Chapter 26
Insurance Adjusters

Part 1
General Provisions

31A-26-101 Purposes.

The purposes of this chapter are:

(1) to promote the professional competence of those engaged in claims adjusting;
(2) to encourage fair and rapid settlement of claims;
(3) to protect claimants under insurance policies from unfair claims adjustment practices;
(4) to prevent compensation arrangements for insurance adjusters that endanger the fairness of claim settlements; and
(5) to govern the qualifications and procedures for the licensing of insurance adjusters.

Amended by Chapter 116, 2001 General Session

31A-26-102 Definitions.

As used in this chapter, unless expressly provided otherwise:

(1) "Company adjuster" means a person employed by an insurer who negotiates or settles claims on behalf of the insurer or an affiliated insurer.
(2) "Designated home state" means the state or territory of the United States or the District of Columbia:
  (a) in which an insurance adjuster does not maintain the adjuster's principal:
    (i) place of residence; or
    (ii) place of business;
  (b) if the resident state, territory, or District of Columbia of the adjuster does not license adjusters for the line of authority sought, the adjuster has qualified for the license as if the person were a resident in the state, territory, or District of Columbia described in Subsection (2)(a), including an applicable:
    (i) examination requirement;
    (ii) fingerprint background check requirement; and
    (iii) continuing education requirement; and
  (c) that the adjuster has designated as the insurance adjuster's designated home state.
(3) "DOD civilian" means the same as that term is defined in Section 53B-8-102.
(4) "Home state" means:
  (a) a state or territory of the United States or the District of Columbia in which an insurance adjuster:
    (i) maintains the adjuster's principal:
      (A) place of residence; or
      (B) place of business; and
    (ii) is licensed to act as a resident adjuster; or
  (b) if the resident state, territory, or the District of Columbia described in Subsection (4)(a) does not license adjusters for the line of authority sought, a state, territory, or the District of Columbia:
    (i) in which the adjuster is licensed;
    (ii) in which the adjuster is in good standing; and

(iii) that the adjuster has designated as the adjuster's designated home state.
(5) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of one or more insurers.
(6) "Insurance adjusting" or "adjusting" means directing or conducting the investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
(7)
(a) "Organization" means a person other than a natural person.
(b) "Organization" includes a sole proprietorship by which a natural person does business under an assumed name.
(8) "Portable electronics insurance" means the same as that term is defined in Section 31A-22-1802.
(9) "Public adjuster" means a person required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants under insurance policies.

Amended by Chapter 438, 2025 General Session

31A-26-103 Workers' compensation claims.

In addition to being subject to this and other chapters of this title, insurers writing workers' compensation insurance in this state are subject to the Labor Commission with respect to claims for and payment of compensation and benefits.

Amended by Chapter 363, 2017 General Session

Part 2
Licensing and Registration of Insurance Adjusters

31A-26-201 Requirement of license.

(1) Except as provided in Subsection (2):
(a) a person may not perform, offer to perform, or solicit the opportunity to perform an act of insurance adjusting without a valid license under Section 31A-26-203; and
(b) a person may not use the insurance adjusting services of another if the person knows or should know that the one providing these services does not have a license as required by law.
(2) The following are exempt from the license requirement of Subsection (1), when acting in the indicated capacity:
(a) an individual engaged in insurance adjusting as a regular salaried employee of, and not an independent contractor for, an insurer;
(b) an arbitrator or an umpire selected by the claimant and insurer to decide, alone or with others, whether a claim should be paid and how much should be paid;
(c) an attorney at law acting in an attorney-client relationship;
(d) an insurance producer, but only as to:
(i) a class of insurance for which the insurance producer is licensed under Section 31A-23a-106; and
(ii) a claim adjusted on the request of an insurer for which the insurance producer is a producer;

(e) a regular salaried employee of, and not an independent contractor for, a policyholder or claimant under an insurance policy;
(f) an employee of a licensed insurance adjuster who provides only administrative or clerical assistance;
(g) an individual who does not do insurance adjusting under Section 31A-26-102, but who is specially employed to obtain facts about a loss for or furnish technical assistance to a licensed adjuster or a company adjuster, including:
(i) a photographer;
(ii) an estimator;
(iii) an appraiser;
(iv) a marine surveyor;
(v) a private detective;
(vi) an engineer; and
(vii) a handwriting expert;
(h) a holder of a group insurance policy, with respect to administrative activities in connection with that insurance policy, who receives no compensation for the policyholder's services beyond the actual expenses estimated on a reasonable basis;
(i) an individual engaged in insurance adjusting as a regular salaried employee of, and not an independent contractor for, an administrator licensed under Chapter 25, Third Party Administrators; or
(j) a person who gives advice or assistance without compensation or expectation of compensation, direct or indirect.
(3) A claim settlement between an insurer and an insured or a claimant under an insurance policy may not be considered invalid as a result of a violation of this section.

Amended by Chapter 10, 2010 General Session

31A-26-202 Application for license.
(1)
(a) The application for a license as an independent adjuster or public adjuster shall be:
(i) made to the commissioner on forms and in a manner the commissioner requires; and
(ii) except as provided in Subsection (4), accompanied by the applicable fee, which is not refunded if the application is denied.
(b) The application shall provide:
(i) information about the applicant's identity, including:
(A) the applicant's:
(I) Social Security number; or
(II) federal employer identification number;
(B) the applicant's personal history, experience, education, and business record;
(C) if the applicant is a natural person, whether the applicant is 18 years old or older; and
(D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-26-213; and
(ii) any other information as the commissioner reasonably requires.
(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.
(3) An applicant's Social Security number contained in an application filed under this section is a private record under Section 63G-2-302.
(4) The following individuals are exempt from paying a license fee:

(a) an individual serving in the armed forces of the United States while the individual is stationed within this state, if:
(i) the individual holds a valid license to practice the regulated occupation or profession issued by any other state or jurisdiction recognized by the department; and
(ii) the license is current and the individual is in good standing in the state or jurisdiction of licensure; and
(b) the spouse of an individual serving in the armed forces of the United States or the spouse of a DOD civilian while the individual or DOD civilian is stationed within this state, if:
(i) the spouse holds a valid license to practice the regulated occupation or profession issued by any other state or jurisdiction recognized by the department; and
(ii) the license is current and the spouse is in good standing in the state or jurisdiction of licensure.

