules were being violated, the commissioner also may suspend or revoke the company's certificate of authority or the agent's license.

Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent, or insurance support organization under false pretenses can be fined up to $10,000 or imprisoned for up to one year, or both.

Gramm-Leach-Bliley Act: The Financial Modernization Act of 1999, know as the "Gramm-Leach-Bliley Act" or GLB Act, has provisions to protect consumers' personal financial information held by financial institutions. There are three main parts to the privacy requirements. They are (1) the Financial Privacy Rule, (2) Safeguard Rule, and (3) pretexting provisions.

The Financial Privacy Rule governs the collection and disclosure of customers' personal financial information by financial institutions and other companies who receive such information. Customers are entitled to receive a privacy notice every year. The notice must be given to the customers or consumers by mail or in person. The privacy notice must be a clear, conspicuous, and accurate statement of the company's privacy practices. It should include what information the company collects about its consumers or customers, with whom the information is shared, and how it safeguards the information. The notice applies to the "nonpublic personal information" the company gathers and discloses about it customers and consumers. Customers and consumers have the right to "opt out" of having their information shared with certain third parties. The GLB Act does not give consumers the right to opt out when the financial institution shares other information with its affiliates.

The Safeguards Rule requires all financial institutions to design, implement, and maintain safeguards to protect customer information. This rule applies not only to financial institutions that collect information from their own customers, but it also applies to financial institutions such as credit reporting agencies that receive customer information from other financial institutions.

The pretexting provision prohibits the practice of obtaining customer information from financial institutions under false pretenses. A pretext interview is an interview whereby a person, in an effort to get confidential information about another person: (1) pretends to be someone he is not; (2) pretends to represent a person he is not in fact representing; (3) misrepresents the true purpose of the interview; or (4) refuses to identify himself upon request. Pretext interviews may not be used by anyone engaged in the business of insurance except when investigating claims where there is a reasonable basis for suspecting fraud, criminal activity, material misrepresentation or non-disclosure.

California Financial Information Privacy Act (SB1 or California Financial Code 4050): The intent of this act is to afford greater privacy protections than those

provided by the GLBA (Gramm-Leach-Bliley Act). It unites the federal GLBA with the Insurance Information Privacy and Protection Act (IPPA) contained in the insurance code. Enacted in 2003, Cal-GLBA's biggest impact is the required implementation of greater "opt-out/opt-in" choices with enhanced privacy requirements. The following is a comparison of the California law (Cal-GLBA) and the federal law (GLBA).

Provision	**Cal-GLBA**	**GLBA**
Selling or sharing information with outside company	Opt-In	Opt-Out
Selling or sharing with affiliates and subsidiaries	Opt-Out	No-Opt
Sharing between 2 financial institutions jointly offering a financial product	Opt-Out	No-Opt
Sharing to complete a transaction	No-Opt	No-Opt
Clear & readable consumer form?	Yes	No

Legend:
Opt-In=Company must receive consumer permission first.
Opt-Out=Consumers can stop sharing if they object.
No-Opt=Consumers cannot stop the sharing

Health Insurance Portability and Accountability Act (HIPAA): HIPAA was enacted in 1996 and affects almost all healthcare providers. This law defines that the information in client files belongs to the client and must be protected. HIPAA has made sweeping changes in the way that medical information is handled and protected.

HIPAA, in general, is designed to make health coverage more portable for individuals who change jobs or health plans by limiting the coverage exclusions that can be imposed when such a change occurs. Employers who provide health insurance for their employees are required to offer full health care coverage immediately to newly hired employees if they previously had "creditable" coverage for 12 straight months with no lapse in coverage of 63 days or more. If an individual did not have creditable coverage, the new insurer can refuse to pay for any pre-existing conditions for 12 months. However, the individual may reduce the exclusion period if he/she had group health plan coverage or health insurance prior to enrolling in the plan. HIPAA allows an individual to reduce the exclusion period by the amount of time that he/she had creditable coverage prior to enrolling in the plan and after any "significant breaks" in coverage. If the enrollee had creditable coverage for the last eight months, there would only be a four-month exclusion period. Late enrollees in group health plans might have to wait up to 18 months for coverage for pre-existing conditions.