Amended by Chapter 175, 2025 General Session
Amended by Chapter 438, 2025 General Session

31A-26-203 Adjuster's license required.
(1) The commissioner shall issue a license to act as an independent adjuster or public adjuster to a person who, as to the license classification applied for under Section 31A-26-204:
(a) satisfies the character requirements under Section 31A-26-205;
(b) satisfies the applicable continuing education requirements under Section 31A-26-206;
(c) satisfies the applicable examination requirements under Section 31A-26-207;
(d) has not committed an act that is a ground for denial, suspension, or revocation provided for in Section 31A-26-213;
(e) if a nonresident, complies with Section 31A-26-208; and
(f) pays the applicable fees under Section 31A-3-103.
(2)
(a) This Subsection (2) applies to the following persons:
(i) an applicant for:
(A) an independent adjuster's license; or
(B) a public adjuster's license;
(ii) a licensed independent adjuster; or
(iii) a licensed public adjuster.
(b) A person described in Subsection (2)(a) shall report to the commissioner:
(i) an administrative action taken against the person, including a denial of a new or renewal license application:
(A) in another jurisdiction; or
(B) by another regulatory agency in this state; and
(ii) a criminal prosecution taken against the person in any jurisdiction.
(c) The report required by Subsection (2)(b) shall:
(i) be filed:
(A) at the time the person applies for an adjustor's license; and
(B) if an action or prosecution occurs on or after the day on which the person applies for an adjustor's license:
(I) for an administrative action, within 30 days of the final disposition of the administrative action; or
(II) for a criminal prosecution, within 30 days of the initial appearance before a court; and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

(3)

(a) The department may require a person applying for a license or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license or consent.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request concerning a person applying for an independent or public adjuster's license:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-26-205 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-26-205; and

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in the state.

(e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) The commissioner may deny a license application to act as an independent adjuster or public adjuster to a person who, as to the license classification applied for under Section 31A-26-204:

(a) fails to satisfy the requirements in this section; or

(b) commits an act that is a ground for denial, suspension, or revocation provided for in Section 31A-26-213.

(5) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance classification only with the concurrence of the Title and Escrow Commission; or

(b) renew a license for a title insurance classification only with the concurrence of the Title and Escrow Commission.

Amended by Chapter 253, 2012 General Session

31A-26-204 License classifications.

A resident or nonresident license issued under this chapter shall be issued under the classifications described under Subsections (1), (2), and (3). A classification describes the matters to be considered under a prerequisite education or examination required of license applicants under Sections 31A-26-206 and 31A-26-207.

(1) Independent adjuster license classifications include:
  (a) accident and health insurance, including related service insurance under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;
  (b) property and casualty insurance, including a surety or other bond;
  (c) crop insurance; and
  (d) workers' compensation insurance.

(2) Public adjuster license classifications include:
  (a) accident and health insurance, including related service insurance under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;
  (b) property and casualty insurance, including a surety or other bond;
  (c) crop insurance; and
  (d) workers' compensation insurance.

(3)
  (a) The commissioner may by rule:
    (i) recognize other independent adjuster or public adjuster license classifications as to other kinds of insurance not listed under Subsection (1); and
    (ii) create license classifications that grant only part of the authority arising under another license class.
  (b) Notwithstanding Subsection (3)(a), for purpose of title insurance, the Title and Escrow Commission may make the rules provided for in Subsection (3)(a), subject to Section 31A-2-404.

Amended by Chapter 349, 2009 General Session

31A-26-205 Character requirements.

Each applicant for a license under this chapter shall show to the commissioner that:

(1) the applicant has the good faith intent to engage in the type of business the license or licenses applied for would permit;

(2)
  (a) if a natural person, the applicant is:
    (i) competent; and
    (ii) trustworthy; or
  (b) if an organization, all the partners, directors, principal officers, or persons in fact having comparable powers are trustworthy, and that the applicant will transact business in such a way that all acts that may only be performed by a licensed adjuster are performed exclusively by natural persons who are licensed under this chapter to transact that business and listed on the organization's license under Section 31A-26-209; and

(3) if a natural person, the applicant is at least 18 years of age.

Amended by Chapter 319, 2018 General Session

31A-26-206 Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe continuing education requirements for each class of license under Section 31A-26-204.

(2)

(a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (2).

(b)

(i) Except as otherwise provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

(ii) A continuing education hour completed in accordance with Subsection (2)(b)(i) may be obtained through:

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) other methods provided by rule.

(iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d)

(i) A licensee is exempt from the continuing education requirements of this section if:

(A) the licensee was first licensed before December 31, 1982;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

(C) the licensee requests an exemption from the department; and

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (2)(b); and

(ii) authorize a professional adjuster association to:

(A) offer a qualified program for a classification of license on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a qualified program, subject to the review and approval of the commissioner.

(f)

(i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and administer a qualified program shall reasonably relate to the cost of administering the qualified program.

(ii) Nothing in this section shall prohibit a provider of a continuing education program or course from charging a fee for attendance at a course offered for continuing education credit.
(iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.
(3) The continuing education requirements of this section apply only to a licensee who is an individual.
(4) The continuing education requirements of this section do not apply to a member of the Utah State Bar.
(5) The commissioner shall designate a course that satisfies the requirements of this section, including a course presented by an insurer.
(6) A nonresident adjuster is considered to have satisfied this state's continuing education requirements if:
(a) the nonresident adjuster satisfies the nonresident home state's continuing education requirements for a licensed insurance adjuster; and
(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's continuing education requirements for an adjuster as satisfying the continuing education requirements of the home state.
(7) A licensee subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education requirement applies.

Amended by Chapter 32, 2020 General Session

31A-26-207 Examination requirements.
(1) The commissioner may require applicants for a particular class of license under Section 31A-26-204 to pass an examination as a requirement to receiving a license. The examination shall reasonably relate to the specific license class for which it is prescribed. The examinations may be administered by the commissioner or as specified by rule.
(2) The commissioner shall waive the requirement of an examination for a nonresident applicant who:
(a) applies for an insurance adjuster license in this state;
(b) has been licensed for the same line of authority in another state; and
(c)
(i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or
(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:
(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or
(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.
(3)
(a) To become a resident licensee in accordance with Sections 31A-26-202 and 31A-26-203, a person licensed as an insurance producer in another state who moves to this state shall make application within 90 days of establishing legal residence in this state.