When someone leaves a health plan, he/she should get a "certificate of creditable coverage". The certificate should list the following: coverage dates; policy ID number; insurer's name and address; and insured's name as well as any family members included under the coverage. When an entire business changes health insurance carriers, certificates of creditable coverage are not necessary as the new health insurance is issued with full **take-over benefits** for all eligible members enrolled on the date that the new insurance starts. This means all pre-existing conditions are covered immediately by the new insurance policy.

HIPAA's rules apply to every employer group health plan that has at least two participants that are current employees, including companies that are self-insured. The law prohibits group health plans and health insurers from discriminating against individuals with regard to eligibility, premiums, or contributions based on any health status related factor (e.g. a plan may not require an individual to pay a premium greater than do similarly situated individuals enrolled on the basis of any health status related factor). HIPAA's rules provide no protection if a person switches from one individual health plan to another individual health plan.

Fiduciary responsibilities: (CIC 1733-1735) A fiduciary is a person who is in a position of financial trust.

1. All funds received by a person who holds any kind of insurance license as agent, broker, or solicitor are received and held by that person in a fiduciary capacity (position of trust). Anyone who diverts or appropriates fiduciary funds for his own use is guilty of theft, which is punishable under criminal law.

   Premiums advanced by a premium financer under terms of a finance agreement are fiduciary funds only if they are received by a person who holds a license.

2. A licensed person who receives fiduciary funds (a) must remit premiums, minus commissions, and any return premiums received or held by him/her to the insurer or entity entitled to get them or (b) must maintain the fiduciary funds on California business in a trustee bank account or depository in California separate from any other account, in an amount at least equal to the premiums and return premiums, less commissions, received by him which have not yet been paid to the persons entitled to them.
   The person may commingle additional funds with fiduciary funds as he may deem prudent for the purpose of advancing premiums, establishing reserves to pay return commissions, or contingencies as may arise in his business of receiving and transmitting premium or return premiums.

3. Fiduciary funds which have not yet been remitted and which are not held in a trust account can be invested in the following instruments:

    - U.S. government bonds and treasury certificates or other obligations backed by the federal government.
    - Certificates of deposit of banks and savings and loan associations licensed by the federal government or any state government.
    - Repurchase agreements collateralized by U.S. government securities.

4. As a condition to maintaining the funds in one of the investment accounts, a written agreement must be obtained from each and every insurer or person entitled to the funds authorizing the maintenance and retention of earnings which accrue on the funds.

5. Evidence of the funds must be maintained on California business by a bank or savings and loan association in a trust account separate from any other account or depository in an amount at least equal to the premiums and return premiums, minus commissions, which have not yet been paid to the insurer or entity entitled to them. The commissioner shall not have jurisdiction over any disputes arising between parties concerning the maintenance of fiduciary funds.

6. A managing general agent must comply with all regulations concerning deposit, maintenance, and remittance of fiduciary funds. A managing general agent is a licensed property and casualty broker/agent or life-only and/or accident and health agent who has a written contract with one or more admitted insurers to manage the production of its business in a designated territory in California. A managing general agent:
    - Hires, supervises, and fire agents.
    - Accepts or declines risks.
    - Collects premiums from producing broker/agents and remits them to insurers under an account current system.
7. A property and casualty broker/agent, personal lines broker/agent, or surplus lines broker can deduct any return premiums due an insured from unpaid premiums the insured owes on the same or any other policy. An insurer may pay return premiums to a fire and casualty broker/agent for this purpose.

Fraudulent claims: It is against the law for a person to knowingly:

- Present a false or fraudulent claim for payment of a loss.
- Present multiple claims for the same loss or injury, including claims to more than one insurer, with intent to defraud.
- Cause or participate in a vehicle collision or other vehicular accident.

- Present a false or fraudulent claim for a loss due to theft, destruction, damage, or conversion of a motor vehicle, motor vehicle part, or motor vehicle contents.
- Prepare, make or subscribe any writing to support a false or fraudulent claim.
- Assist, abet, solicit, or conspire with any person who knowingly commits any of these violations.
- Make a false or fraudulent claim for payment of a health care benefit.
- Submit a claim for a health care benefit which was not used by the claimant.
- Present multiple claims for payment of the same health care benefit with intent to defraud.
- Present for payment any undercharges for health care benefits on behalf of a claimant unless known overcharges for health care benefits for that claimant are presented for reconciliation at the same time. (CIC 1871.4)

A violator can be imprisoned for up to one year in county jail, or 2, 3, or 5 years in state prison and/or be fined up to $150,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine. If the violator has a prior felony conviction for the same offense, there shall be an additional two year sentence for each previous conviction. Additional criminal charges also may be imposed.