(b) A person who becomes a resident licensee under Subsection (3)(a) may not be required to meet prelicensing education or examination requirements to obtain any line of authority previously held in the prior state unless:
(i) the prior state would require a prior resident of this state to meet the prior state's prelicensing education or examination requirements to become a resident licensee; or
(ii) the commissioner imposes the requirements by rule.
(4) The requirements of this section only apply to an applicant who is a natural person.
(5) The requirements of this section do not apply to:
(a) a member of the Utah State Bar; or
(b) an applicant for the crop insurance license class who has satisfactorily completed:
(i) a national crop adjuster program, as adopted by the commissioner by rule; or
(ii) the loss adjustment training curriculum and competency testing required by the Federal Crop Insurance Corporation Standard Reinsurance Agreement through the Risk Management Agency of the United States Department of Agriculture.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-26-208 Nonresident jurisdictional agreement.
(1)
(a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state or designated home state and the conditions of Subsection (1)(b) are met, the commissioner shall:
(i) waive any license requirement for a license under this chapter; and
(ii) issue the nonresident license applicant a nonresident adjuster's license.
(b) Subsection (1)(a) applies if:
(i) the nonresident license applicant:
(A) is licensed in the nonresident license applicant's home state or designated home state at the time the nonresident license applicant applies for a nonresident adjuster license;
(B) has submitted the proper request for licensure;
(C) has submitted to the commissioner:
(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state or designated home state; or
(II) a completed uniform application; and
(D) has paid the applicable fees under Section 31A-3-103;
(ii) the nonresident license applicant's license in the applicant's home state or designated home state is in good standing; and
(iii) the nonresident license applicant's home state or designated home state awards nonresident adjuster licenses to residents of this state on the same basis as this state awards licenses to residents of that home state or designated home state.
(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the commissioner and courts of this state on any matter related to the adjuster's insurance activities in this state, on the basis of:
(a) service of process under Sections 31A-2-309 and 31A-2-310; or
(b) other service authorized under the Utah Rules of Civil Procedure or Section 78B-3-206.
(3) The commissioner may verify an adjuster's licensing status through the database maintained by:
(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Amended by Chapter 319, 2018 General Session

31A-26-209 Form and contents of license.

(1) Licenses issued under this chapter shall be in the form the commissioner prescribes and shall set forth:
(a) the name, address, and the one or more telephone numbers of the licensee;
(b) the license classifications under Section 31A-26-204;
(c) the date of license issuance; and
(d) any other information the commissioner considers advisable.

(2) An adjuster doing business under any other name than the adjuster's legal name shall notify the commissioner prior to using the assumed name in this state.

(3)
(a) An organization shall be licensed as an agency if the organization acts as:
(i) an independent adjuster; or
(ii) a public adjuster.
(b) The agency license issued under Subsection (3)(a) shall set forth the names of all natural persons licensed under this chapter who are authorized to act in those capacities for the organization in this state.

Amended by Chapter 168, 2017 General Session

31A-26-210 Reports from organizations licensed as adjusters.

(1) An organization licensed as an adjuster under Section 31A-26-203 shall designate an individual who has an individual adjuster license to act on the organization's behalf in order for the licensee to do business for the organization in this state.

(2) An organization licensed under this chapter shall report to the commissioner, at intervals and in the form the commissioner establishes by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:
(a) a new designation; and
(b) a terminated designation.

(3) An organization licensed under this chapter shall notify an individual licensee that the individual's designation has been terminated by the organization and of the reason for the termination at an interval and in the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4)
(a) An organization licensed under this chapter shall report to the commissioner the cause of termination of a designation if:
(i) the reason for termination is a reason described in Subsection 31A-26-213(5)(b); or
(ii) the organization has knowledge that the individual licensee is found to have engaged in an activity described in Subsection 31A-26-213(5)(b) by:
(A) a court;
(B) a government body; or

(C) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The information provided the commissioner under Subsection (4)(a) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(c) An organization is immune from civil action, civil penalty, or damages if the organization complies in good faith with this Subsection (4) in reporting to the commissioner the cause of termination of a designation.

(d) Notwithstanding any other provision in this section, an organization is not immune from an action or resulting penalty imposed on the reporting organization as a result of a proceeding brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection (4).

(5) An organization licensed under this chapter may act in a capacity for which it is licensed only through an individual who is licensed under this chapter to act in the same capacity.

(6) An organization licensed under this chapter shall designate and report promptly to the commissioner the name of the designated responsible licensed individual who has authority to act on behalf of the organization in all matters pertaining to compliance with this title and orders of the commissioner.

(7) If an agency has a contract with or designates a licensee in a report submitted under Subsection (2) or (6), there is a rebuttable presumption that the contracted or designated licensee acts on behalf of the agency.

(8)

(a) When a license is held by an organization, both the organization itself and an individual contracted or designated under the license shall, for purposes of this section, be considered to be the holders of the organization license.

(b) If an individual designated under the organization license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the organization license, the commissioner may assess a forfeiture against, suspend, revoke, or limit the license of, or take a combination of these actions against:

(i) that individual;

(ii) the organization, if the organization:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for assessing a forfeiture or suspending, revoking, or limiting the license; or

(iii)

(A) the individual; and

(B) the organization, if the organization meets the requirements of Subsection (8)(b)(ii).

Amended by Chapter 168, 2017 General Session

31A-26-211 Claims liaison.

Authorized insurers with employees engaged in insurance adjusting may be required by the commissioner to designate one or more natural persons to whom the commissioner or the commissioner's staff may direct inquiries concerning the insurer's claims adjustments. Insurers shall report to the commissioner the name, title, business address, telephone number of, and any changes in its designees under this section.

Amended by Chapter 302, 2025 General Session

31A-26-212 Emergency license.

In the event of a catastrophe or emergency which arises out of a disaster, act of God, riot, civil commotion, conflagration, or other similar occurrence, the commissioner shall, upon application, issue emergency licenses to persons who are not licensed adjusters. An emergency license shall be applied for within a week of beginning claims adjustment. It may remain in force for not more than 90 days, unless extended by the commissioner before it expires for an additional period of not more than 90 additional days. The insurer who contracts with an independent adjuster who is so licensed is responsible for all the independent adjuster's claims practices while so engaged, as if the independent adjuster were a regular salaried employee. The fee for an emergency license is the same as the fee required of other licensed adjusters, unless the commissioner waives the fee.