An insurer's claim form must carry the statement: "For your protection, California law requires the following to appear on this form" (or similar wording) followed by "A person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison". (CIC 1871.2) The person may be found guilty of perjury.

The California legislature is aware that the business of insurance involves many transactions that have potential for abuse and illegal activities. Many law enforcement agencies at the state and local levels are responsible for investigating and prosecuting fraudulent activities. Every insurer admitted to do business in this state shall maintain a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds (CIC 1875.20) Insurers and their agents shall have access to all relevant public records that are required to be open for inspection when they are investigating suspected fraudulent claims. (1871.1)

Fraudulent claims harm everyone as they add to an insurer's overall claims experience. This might skew the actuarial projections of the insurer. To make up for these losses, an insurer will need to increase premiums which is an expense that will be borne by all policyholders. (CIC 1871)

There is a Bureau of Fraudulent Claims within the Department of Insurance. It was created to enforce the provisions prohibiting fraudulent claims and to enforce related sections of the Penal Code. (CIC 1872) To help prevent fraud,

there is the National Automobile Theft Bureau. Every insurer is required to report private passenger automobiles involved in theft and salvage total losses. (CIC 1874.6)

Before settling a claim involving vehicle theft, the insurer shall secure a claim form from the insured that includes a warning that false representations on the form subjects the insured to the penalty of perjury, a detailed description of the insured vehicle, the purchase location of the insured vehicle, purchase date and name of seller, a detailed statement of the circumstances surrounding the theft, and the insured's current driver's license number. The insured must sign the claim form in the presence of the insurance agent, broker, or adjuster, or other claims representative who must verify the insured's driver's license number, or submit a notarized claim form, and the claim form shall be signed under penalty of perjury. The insurer must retain for three years all settlement checks in settling an auto theft, the original claim form, and a legible copy of the police report. (1871.3)

The Arson Information Reporting System permits insurers, law enforcement agencies, fire investigative agencies, and district attorneys to deposit arson case information in a common database within the Department of Justice. The purpose of this database is to identify utilization patterns by individual claimants and methods of operation of individuals, groups, or businesses engaged in the commission of arson and to prevent the perpetration of insurance fraud by arson. (CIC 1875.8)

When an insurer knows or reasonably believes it knows the identity of a person whom it has reason to think committed a fraudulent act relating to a worker's compensation insurance claim and believes it has not been reported to an authorized governmental agency, the insurer or its agent shall notify the local district attorney's office and the Bureau of Fraudulent Claims of the Department of Insurance. The insurer must state in its notice the basis of its knowledge or reasonable belief. (CIC 1877.3(b)(1)

The commissioner may license an organization as an insurance claims analysis bureau provided it meets the necessary requirements. The commissioner shall license an insurance claims analysis bureau by class of claims for the following classes of insurance:

- Automobile bodily injury
- Automobile physical damage
- Automobile theft
- Fire and allied lines property damage
- General liability bodily injury
- Disability
- Life
- Workers' compensation (CIC 1875.13)

An insurance claims analysis bureau shall perform the following functions:

- Collect and compile information and data from members or subscribers concerning insurance claims.
- Disseminate information to members or subscribers relating to insurance claims for the purpose of preventing and suppressing insurance fraud.
- Promote training and education to further insurer investigation, suppression, and prosecution of insurance fraud.
- Provide, without a fee or charge, to the commissioner, all California data and information contained in the records of the insurance claims analysis bureau in furtherance of the prevention and prosecution of insurance fraud. (CIC 1875.14)

Every insurer admitted to do business in this state shall maintain a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds. (CIC 1875.20)

Civil liability: (1872.5) No insurer or the insurer's employees, or agents, can be sued for libel, slander, or any other relevant cause of tort action for providing, without malice, any of the following:

- Any information or reports relating to suspected fraudulent insurance transaction furnished to law enforcement officials or licensing officials governed by the Business and Professions Code.
- Any reports or information relating to suspected fraudulent insurance transactions furnished to other persons subject to this ruling.
- Any information or reports required by the code or the commissioner under the authority granted by the code.