Amended by Chapter 302, 2025 General Session

31A-26-213 Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:
  (a) revoked or suspended under Subsection (5);
  (b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;
  (c) the licensee dies or is adjudicated incompetent as defined under:
    (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
    (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;
  (d) lapsed under Section 31A-26-214.5; or
  (e) voluntarily surrendered.
(2) The following may be reinstated within one year after the day on which the license is no longer in force:
  (a) a lapsed license; or
  (b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which it is voluntarily surrendered.
(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:
  (a) this title; or
  (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(4) A license classification issued under this chapter remains in force until:
  (a) the qualifications pertaining to a license classification are no longer met by the licensee; or
  (b) the supporting license type:
    (i) is revoked or suspended under Subsection (5); or
    (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action.
(5)
  (a) If the commissioner makes a finding under Subsection (5)(b) as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:
    (i) revoke:
      (A) a license; or
      (B) a license classification;

(ii) suspend for a specified period of 12 months or less:
(A) a license; or
(B) a license classification;
(iii) limit in whole or in part:
(A) a license; or
(B) a license classification;
(iv) deny a license application;
(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant:
(i) is unqualified for a license or license classification under Section 31A-26-202, 31A-26-203, 31A-26-204, or 31A-26-205;
(ii) has violated:
(A) an insurance statute;
(B) a rule that is valid under Subsection 31A-2-201(3); or
(C) an order that is valid under Subsection 31A-2-201(4);
(iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;
(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the judgment became final;
(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;
(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance adjuster that transacts business in this state without a license;
(vii) refuses:
(A) to be examined; or
(B) to produce its accounts, records, and files for examination;
(viii) has an officer who refuses to:
(A) give information with respect to the insurance adjuster's affairs; or
(B) perform any other legal obligation as to an examination;
(ix) provides information in the license application that is:
(A) incorrect;
(B) misleading;
(C) incomplete; or
(D) materially untrue;
(x) has violated an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;
(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;
(xiii) has intentionally misrepresented the terms of an actual or proposed:
(A) insurance contract; or
(B) application for insurance;
(xiv) has been convicted of, or has entered a plea in abeyance as defined in Section 77-2a-1 to:
(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;
(xvi) in the conduct of business in this state or elsewhere has:
(A) used fraudulent, coercive, or dishonest practices; or
(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
(xvii) has had an insurance license or other professional or occupational license or registration, or equivalent, denied, suspended, revoked, or surrendered to resolve an administrative action;
(xviii) has forged another's name to:
(A) an application for insurance; or
(B) a document related to an insurance transaction;
(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;
(xx) has knowingly accepted insurance business from an individual who is not licensed;
(xxi) has failed to comply with an administrative or court order imposing a child support obligation;
(xxii) has failed to:
(A) pay state income tax; or
(B) comply with an administrative or court order directing payment of state income tax;
(xxiii) has been convicted of a violation of the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent in accordance with 18 U.S.C. Sec. 1033 to engage in the business of insurance or participate in such business;
(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public; or
(xxv) has been convicted of any criminal felony involving dishonesty or breach of trust and has not obtained written consent in accordance with 18 U.S.C. Sec. 1033 to engage in the business of insurance or participate in such business.
(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.
(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:
(i) the individual;
(ii) the agency, if the agency:
(A) is reckless or negligent in its supervision of the individual; or
(B) knowingly participated in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or
(iii)
(A) the individual; and
(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
(6) A licensee under this chapter is subject to the penalties for conducting an insurance business without a license if:
(a) the licensee's license is:
(i) revoked;
(ii) suspended;
(iii) limited;
(iv) surrendered in lieu of administrative action;

(v) lapsed; or
(vi) voluntarily surrendered; and
(b) the licensee:
(i) continues to act as a licensee; or
(ii) violates the terms of the license limitation.
(7) A licensee under this chapter shall immediately report to the commissioner:
(a) a revocation, suspension, or limitation of the person's license in any other state, the District of Columbia, or a territory of the United States;
(b) the imposition of a disciplinary sanction imposed on that person by any other state, the District of Columbia, or a territory of the United States; or
(c) a judgment or injunction entered against that person on the basis of conduct involving:
(i) fraud;
(ii) deceit;
(iii) misrepresentation; or
(iv) a violation of an insurance law or rule.
(8)
(a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time not to exceed five years within which the former licensee may not apply for a new license.
(b) If no time is specified in the order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years without the express approval of the commissioner.
(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.
(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Amended by Chapter 194, 2023 General Session

31A-26-214 Probation -- Grounds for revocation.
(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:
(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-26-213; or
(b) at the issuance of a new license:
(i) with an admitted violation under 18 U.S.C. Sec. 1033; or
(ii) with a response to a background information question on any new license application indicating that:
(A) the person has been convicted of a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;
(B) the person is currently charged with a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication was withheld;
(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may put a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to violations under 18 U.S.C. Sec. 1033.

(3) A probation order under this section shall state the conditions for retention of the license, which shall be reasonable.

(4) A violation of the probation is grounds for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-26-214.5 License lapse and voluntary surrender.

(1)

(a) A license issued under this chapter shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) complete continuing education requirements under Section 31A-26-206 before submitting the license renewal application;

(iii) submit a completed renewal application as required by Section 31A-26-202;

(iv) submit additional documentation required to complete the licensing process as related to a specific license type or license classification; or

(v) maintain an active license in the licensee's home state if the licensee is a nonresident licensee.

(b)

(i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) some other extenuating circumstances, such as long-term medical disability.

(ii) A licensee described in Subsection (1)(b)(i) may request:

(A) reinstatement of the license no later than one year after the day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103;

(III) continuing education requirements; or

(IV) other sanction imposed for failure to comply with renewal procedures.

(2) If a license issued under this chapter is voluntarily surrendered, the license may be reinstated:

(a) during the license period in which it is voluntarily surrendered; and

(b) no later than one year after the day on which the license is voluntarily surrendered.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-26-215 Temporary license -- Appointment of trustee for terminated licensee's business.

(1)

(a) The commissioner may issue a temporary insurance adjuster license:
(i) to a person listed in Subsection (1)(b):
(A) if the commissioner considers that the temporary license is necessary:
(I) for the servicing of an insurance business in the public interest; and
(II) to provide continued service to the insureds who are being serviced in a circumstance described in Subsection (1)(b);
(B) for a period not to exceed 180 days; and
(C) without requiring an examination; or
(ii) in any other circumstance:
(A) if the commissioner considers the public interest will best be served by issuing the temporary license;
(B) for a period not to exceed 180 days; and
(C) without requiring an examination.
(b) The commissioner may issue a temporary insurance producer license in accordance with Subsection (1)(a) to:
(i) the surviving spouse or court-appointed personal representative of a licensed insurance adjuster who dies or acquires a mental or physical disability to allow adequate time for:
(A) the sale of the insurance business owned by the adjuster;
(B) recovery or return of the adjuster to the business; or
(C) the training and licensing of new personnel to operate the adjuster's business;
(ii) to a member or employee of a business entity licensed as an insurance adjuster upon the death or disability of an individual designated in:
(A) the business entity application; or
(B) the license; or
(iii) the designee of a licensed insurance adjuster entering active service in the armed forces of the United States of America.
(2) If a person's license is terminated under Section 31A-26-213, the commissioner may appoint a trustee to provide in the public interest continuing service to the insureds who procured insurance through the person whose license is terminated:
(a) at the request of the person whose license is terminated; or
(b) upon the commissioner's own initiative.
(3) This section does not apply if the deceased or disabled adjuster has not owned or does not own an ownership interest in the accounts and associated expiration lists that were previously serviced by the adjuster.
(4)
(a) A person issued a temporary license under Subsection (1) receives the license and shall perform the duties under the license subject to the commissioner's authority to:
(i) require a temporary licensee to have a suitable sponsor who:
(A) is a licensed producer; and
(B) assumes responsibility for all acts of the temporary licensee; or
(ii) impose other requirements that are:
(A) designed to protect the insureds and the public; and
(B) similar to the condition described in Subsection (4)(a)(i).
(b) A trustee appointed under Subsection (2) shall receive the trustee's appointment and perform the trustee's duties subject to the conditions listed in Subsections (4)(b)(i) through (xv).
(i) A trustee appointed under this section shall be licensed under this chapter to perform the services required by the trustor's clients.