File and Record Documentation: (Title 10, CCR 2695.3)

Every licensee's claim files shall be subject to examination by the commissioner. These files shall contain all documents, notes and work papers (including copies of all correspondence) that reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined.

To assist in such examination all insurers shall:

1. Maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of claim, date of acceptance, denial or date closed without payment. This data must be available for all open and closed files for the current year and the four preceding years.

2. Record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file.

3. Maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, non-existence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with these rules continue to exist.

Duties upon Receipt of Communications: (Title 10. CCR 2695.5)

Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than 21 calendar day of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts known by the licensee. The response is to address all inquiries made by the Department of Insurance and include copies of any documentation and claim files requested.

When a licensee receives any communication from a claimant where a response is expected, the licensee shall immediately, but in no event more than 15 calendar days, furnish the claimant with a complete response based on the facts known by the licensee.

The person authorized to represent the claimant shall be stated in writing and signed and dated by the claimant. A claimant may revoke such a designation by writing the insurer to this effect.

Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer. Upon receipt of notice of claim, every insurer shall immediately, but in no event more than 15 calendar days later, (1) acknowledge receipt of such notice of claim unless payment has already been made; (2) provide to the claimant necessary forms, instructions, and reasonable assistance; and (3) begin any necessary investigation of the claim. An insurer cannot require that the notice of claim be provided in writing unless such requirement is specified in the insurance policy or an endorsement. If the acknowledge is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated.

Fair Claims Settlement Practices Regulations:

Definitions:

Claimant: Any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant: an insurance adjuster, a public adjuster, or any member of the claimant's family. (Title 10, CCR 2695.2(c)

Notice of Legal Action: Notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding. (Title 10, CCR 2695.2(o)

Proof of Claim: Any documentation in the claimant's possession submitted to the insurer that provides any evidence of the claim and that supports the magnitude or the amount of the claimed loss. (Title 10, CCR 2695.2(s)

Standards for Prompt, Fair and Equitable Settlements: (Title 10, CCR 2695.7)

No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured. (Title 10, CCR 2695.7(a) Upon receiving proof of claim every insurer shall immediately, but in no event more than 40 calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety. This time frame does not apply to disability insurance, disability income insurance, mortgage guaranty insurance, or automobile repair bills arising from collision and comprehensive claims. (Title 10, CCR 2695.7(b)

When an insurer denies or rejects an insured's claim, in whole or in part, it must do so in writing and contain the bases for such rejection or denial. If a claimant believes that a claim has been wrongfully denied or rejected, he/she may have the matter reviewed by the California Department of Insurance and the insurer must inform the claimant of this fact as well as providing address and telephone of the unit of the Department that reviews claim practices.

If more time is required than the allotted 40 days to determine whether a claim should be accepted or denied, every insurer shall provide the claimant with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every 30

calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made. An insurer does have to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim. (Title 10, CCR 2695.7(c)

No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

1. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim.
2. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available.
3. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages.
4. The extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits.
5. The procedures used by the insurer in determining the dollar amount of property damage.
6. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter.
7. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim. (Title 10, CCR 2695.7(g)

Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer shall immediately, but in no event more then 30 calendar days later, tender payment or otherwise take action to perform its claim obligation. In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more the 30 calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. These time frames do not apply to disability insurance, disability income insurance, mortgage guaranty insurance, automobile repair bills arising from collision and comprehensive insurance, and title insurance. (Title 10, CCR 2695.7(h) No insurer shall inform a claimant that his/her right may be lost if a form or release is not completed within a specified time period unless the information is given to advise the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the Department of Insurance regarding the handling of a claim as a condition to the settlement of any claim.

ERRORS AND OMISSIONS INSURANCE

Insurance agents can be held legally liable for the consequences of any errors or omissions they have made while conducting their business. For this reason, insurance agents need to carry professional liability insurance which is called errors and omissions insurance (E&O). E&O insurance provides coverage for an act, error, or omission the agent makes in rendering or failing to render professional services in the conduct of his/her insurance profession.

E&O insurance does not offer protection from intentional acts, criminal acts, liability assumed under contract, or bodily and personal injury. Apart from this, E&O policies have few exclusions. Although there is no standard E&O policy, there are certain characteristics that they do have. These policies normally have high deductibles—usually $1,000 or more. Coverage normally is written on a limit per claim basis, but aggregate limits for all claims during the policy period are available. Limits of coverage commonly range from $100,000 to several million dollars.

The insurance company providing E&O coverage will provide a defense for the agent even if the charge is frivolous.

SOLVENCY

Definitions:

Insolvency means any impairment of minimum “paid-in capital” required of an insurer for the class(es) of insurance which it transacts. An insurer cannot escape the condition of insolvency by being able to provide for all its liabilities and for reinsurance of all outstanding risks. An insurer must also be possessed of additional assets equivalent to such aggregate “paid-in capital” required by the code after making provision for all such liabilities and for such reinsurance. (CIC 985)

Paid-in capital is capital received from investors in exchange for stock as distinguished from capital generated from earnings or donated. According to the code, a foreign mutual insurer must have the value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks plus its paid-in capital must be composed of available cash assets amounting to at least $200,000. In the case of other insurers, they must possess the lower of the following amounts:

(1) The value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks.

(2) The aggregate par value of its issued shares of stock, including treasury shares. (CIC 36)

Conservation means the commissioner thinks an insurer can be saved from insolvency. The commissioner may apply to the superior court of the county in which the insurer has its principal office and become the conservator of the business. The commissioner will take over the insurer's assets, property, books, and records and run the business. The following are grounds for the commissioner to take over an insurer:

a. The company has refused to submit books, papers, or accounts to the commissioner for inspection.
b. The company has neglected or refused a commissioner's order to make good any deficiency in its capital (stock company) or reserve (mutual company).
c. Without getting the commissioner's written consent, the company transfers or tries to transfer all its property or business to another person or consolidates its property and assets with another business.
d. After an examination by the commissioner, the company is found to be in such bad financial condition that continuing to conduct its business is hazardous to the public, creditors, or policyholders.
e. The business entity has violated its charter or state law.
f. Any officer of the business refuses to be examined under oath about the company's affairs.
g. An officer or attorney in fact has wrongfully diverted or embezzled any of the company's assets.
h. A domestic insurer does not comply with the state's requirements for a certificate of authority or that the company's certificate has been revoke.
i. The insurer was found to be insolvent at its last examination by the insurance department. (CIC 1011)

Whenever the above conditions exist or it appears that irreparable loss and injury to property or business may occur, the commissioner, without notice and before applying to the court for any order, shall take possession of the property, business, books, records and accounts and of the offices and premises occupied for the transaction of business and retain possession subject to the order of the court. Any person having possession of and refusing to deliver any of the books, records or assets of a person against whom a seizure order has been issued, shall be guilty of a misdemeanor and punishable by fine not exceeding one thousand dollars or imprisonment not exceeding one year, or both such fine and imprisonment. (CIC 1013)

Liquidation means the commissioner feels it would be futile to proceed as conservator of the insurer and applies to the court for an order to liquidate and wind up the business of the insurer. (CIC 1016)

California Life and Health Insurance Guarantee Association (CIC 1067-1067.18)

The purpose of the California Life and Health Insurance Guarantee Association is to protect policyowners, insureds, and beneficiaries against loss when a member company is financially impaired and cannot pay its contractual obligations under life insurance, health insurance, and annuity contracts. To provide this protection, an association of insurers is created to pay benefits and members of the association are subject to assessment to provide funds. (CIC 1067.01) All admitted life and health insurers are obligated to join this association. The association is managed by a board of directors and shall consist of not less than 9 nor more than 13 member insurers. The members of the board shall be selected by member insurers and approved by the commissioner. (CIC 1067.06)

The protection of the association extends to persons who are owners of policies or certificate holders and who are residents of this state. The association also provides coverage to nonresidents if all of the following conditions are met: (1) the insurer that issued the policy is domiciled in this state; (2) the insurer never held a license or Certificate of Authority in the state in which the person resides; (3) the state in which the person resides has an association similar to the association that exists in California; and (4) the person is not eligible for coverage by the association in the state of residence. (CIC 1067.02(a)(1)

If an impaired member is a domestic company, the association may do one of the following after receiving the commissioner's approval:

1. Guarantee, assume or reinsure the impaired company's policies or contracts.
2. Provide monies, pledges, notes, guarantees or other means to ensure payment of an impaired insurer's obligations.
3. Loan money to the impaired company.