(ii) When possible, the commissioner shall appoint a trustee who is no longer actively engaged on the trustee's own behalf in business as an adjuster.
(iii) The commissioner shall only select a person to act as trustee who is trustworthy and competent to perform the necessary services.
(iv) If the deceased, disabled, or unlicensed person for whom the trustee is acting is an associated adjuster, the insurers through or with which the former adjuster's business was associated shall cooperate with the trustee in allowing the trustee to service the claims associated with or through the insurer.
(v) The trustee shall abide by the terms of any agreement between the former adjuster and the associated insurer, except that terms in those agreements terminating the agreement upon the death, disability, or license termination of the former agent do not bar the trustee from continuing to act under the agreement.
(vi) The commissioner shall set the trustee's compensation which:
(A) may be stated in terms of a percentage of commissions;
(B) shall be equitable; and
(C) paid exclusively from:
(I) the commissions generated by the former adjuster's accounts serviced by the trustee; and
(II) other funds the former adjuster or the former adjuster's successor in interest agree to pay.
(vii) The trustee has no special priority to commissions over the former adjuster's creditors.
(viii) The following may not be held liable for errors or omissions of the former adjuster or the trustee:
(A) the commissioner; or
(B) the state.
(ix) The trustee may not be held liable for errors and omissions that were caused in any material way by the negligence of the former adjuster.
(x) The trustee may be held liable for errors and omissions that arise solely from the trustee's negligence.
(xi) The trustee's compensation level shall be sufficient to allow the trustee to purchase errors and omissions coverage, if that coverage is not provided to the trustee by:
(A) the former adjuster; or
(B) the former adjuster's successor in interest.
(xii) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients, either directly or indirectly.
(xiii) The trustee may not purchase the accounts or expiration lists of the former adjuster, unless the commissioner expressly ratifies the terms of the sale.
(xiv) The commissioner may adopt rules that:
(A) further define the trustee's fiduciary duties; and
(B) explain how the trustee is to carry out the trustee's responsibilities.
(xv) The trust may be terminated by:
(A) the commissioner; or
(B) the person that requested the trust be established.
(c) A person described in Subsection (4)(b)(xv)(B) shall terminate the trust by sending written notice to:
(i) the trustee; and
(ii) the commissioner.
(5)

(a) The commissioner may by order limit the authority of any temporary licensee or trustee in any way considered necessary to protect:
(i) persons being serviced; and
(ii) the public.
(b) The commissioner may by order revoke a temporary license or trustee's appointment if the interest of persons being serviced or the public are endangered.
(c) A temporary license or trustee's appointment may not continue after the owner or personal representative disposes of the business.

Amended by Chapter 366, 2011 General Session

31A-26-216 Portable electronics adjusting.

(1) As used in this section, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of a portable electronics insurance claim that:
(a) may only be used by a Utah licensed independent adjuster, a Utah licensed producer, or an individual supervised as provided in this section;
(b) complies with the claims payment requirements of this title; and
(c) is certified as compliant with this section by a Utah licensed independent adjuster that is an officer of an organization licensed under this chapter.
(2) An individual is exempt from licensure as an adjuster, if the individual for purposes of a portable electronics insurance claim:
(a) collects claim information from, or furnishes claim information to, insureds or claimants;
(b) conducts data entry, including entering data into an automated claims adjudication system;
(c) is an employee of a licensed independent adjuster or its affiliate; and
(d) is one of no more than 25 individuals who are under the supervision of:
(i) a Utah licensed independent adjuster; or
(ii) a Utah licensed producer who is exempt from licensure pursuant to Section 31A-26-201.

Enacted by Chapter 151, 2012 General Session

Part 3
Claim Practices

31A-26-301 Timely payment of claims.

(1)
(a) Unless otherwise provided by law, an insurer shall timely pay every valid insurance claim made by an insured.
(b) By rule the commissioner may prescribe:
(i) the kinds of notice and proof of loss that will establish validity;
(ii) the manner in which an insurer may make a bona fide denial of a claim;
(iii) the periods of time within which payment is required to be made to be timely; and
(iv) the reasonable interest rates to be charged upon late claim payments.
(2)
(a) Notwithstanding Subsection (1) and subject to Subsection (2)(b), the payment of a claim is not overdue during any period in which:

(i) the insurer is unable to pay the claim because there is no recipient legally able to give a valid release for the payment; or
(ii) the insurer is unable to determine who is entitled to receive the payment.
(b) Subsection (2)(a) applies only if the insurer:
(i) promptly notifies the claimant of the inability to pay the claim; and
(ii) offers in good faith to pay the claim promptly when the inability to pay the claim is removed.
(3) This section applies only to a claim for first party benefits made by a person who is:
(a) named or defined as an insured under the terms of an insurance policy;
(b) described as a covered person under the terms of a policy of health care insurance as defined in Section 31A-1-301; or
(c) named, defined, or described:
(i) as:
(A) an insured;
(B) a beneficiary;
(C) a policyholder; or
(D) otherwise covered person; and
(ii) under the terms of:
(A) a life insurance policy; or
(B) an annuity.

Amended by Chapter 309, 2002 General Session

31A-26-301.5 Health care claims practices.
(1)
(a) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for paying for health care services the insured receives.
(b) If a health care service is covered by one or more individual or group health insurance policies, all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies.
(2) A health care provider may:
(a) except as provided in Section 31A-22-610.1, bill and collect for any deductible, copayment, or uncovered service; and
(b) bill an insured for services covered by health insurance policies or otherwise notify the insured of the expenses covered by the policies.
(3) Beginning October 31, 1992, all insurers covering the insured shall notify the insured of payment and the amount of payment made to the health care provider.
(4) A health care provider shall return to an insured any amount the insured overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:
(a) the insured has multiple insurers with whom the health care provider has contracts that cover the insured; and
(b) the health care provider becomes aware that the health care provider has received, for any reason, payment for a claim in an amount greater than the health care provider's contracted rate allows.
(5)
(a) The commissioner shall make rules consistent with this chapter governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process.