To provide funds to run the association, the association may assess the member insurers for the necessary amounts. If an insurer does not pay the assessment when due, it is subject to having its certificate of authority suspended or revoked by the commissioner.

The contracts covered by the guarantee association are direct, non-group life, health, annuity, and supplemental policies or contracts and certificates under direct group life, health, annuity, and supplemental policies and contracts. (CIC 1067.02(b)(1) Coverage is not provided for:

- Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policyholder.
- Any policy or contract of reinsurance, unless assumption certificates have been issued.
- Any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds statutory limitations.
- Guaranteed investment contracts, guaranteed interest contracts, funding agreements, deposit administration contracts, and all other unallocated annuity contracts.
- Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured.
- Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policyholder, in connection with the service to or administration of the policy or contract.
- Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a Certificate of Authority to issue the policy or contract in the state.
- Any annuity issued by a charitable organization that is duly qualified as such under applicable provisions of the Internal Revenue Code, and that is not engaged in the business of insurance as its primary business. (CIC 1067.02(b)(2)

The benefits that the association may be liable to pay for any one life may not exceed the lesser of:

1. 80% of contractual obligations (subject to certain limitations);
2. $250,000 in life insurance death benefits, but no more than $100,000 in net cash surrender value for life insurance;
3. $100,000 in the present value of annuity benefits, including net cash surrender values.

There is a maximum aggregate amount of $250,000 with respect to any one individual for which the association will assume liability.

With respect to any one owner of multiple policies of individual life insurance, whether the policy owner is an individual, firm, corporation, or other legal entity, and whether the persons insured are officers, employees, or other persons in whose lives the policy owner has an insurable interest, the maximum benefit is $5,000,000 regardless of the number of the policies and contracts held by the owner.

The health insurance benefits for which the association may become liable shall in no event exceed the lesser of the following:

1. The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not impaired or insolvent.
2. With respect to any one individual, regardless of the number of contracts, $200,000 in health insurance benefits. This amount shall increase or decrease based upon changes in the health care cost component of the consumer price index from January 1, 1991 to the date on which the insurer becomes insolvent.

California Insurance Guarantee Association

Insurers selling fire, marine, plate glass, liability, workers' compensation, common carrier liability, boiler and machinery, burglary, sprinkler, team and vehicle, automobile, aircraft and miscellaneous insurance in California must belong to the California Insurance Guarantee Association. This includes nearly all types of property and casualty insurance except the ocean marine portion of marine insurance, reinsurance, or fraternal fire insurance. (CIC 1063)

The purpose of the association is to protect the interests of policyholders and beneficiaries against loss because an insolvent insurer is unable to pays its contractual obligations under property and casualty insurance policies. The association is managed by a board of nine member insurers who are appointed by the commissioner. If a company becomes insolvent, each member company is assessed money on a percentage basis to pay contractual obligations of the insolvent insurer and necessary administrative expenses. The percentage for any one company is determined by dividing the company's premiums from that line of business in California by all premiums for that line of business in the state.

Covered claims (except in the case of workers' compensation claims) do not include claims of $100 or less, nor the first $100 of any claim that exceeds $100, nor the part of any claim that exceeds $500,000 or the policy limit of the contract.

DISCRIMINATORY PRACTICES

Certain property and liability insurance: (CIC 679.70) The prohibitions regarding discrimination apply to policies in California other than automobile and worker's compensation. They include insurance against loss or damage to residential real and personal property and coverage for the legal liability of a natural person. Most of these provisions also apply to life and disability insurance.

Failure or refusal to accept application: (CIC 679.71) Unless the insurance will be issued by another insurer under the same management and control, an insurance company cannot refuse to accept an application, issue a policy, or cancel a policy because of a person's marital status, sex, race, color, religion,

national origin, or ancestry. An insurer may not charge a higher premium for insurance because of any of these reasons.

Application or report carrying identification: (CIC 10141-10142) An application or investigative report furnished by an insurer to its agents or employees in the course of determining an applicant's insurability, cannot carry any identification as to the applicant's race, color, religion, national origin, or ancestry. If it is used only to identify the applicant and not as a basis for discrimination, the insurer may ask where an applicant was born.

Practices based on race or color: A licensed insurer may not refuse to accept an application, issue, or cancel insurance or charge a higher premium because of a person's race, color, religion, national origin, ancestry, or sexual orientation. In underwriting life and disability insurance, an insurer may not consider an applicant's sexual orientation or use marital status, living arrangements, occupation, gender, beneficiary designation, or zip codes to establish an applicant's sexual orientation or to decide if the applicant should be tested for HIV antibodies. The penalty for knowingly violating this provision can be a fine of $1,000 up to $5,000 plus court costs. (CIC 10140)

The insurance code requires strict confidentiality of personal information obtained through HIV testing and requires informed consent before any insurer tests for HIV. (CIC 799)

Genetic disability traits: (CIC 10143) An insurer may not refuse to issue, sell, or renew a life or disability policy solely because the person to be insured carries a gene which may cause a disability in the insured's children but which causes no ill effects to the carrier. Examples include sickle cell, Tay-Sachs, and X-linked hemophilia. An insurer may not charge an applicant a higher premium (individual or group) due to a person to be insured having these traits.

An insurer may not insert a condition or stipulation in a policy that the insured person with such a trait, his/her heirs, or beneficiaries must accept less than the full value of the policy in event of a claim. An insurer may not pay a lower commission to an agent or broker for selling or renewing life or disability policies on persons possessing these traits.

Physically or mentally impaired: (CIC 10144) An insurer who issues individual or group life, annuity, or disability policies may not refuse to insure, continue to insure, limit the amount or kind of coverage available, or charge a higher premium for the same coverage to a physically or mentally impaired person except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual and reasonably anticipated experience.

Physical or mental impairment means any physical, sensory, or mental impairment that substantially limits one or more of that person's major life activities.

Blindness or partial blindness: (CIC 10145) An insurer who issues individual or group life, annuity, or disability policies may not refuse to insure, continue to insure, limit the amount or kind of coverage available, or charge a higher premium for the same coverage because an applicant is blind or partially blind.

Special Concerns—Senior citizens

All insurers and licensees owe a prospective insured who is 65 years of age of older, a duty of honesty, good faith, and fair dealing.

Pretext Interviews

Pretext interviews are illegal. A pretext interview is when the interviewer does not reveal his true identity, pretends to be someone who he is not, or misrepresents the true purpose of the interview. The insurance industry does not want unscrupulous agents preying on senior citizens by selling them unnecessary policies or policies that are over-priced.

Pretext interviews are legal when conducted by insurance adjusters when there is sufficient evidence of fraud or material misrepresentation. (CIC 791.03)

Post Claims Underwriting

No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of post claims underwriting. Post claims underwriting means the rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate. (CIC 10384)

Insurers cannot legally refuse to pay a claim which is not excluded by the contract. As long as the applicant for insurance answered all questions on the application form truthfully, the insurer must cover the claim. Of course, if the applicant lied or concealed material information, the insurer would have the right to refuse coverage or to rescind the policy.

The applications for Medicare supplement insurance and long-term care insurance contain questions to elicit information concerning the applicant's health status. This is to make sure that there is not a problem in the future regarding his/her coverage.

REVIEW QUESTIONS

1. A life agent must maintain records regarding insurance transactions for how long?

   A. 1 year
   B. 2 years
   C. 3 years
   D. 5 years

2. When an insurer endorses, rejects, declines, cancels, or surrenders a policy, unearned premium must be returned to the insured or person entitled within:

   A. 10 days
   B. 15 days
   C. 25 days
   D. 30 days

3. Concealment entitles the injured party to rescind the contract under which conditions?

   A. When the concealed facts are material and intentional.
   B. When the concealed facts are material and unintentional
   C. When the concealed facts are material whether intentional or unintentional.
   D. Concealment is not grounds for rescinding a contract.