(b) These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:
(i) a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed; and
(ii) a prohibition against an implication that the health care provider is charging excessively if the health care provider is:
(A) a participating provider; and
(B) prohibited from balance billing.

Amended by Chapter 203, 2018 General Session

31A-26-301.6 Health care claims practices.
(1) As used in this section:
(a) "Health care provider" means a person licensed to provide health care under:
(i) Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or
(ii) Title 58, Occupations and Professions.
(b) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:
(i) a health maintenance organization; and
(ii) a third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.
(c) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:
(i) an agreement between the insurer and the provider;
(ii) an accident and health insurance policy or contract of the insurer; or
(iii) state or federal law.
(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.
(3)
(a) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall:
(i) pay the claim; or
(ii) deny the claim and provide a written explanation for the denial.
(b)
(i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a) may be extended by 15 days if the insurer:
(A) determines that the extension is necessary due to matters beyond the control of the insurer; and
(B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of:
(I) the circumstances requiring the extension of time; and
(II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.
(ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim:
(A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and

(B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (3)(b)(ii)(A).

(4)

(a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation of the denial.

(b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer:

(i) determines that the extension is necessary due to matters beyond the control of the insurer; and

(ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of:

(A) the circumstances requiring the extension of time; and

(B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the 30-day extension period ends, the insurer:

(i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and

(ii) notifies the insured of:

(A) the circumstances requiring the extension; and

(B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(d) A notice of extension under this Subsection (4) shall specifically explain:

(i) the standards on which entitlement to a benefit is based; and

(ii) the unresolved issues that prevent a decision on the claim.

(e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim:

(i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and

(ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c).

(5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information.

(6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c).

(7)

(a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.
(b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured:
(i) a written explanation of the part of the claim that was denied; and
(ii) notice of the adverse benefit determination review process established under Section 31A-22-629.
(c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26B-3-101, unless required by the Department of Health and Human Services or federal law.

(8)
(a) A late fee shall be imposed on:
(i) an insurer that fails to timely pay a claim in accordance with this section; and
(ii) a provider that fails to timely provide information on a claim in accordance with this section.
(b) The late fee described in Subsection (8)(a) shall be determined by multiplying together:
(i) the total amount of the claim the insurer is obliged to pay;
(ii) the total number of days the response or the payment is late; and
(iii) 0.033% daily interest rate.
(c) Any late fee paid or collected under this Subsection (8) shall be separately identified on the documentation used by the insurer to pay the claim.
(d) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1.

(9) Each insurer shall establish a review process to resolve claims-related disputes between the insurer and providers.

(10) An insurer or person representing an insurer may not engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:
(a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim;
(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;
(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;
(d) failing to maintain a payment process sufficient to comply with this section;
(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;
(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;
(g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;
(h) failing to pay the sum when required and as required under Subsection (8) when a violation has occurred;
(i) threatening to retaliate or actual retaliation against a provider for the provider applying this section;
(j) any material violation of this section; and
(k) any other unfair claim settlement practice established in rule or law.

(11)

(a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.
(b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith insurance claim.
(c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.
(12)
(a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.
(b) The commissioner may adopt rules only as necessary to implement this section.
(c) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.
(d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection (9).
(13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.
(14) Nothing in this section may be construed as limiting the ability of an insurer to:
(a) recover any amount improperly paid to a provider or an insured:
(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;
(ii) within 24 months of the amount improperly paid for a coordination of benefits error;
(iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or
(iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program;
(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;
(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or
(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.
(15) A provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).
(16)
(a) An insurer may offer the remittance of payment through a credit card or other similar arrangement.
(b)
(i) A provider may elect not to receive remittance through a credit card or other similar arrangement.
(ii) An insurer:
(A) shall permit a provider's election described in Subsection (16)(b)(i) to apply to the provider's entire practice;
(B) may not require a provider's election described in Subsection (16)(b)(i) to be made on a patient-by-patient basis; and
(C) shall allow a provider to opt out of all credit card or other similar arrangements for every plan offered by the insurer through a single opt out process.

(iii) If a provider elects not to receive remittance through a credit card or other similar arrangement, that decision remains in effect until:
(A) the provider affirmatively elects to receive remittance through credit card or similar arrangement; or
(B) a new contract is issued.
(c) An insurer may not require a provider or insured to accept remittance through a credit card or other similar arrangement.
(d) An insurer shall allow a tangible check as a form of acceptable payment.

Amended by Chapter 276, 2025 General Session

31A-26-301.7 Dental claim transparency and practices.
(1) As used in this section:
(a) "Bundling" means the practice of combining distinct dental procedures into one procedure for billing purposes.
(b) "Dental plan" means the same as that term is defined in Section 31A-22-646.
(c) "Downcoding" means the adjustment of a claim submitted to a dental plan to a less complex or lower cost procedure code.
(d) "Covered services" means the same as that term is defined in Section 31A-22-646.
(e) "Material change" means a change to:
(i) a dental plan's rules, guidelines, policies, or procedures concerning payment for dental services;
(ii) the general policies of the dental plan that affect a reimbursement paid to providers; or
(iii) the manner by which a dental plan adjudicates and pays a claim for services.
(2) An insurer that contracts or renews a contract with a dental provider shall:
(a) make a copy of the insurer's current dental plan policies available online; and
(b) if requested by a provider, send a copy of the policies to the provider through mail or electronic mail.
(3) Dental policies described in Subsection (2) shall include:
(a) a summary of all material changes made to a dental plan since the policies were last updated;
(b) the downcoding and bundling policies that the insurer reasonably expects to be applied to the dental provider or provider's services as a matter of policy; and
(c) a description of the dental plan's utilization review procedures, including:
(i) a procedure for an enrollee of the dental plan to obtain review of an adverse determination in accordance with Section 31A-22-629; and
(ii) a statement of a provider's rights and responsibilities regarding the procedures described in Subsection (3)(c)(i).
(4) An insurer may not maintain a dental plan that:
(a) based on the provider's contracted fee for covered services, uses downcoding in a manner that prevents a dental provider from collecting the contracted fee for the actual service performed from either the plan or the patient;
(b) uses bundling in a manner where a procedure code is labeled as nonbillable to the patient unless, under generally accepted practice standards, the procedure code is for a procedure that may be provided in conjunction with another procedure;
(c) does not allow a dental provider to seek payment of the contracted fee for a covered service from the patient when the insurer denies payment for the service, unless under generally accepted practice standards, the service performed should not be billed; or
(d) beginning January 1, 2026, automatically recoups an overpayment unless:

(i) the recoupment occurs more than 60 days from the day the insurer sends a notice of the overpayment; or
(ii) the dental provider affirmatively elects to have recoupment occur earlier than 60 days from the day the insurer sends a notice of the overpayment.

(5)
(a) An insurer shall ensure that an explanation of benefits for a dental plan includes the reason for any downcoding or bundling result.
(b) A dental provider who receives an overpayment from a dental plan shall return the amount of the overpayment through check or other means to the dental plan within 60 days from the day the insurer sends a notice of the overpayment.
(c) A dental provider shall make reasonable efforts to inform patients of services that may not be covered by the patient's dental plan if the dental provider will perform a service that may not be covered.

Amended by Chapter 276, 2025 General Session

31A-26-302 Settlement of claims in credit life and accident and health insurance.

(1) The creditor shall promptly report all claims to the insurer or its designated claim representative. The insurer shall maintain adequate claims files. All claims shall be settled as soon as possible in accordance with the terms of the insurance contract.
(2) The insurer shall pay all claims either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of that claimant to another.
(3) A person other than the insurer or its designated claim representative may not settle or adjust claims. The creditor may not be designated as a claims representative.

Amended by Chapter 116, 2001 General Session

31A-26-303 Unfair claim settlement practices.

(1) No insurer or person representing an insurer may engage in any unfair claim settlement practice under Subsections (2), (3), and (4).
(2) Each of the following acts is an unfair claim settlement practice:
(a) knowingly misrepresenting material facts or the contents of insurance policy provisions at issue in connection with a claim under an insurance contract; however, this provision does not include the failure to disclose information;
(b) attempting to use a policy application which was altered by the insurer without notice to, or knowledge, or consent of, the insured as the basis for settling or refusing to settle a claim; or
(c) failing to settle a claim promptly under one portion of the insurance policy coverage, where liability and the amount of loss are reasonably clear, in order to influence settlements under other portions of the insurance policy coverage, but this Subsection (2)(c) applies only to claims made by persons in direct privity of contract with the insurer.
(3) Each of the following is an unfair claim settlement practice if committed or performed with such frequency as to indicate a general business practice by an insurer or persons representing an insurer:
(a) failing to acknowledge and act promptly upon communications about claims under insurance policies;
(b) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims under insurance policies;

(c) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by those insureds when the amounts claimed were reasonably near to the amounts recovered;
(d) failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment was made;
(e) failing to promptly provide to the insured a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement;
(f) appealing from substantially all arbitration awards in favor of insureds for the purpose of compelling them to accept settlements or compromises for less than the amount awarded in arbitration;
(g) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms which contain substantially the same information; or
(h) not attempting in good faith to effectuate a prompt, fair, and equitable settlement of claims in which liability is reasonably clear.
(4) The commissioner may define by rule, acts or general business practices which are unfair claim settlement practices, after a finding that those practices are misleading, deceptive, unfairly discriminatory, overreaching, or an unreasonable restraint on competition.
(5) This section does not create any private cause of action.

Amended by Chapter 91, 1987 General Session

31A-26-304 Prohibition of conflicting roles.

A person licensed concurrently as both an independent and a public adjuster may not represent both the insurer and the insured in the same transaction.

Enacted by Chapter 242, 1985 General Session

31A-26-305 Request for accepted check.

If an insurance policy claimant entitled to receive money in settlement of a claim makes a timely request to the insurer for payment by accepted check, the insurer shall make payment to the claimant with a check accepted by the drawee under Sections 70A-3-410 through 70A-3-413.

Amended by Chapter 204, 1986 General Session

31A-26-306 Place of business -- Records.

(1)
(a) An insurance adjuster licensed under this chapter shall register and maintain with the commissioner:
(i) the address and telephone number of the licensee's principal place of business;
(ii) a valid business email address at which the commissioner may contact the licensee; and
(iii) if the licensee is an individual, the licensee's residence address and telephone number.
(b) A licensee shall notify the commissioner within 30 days of a change in one of the following required to be registered under Subsection (1)(a):
(i) an address;
(ii) a telephone number; or
(iii) a business email address.

(2) Except as provided under Subsection (3), an insurance adjuster shall keep at the address registered under Subsection (1), a record of the transactions consummated under the insurance adjuster's license, including a record of:
(a) each investigation or adjustment undertaken or consummated; and
(b) a fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment.
(3) Subsection (2) is satisfied if the records specified in Subsection (2) can be obtained immediately from a central storage place elsewhere by on-line computer terminals located at the registered address.
(4)
(a) A record maintained as to a transaction under Subsection (2) shall be kept available for the inspection of the commissioner during all business hours for a period of time after the date of the transaction specified by the commissioner by rule, but in no case for less than the current calendar year plus three years.
(b) Discarding a record after the then applicable record retention period is passed does not place the licensee in violation of a later-adopted longer record retention period.

Amended by Chapter 284, 2011 General Session

31A-26-307 Claim reports to commissioner.

On the commissioner's request, any insurer or licensed adjuster connected with a loss or claim shall report to the commissioner all facts relative to the loss or claim arising under any insurance contract covering a subject of insurance that is resident, located, or to be performed in this state.

Enacted by Chapter 242, 1985 General Session

31A-26-308 Settlement of liability insurance claim not admission of liability.

No settlement or partial settlement of a claim against any insured under a liability insurance policy is an admission, by either the insured or the insurer, of the liability of the insured on any claim arising from the same event or set of facts, whether the settlement is made by the insured, the insurer, or any other person on behalf of the insured or the insurer.

Enacted by Chapter 242, 1985 General Session

31A-26-309 Adjuster's duty to report illegal insurance.

Section 31A-15-110 applies to the adjuster's duty to report illegal insurance.

Enacted by Chapter 242, 1985 General Session

31A-26-310 Compensation of insurer's or insured's claims adjuster.

(1)
(a) Except as provided in Subsection (2), an insurer or an insured may not pay a person who is representing the insurer or insured in connection with an insurance claim adjustment on any basis that is dependent, in whole or in part, upon the amounts paid an insured or claimant under an insurance policy.
(b) Subsection (1)(a) includes payments to:
(i) an employee of:
(A) the insurer; or

(B) the insured;
(ii) an independent contractor; or
(iii) a public adjuster.
(2) Subsection (1) does not prohibit a compensation arrangement:
(a) based upon the overall profitability of the insurer;
(b) based upon the discovery or proof of fraudulent insurance claims; or
(c) conforming to an order or rule of the commissioner that addresses the compensation of persons engaged in insurance adjusting on behalf of:
(i) an insurer; or
(ii) an insured.