4. Neglect to communicate that which a person knows and ought to communicate is:

   A. A false representation
   B. Concealment
   C. A false warranty
   D. Twisting

5. An implied warranty is:

   A. A guarantee stated in a policy.
   B. Included in the policy in writing.
   C. Included in the policy but not specifically stated in it.
   D. Is not included in the policy.

6. If an insurer is approved to transact insurance in the state of California, it is considered to be:

   A. An admitted insurer
   B. A foreign insurer
   C. A domestic insurer
   D. A non-admitted insurer

7. Under normal circumstances, an agent may write insurance business for:

   A. Any insurer
   B. Admitted insurers
   C. Non-admitted insurers
   D. Any of the above

8. An exclusive agent may work for several insurance companies as long as those companies are admitted insurers.

   A. True
   B. False

9. A natural person employed by an agent/broker to aid in transacting insurance other than life and health insurance is an:

   A. Insurance agent
   B. Insurance broker
   C. Insurance solicitor
   D. None of the above

10. Which of the following best describes an insurance agent?

   A. One who is appointed by an insurer, transacts other than life and health insurance, receives commissions, and transacts on behalf of a client.
   B. One who is not appointed by anyone, transacts other than life and health insurance, receives commissions, and transacts on behalf of the insurer.
   C. One who is appointed by an insurer, transacts other than life and health insurance, receives either a broker's fee or a commission, and transacts on behalf of the insurer.
   D. One who is appointed by an insurer, transacts other than life and health insurance, receives commissions, and transacts on behalf of the insurer.

11. Transacting insurance includes:

A. Solicitation
B. Negotiation
C. Execution of a contract of insurance
D. All the above.

12. Which of the following names would the insurance commissioner not disapprove?

A. Bona fide natural name
B. True corporate name
C. True name
D. Fictitious name

13. What is true about insurance records kept by an agent or broker?

A. The commissioner may inspect any records after sending a 30-day prior notice.
B. The commissioner may inspect certain records at any time.
C. The commissioner may inspect certain records after sending a 30-day prior notice.
D. The commissioner may inspect any record at any time.

14. Which of the following may a licensee do with return premium on a canceled policy?

1. Hold in a fiduciary account.
2. Remit it to the policyholder immediately.

A. 1 only
B. 2 only
C. Both 1 & 2
D. None of the above

15. Which of the following persons cannot be insured?

A. An individual person
B. A corporation
C. A public enemy
D. An organization

16. The commissioner may deny a license, without a hearing, if the applicant has been convicted of a misdemeanor denounced by the insurance code.

A. True
B. False

17. The commissioner may deny a license if the applicant has had a previous application denied or had a previous license suspended or revoked for cause within _____ before the filing of the application.

A. 1 year
B. 3 years
C. 5 years
D. An indefinite amount of time

18. Under what circumstances would a license terminate?

A. The licensee surrenders the license for cancellation.
B. The death of the licensee.
C. The broker does not have the required bond in force.
D. All of the above.

19. Which of the following describes a pretext interview?

A. A person attempts to gather information by pretending to be someone he is not.
B. A person attempts to gather information by pretending to represent someone he does not represent.
C. A person attempts to gather information by misrepresenting the purpose of the interview.
D. All of the above.

20. A licensee misrepresents the financial condition of an insurer. This is an example of:

A. Twisting
B. Concealment
C. Unfair trade practice
D. None of the above

21. If a licensee violates any provision relating to twisting, concealment, or misrepresentation, he may be imprisoned for up to _____ months.

A. 6
B. 12
C. 18
D. 24

22. A person who makes a fraudulent claim or assists in making a fraudulent claim is guilty of a criminal act and may be imprisoned for how many years?

A. 2 years
B. 3 years
C. 5 years
D. Any of the above

23. An agent may advertise that his insurance company is a member of a Guarantee Association.

A. True
B. False

24. Which of the following is <u>not</u> an unfair trade practice?

A. Filing a false financial statement of an insurer's financial condition.
B. Discriminating between persons of the same class.
C. Informing a client of the statute of limitations.
D. Conspiring to commit an act of boycott.

25. Insurance licensees must put their license numbers on which of the following?

A. Business cards
B. Written quotations for insurance products
C. Printed advertisements
D. All the above