Amended by Chapter 252, 2003 General Session

31A-26-311 Rescission of contracts with public adjusters.
(1) Except as provided in Subsection (2), an insured or claimant under an insurance policy who contracts with a public adjuster to assist in the settlement of a claim may rescind that contract by delivering written notice of rescission to the public adjuster within 10 days of entering into the contract.
(2) Subsection (1) does not apply if prior to the rescission the public adjuster has effected an acceptable settlement of the claim.

Enacted by Chapter 204, 1986 General Session

31A-26-312 Prohibited conduct.
(1) An independent adjuster or public adjuster may not:
(a) participate directly or indirectly in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the independent adjuster or public adjuster;
(b) engage in any other activities that may reasonably be construed as presenting a conflict of interest, including soliciting or accepting remuneration from, or having a financial interest in, or deriving any direct or indirect financial benefit from, a salvage firm, repair firm, construction firm, or other firm that obtains business in connection with a claim that the independent adjuster or public adjuster has a contract or agreement to adjust;
(c) subject to Subsection (2), directly or indirectly solicit employment for an attorney or enter into a contract with an insured for the primary purpose of referring an insured to an attorney and without actually performing the services customarily provided by an independent adjuster or public adjuster;
(d) act on behalf of an attorney in having an insured sign an attorney representation agreement; or
(e) accept a fee, commission, or other valuable consideration of any nature, regardless of form or amount, in exchange for the referral by an independent adjuster or public adjuster of an insured to a third-party person, including an attorney, appraiser, umpire, construction company, contractor, repair firm, or salvage company.
(2) Subsection (1)(c) may not be construed to prohibit an independent adjuster or public adjuster from recommending a specific attorney to an insured.
(3) An independent adjuster or public adjuster who violates this section is subject to Section 31A-2-308.

Enacted by Chapter 168, 2017 General Session

31A-26-313 Health care collection actions -- Notification required.

(1) As used in this section:

(a)

(i) "Collection action" means any action taken to recover funds that are past due or accounts that are in default:

(A) for health care services; and

(B) that directly results in an adverse report to a credit bureau.

(ii) "Collection action" includes using the services of a collection agency to engage in collection action.

(iii) "Collection action" does not include:

(A) billing or invoicing for funds that are not past due or accounts that are not in default; or

(B) providing the notice required in this section.

(b) "Credit bureau" means a consumer reporting agency as defined in 15 U.S.C. Sec. 1681a.

(c) "Text message" means a real time or near real time message that consists of text and is transmitted to a device identified by a telephone number.

(2)

(a) Before engaging in a collection action, a health care provider:

(i) shall, after the day on which the period of time for an insurer to pay or deny a claim without penalty, described in Section 31A-26-301.6, expires, send a notice described in Subsection (3) to the insured by certified mail with return receipt requested, priority mail, first class mail, email, or text message; and

(ii) for a Medicare beneficiary or retiree 65 years of age or older, shall, after the date that Medicare determines Medicare's liability for the claim, send a notice described in Subsection (3) to the insured by certified mail with return receipt requested, priority mail, first class mail, or text message.

(b) A health care provider may not engage in a collection action before the date described in Subsection (3)(b) for that collection action.

(3) The notice described in Subsection (2)(a) shall state:

(a) the amount that the insured owes;

(b) the date by which the insured must pay the amount owed that is:

(i) at least 45 days after the day on which the health care provider sends the notice; or

(ii) if the insured is a Medicare beneficiary or retiree 65 years of age or older, at least 60 days after the day on which the health care provider sends the notice;

(c) that if the insured fails to timely pay the amount owed, the health care provider or a third party may make a report to a credit bureau or use the services of a collection agency; and

(d) that each action described in Subsection (3)(c) may negatively impact the insured's credit score.

(4) A health care provider is not subject to the requirements described in Subsection (2) if the health care provider complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.

(5) A health care provider that contracts with a third party to engage in a collection action is not subject to the requirements described in Subsection (2) if:

(a) entering into the contract does not require a report to a credit bureau by either the health care provider or the third party; and

(b) the third party agrees to provide the notice in accordance with Subsection (2) before the third party may engage in any activity that directly results in a report to a credit bureau.

(6) If a third party fails to comply with the notice requirements described in this section, the health care provider that renders the health care service is liable for any penalty resulting from the noncompliance of the third party.

Amended by Chapter 321, 2019 General Session

Part 4
Public Adjusters

31A-26-401 Required contracts.

(1) A public adjuster may not, directly or indirectly, act within this state as a public adjuster without having first entered into a contract, in writing, on a form filed with the department in accordance with Section 31A-21-201, executed in duplicate by the public adjuster and the insured or the insured's duly authorized representative. A public adjuster may not use a form of contract that is not filed with the department.

(2) A contract described in Subsection (1) is subject to recision in accordance with Section 31A-26-311.

(3)

(a) A contract described in Subsection (1) shall include a prominently displayed notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY."

(b) The commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, may require additional prominently displayed notice requirements in the contract as the commissioner considers necessary.

(4) A public adjuster shall keep at the public adjuster's principal place of business a copy of each contract entered into in this state for the current year plus three years, and each contract shall be available at all times for inspection, without notice, by the commissioner or the commissioner's authorized representative.

(5) A public adjuster may not enter into a contract with an insured and collect compensation as provided in the contract without actually performing the services customarily provided by a licensed public adjuster for the insured.

Enacted by Chapter 168, 2017 General Session

31A-26-402 Compensation.

(1) Except as provided by Subsection (2), a public adjuster may receive compensation for service provided under this chapter consisting of an hourly fee, a flat rate, a percentage of the total amount paid by an insurer to resolve a claim, or another method of compensation.

(2)

(a) A public adjuster may not receive a compensation consisting of a percentage of the total amount paid by an insurer to resolve a claim on a claim on which the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy.

(b) A public adjuster is entitled to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim that is subject to this Subsection (2) and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(3) Except for the payment of compensation by the insured, a person paying proceeds of a policy of insurance or making a payment affecting an insured's rights under a policy of insurance shall:
(a) include the insured as a payee on the payment draft or check; and
(b) require the written signature and endorsement of the insured on the payment draft or check.
(4) A public adjuster may not accept any payment that violates this section notwithstanding whether the insured gives authorization to the public adjuster. A public adjuster may not sign and endorse any payment draft or check on behalf of an insured.

Enacted by Chapter 168, 2017 General Session

31A-26-403 Rulemaking.

The commissioner may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:
(1) addressing the forms required by this part;
(2) providing for notice requirements in contracts; and
(3) establishing the scope of a contract a public adjuster enters into with an insured that the public adjuster represents.

Enacted by Chapter 168, 2017 General Session